New Hampshire
Department of Health and Human Services

Building Capacity for Transformation Waiver

Integrated Delivery Network

Semi-Annual Report

(July – December 2018)

Network4Health (IDN 4)

April 3, 2019

Table of Contents

1.	**Project Plan Implementation Narrative**	**4**
2.	**Project A1: Behavioral Health Workforce Capacity Development**	**17**
a.	Narrative Response	17
b.	Fundamentals of Management Course - Survey Results (Attachment_A1.3a)	35
c.	Workforce Wednesday Newsletter Sample (Attachment_A1.3b)	42
d.	Project Plan (Attachment_A1.3c)	53
3.	**Project A2: IDN Health Information Technology (HIT) to Support Integration**	**58**
a.	Narrative Response	58
b.	Project Plan (Attachment_A2.3a)	69
c.	HIT Partner Accomplishments (Attachment_A2.3b)	72
4.	**Project B1: Integrated Healthcare**	**74**
a.	Narrative Response	74
b.	Coordinated Care Project Plan (Attachment_B1.2a)	124
c.	Integrated Care Project Plan (Attachment_B1.2b)	128
d.	CCSA Partner Status (Attachment_B1.8a)	132
e.	Training Plan (Attachment_B1.8c)	133
f.	Integrating Healthcare Delivery – Recommended Protocols and Best Practices (Attachment_B1.8h)	135
g.	MAT Best Practices (Attachment_B1.9b1)	171
h.	Institute for Clinical Systems Improvement: Depression in Primary Care (Attachment_B1.9b2)	245
i.	Health Care for the Homeless (HCH) Referral Tracking Policy (Attachment_B1.9d1)	377
j.	HCHC Process for Tracking Referrals (Attachment_B1.9d2)	382
k.	CCSA Workflow (Attachment_B1.9d3)	384
l.	MCHC Workflow for the Completion of CCSA (Attachment_B1.9d4)	389
m.	Coordinated Care and Integrated Care Partner Status (Attachment_B1.10)	392
5.	**Projects C: Care Transitions-Focused**	**393**
a.	Narrative Response	393
b.	Project Plan (Attachment_C1.1)	403
6.	**Projects D: Capacity Building Focused**	**412**
a.	Narrative Response	412
b.	Project Plan (Attachment_D3.1)	429

7. Projects E: Integration Focused **438**

a. Narrative Response 438

b. ITCOD Newsletter (Attachment_E4.1a) 476

c. Project Plan (Attachment_E4.1b) 481

d. Recommended Protocols (Attachment_E4.7) 487

e. Training Participants (Attachment_E4.9) 506

8. APM Implementation Planning **516**

a. Narrative Response 516

Project Plan Implementation Narrative

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

Network4Health has continued to make significant progress during the period from July 1, 2018 to December 31, 2018. Activities designed to operationalize the Network4Health project plans are well underway as described in the following sections of this Semi-Annual Report. Significant progress has been made in all the statewide and local projects over the past six months. Highlights include:

- The opening of the Partial Hospitalization Program opened in October 2018 at the Elliot Hospital with a capacity of 12 clients. As described in detail in our reporting on project D3, to date they have successfully managed nearly 50 referrals.
- Through our A1 Workforce project, new and/or enhanced partnerships have been established with colleges and programs within among our partner organizations such as: the Intensive Transition Team at the Mental Health Center of Greater Manchester and the Manchester Community Health Center (MCHC); IC Cohort 2 practices from Healthcare for the Homeless (HCH), Center for Life Management (CLM), Elliot Health System (EHS), Fusion Health Services and Families in Transition (FIT). A number of staff positions have been posted and filled to advance the Integrated Enhancement Plans (IEPs) that are in place for integrated care, for the B1 Integrated Care project.
- Through our A2 project, several technology enhancements are now operational and allow for improved communication and management of our patients, i.e. event notification, core comprehensive assessments for the social determinants of health and sharing of data with partners and the state.

The regional public health networks continue to engage our communities by facilitating information sessions throughout our region. Presently plans are in place to more actively engage our business communities by offering a three part series on the “Opioid Crisis” for the Manchester Chamber of Commerce. Topics include are “Understanding Addiction”, “Addiction Treatment and Recovery”, and “Role of the Business Community in the Addiction Epidemic”.

The recent funding uncertainty, related to ongoing negotiations between NH Department of Health and Human Services (DHHS) and NH counties, has raised concerns among our network partners. In particular, partners have raised questions and concerns about hiring planned new staff at a time when continued waiver funding is unresolved. Network4Health is dedicated to working with the NH DHHS to meet the established waiver goals and objectives. However, any funding decreases will necessitate a reevaluation of all project priorities and may require modifications to project plans.

Soliciting Community Input

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

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

Community engagement sessions- South Central and Greater Manchester Community Outreach Coordinators participated in facilitating "focus group" type sessions with stakeholders and consumers. Between July 2018 and December 31, 2018 Network4Health, in collaboration with the South Central and Greater Manchester Public Health Networks, conducted a total of 8 community engagement sessions. Groups were held in the following locations with 65 total participants:

a. 1269 Cafe (7 participants) Manchester, NH
b. Hope for NH Recovery (6 participants) Manchester, NH
c. Farnum Center (2 groups, 1 male group and 1 female group totaling 35 participants) Manchester, NH
d. Cypress Center (2 participants) Manchester, NH
e. Families Advocating Substance Treatment, Education, and Recovery (FASTER) (5 participants) Derry, NH
f. Partial Hospitalization Program at Parkland (7 participants) Derry, NH
g. Parenting a Second Time Around (PASTA) (3 participants) Danville, NH

A set of vetted questions have been utilized to determine changes over past year and continued challenges and barriers from both stakeholders and a client perspective.- The specific questions include:

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

This qualitative data has proven invaluable to our work and helps us to answer the question 'why' when we look at quantitative data sources and identify gaps.÷ Much of what is reported from this set of focus groups is very consistent with the previous groups. The following participant comments have been organized according to common themes that have been observed by group facilitators.

CARE:

- High cost of care and wait times/ contact problems.
- Inconsistencies in insurance coverage and practices willing to accept all insurance plans. Healthcare gaps - between Medicaid and paying for own - high co pays "Our heads need to be the priority not what's in our pockets."
- Long waits for care in general, inpatient beds, and for community mental health services.
- Not enough help for patients to get/keep insurance [Medicaid].
- Not enough staff (clinicians, social workers, etc.) High turnover.

- Long stays at a hospital while waiting for an inpatient bed.
- Lack of coordinated care.
- Not all facilities claiming to be able to treat dual diagnosis have the skills to do so. Facilities vary in the ability to provide consistent care for patients with SUD – "Hospitals wouldn't allow for detox." "Hospitals would only allow alcohol detox." Nursing staff threaten patients when they are seen as uncooperative. ED staff lecture patients/family members. Dehumanize patient.
- Oral health is a gap.
- Lack of follow up services especially after discharge from the hospital or service.
- Patients are turned away from hospitals when asking for help.

STIGMA & MENTAL HEALTH:

- Mental health stigma at ER - perceived feelings of being treated poorly.
- Stigma still exists and makes it difficult to access services. Stigma can be especially difficult for people of different cultures.
- Homeless patients are treated differently. Reporting that their medical needs are not being taken seriously.
- Stigma evident among providers once the individual is identified as having a SUD, been incarcerated or has overdosed.
- Mental illness prejudice at primary care providers (PCP).
- Some PCP's think that individuals with mental illness is just drug seeking. Private practices are denying people with severe mental illness and being turned away.
- People leave PCP because of negative comments about MH.
- Hospitals and nursing staff are the first places/people to judge patients.

INTEGRATION:

- You must do all the coordination work on your own.
- Wait times during care transition.
- Lack of places to get sober during transitions.
- There was no follow-up from hospital after discharge. Not enough communication from hospital about discharge plan.
- There is a lack of communication between services: hospital diagnosis didn't make it to mental health center.
- Difficulty in getting providers to work cooperatively especially when a patient has a co-occurring medical /behavioral health issue.
- Lack of support for people with a mental health illness.
- Parents are not allowed to advocate for adult children or participate in the care when the adult child is not able to do so for him/herself.

OTHER:

- Medicaid not easy to navigate through the system to access needed care.
- Not aware of Medicaid changes. No one in the room reported knowing about the new work requirements.
- Housing, i.e. dry shelter for people in recovery.

- Community re-entry supports are minimal to non-existent.
- Lack of understanding of Harm Reduction approach to care.
- Challenges accessing Medication Assisted treatment (MAT).
- Access to health insurance, esp. for families with children. "Unable to get support from the state."
- Need to provide education on mental health evaluation and bias training to for providers and law enforcement.
- Shelters have too many rules and punitive approach. "They listen, but they do not hear."
- State guidelines for obtaining services need to be re-evaluated to include the role of grandparents.
- No Section 8 housing.
- Lack of discharge planning for a patient being discharged after receiving Narcan.

SUCCESSES

- Places with child care work great (e.g., FIT).
- Positive moves in services and technology.
- There has been an increase in hospitals wanting to hire individuals in recovery so they can both better educate the other staff and relate to the patients coming in with substance misuse disorders.
- Parkland has opened their behavioral health wing.
- Community Narcan trainings are happening.
- Safe Station is working.
- Positive praise for the roles of Case Managers and Transitions teams.
- Drug court extremely helpful. Helped get Medicaid that covers healthcare costs.
- Psychiatrists are excellent, just overworked.
- Outpatient programs.
- There has been a change in language from "junkie" to "person suffering from SUD."
- More people are being open about family misuse.
- Parenting A Second Time Around (PASTA) groups are starting.
- 211 as a centralized access point for SUD resources.

Greater Manchester Happenings:

1. **EmpowerYOU Community Learning Series** – July was the last session of the learning series. The sessions were free, open to the public, required no registration. Sessions were held in a local art gallery and were presented by trusted community partners. For each session we also recorded a podcast with the presenter to reach a wider audience. We created a "10 things you can do" sheet for each presentation to share widely on social media and other platforms to help empower our community members to be a part of the solution. Podcasts and 10 things handouts can all be found at www.makinithappen.org

2. During December the **Continuum of Care** (CoC) worked with the Chamber of Commerce to plan member led sessions for 2019 to reach the business community.

3. **Manchester Safe Station** – The Greater Manchester Community Outreach Coordinator helps to coordinate community meetings for the Safe Station program. This has included a data workgroup that has created a unique identifier that is both HIPPA and CFR 42 part 2 compliant

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

4. The Community Outreach Coordinator also facilitates the **Greater Manchester SUD Collaborative** - the Collaborative is a group of providers across healthcare, prevention, intervention, treatment and recovery. The group is largely on the ground providers working in day to day delivery of direct services. This group follows Safe Station and Network4Health updates each month to understand changes, challenges and progress. This group works to identify gaps, needs and barriers for their clients, themselves and their organizations and looks to find creative solutions. The group met six times between July-December. Participants self-report that they are more likely to understand the quickly changing SUD landscape because of their attendance and that they are more likely to make referrals to providers whom they have met and seen the facility. Already many providers have developed relationships with each other through this collaborative.

   The Collaborative has formed several workgroups around prevention, treatment and recovery. These workgroups meet as often as needed. During the reporting period, the treatment workgroup has been focused on creating a SUD Data dashboard across the continuum. Shared data with partners helps us to identify priority need and to invest time and resources appropriately and make data driven decisions. Over time the Collaborative hopes to build out the dashboard to assist in results based accountability. Program measures should map up to impact health indicators.

5. **Youth Collaborative** - The SUD Collaborative has continued to grow and the need arose for a separate youth focused collaborative. This group includes youth serving providers in prevention, intervention, treatment, recovery, and healthcare. Office of Youth Services, Manchester School District SAPs, NH Healthy Families, Beacon, NH Children Behavioral Health Collaborative, Manchester Public Library, Manchester Health Department, DCYF, are examples of attendees. This group met 6 times between July-December.

6. **Overdose Prevention and Response Pilot Project,** with the Centers for Disease Control (CDC), The National Association for County and City Health Officials (NACCHO) and The National Resource Center for Academic Detailing (NaRCAD), included a written ~~a~~ community action plan and ongoing work with Academic Detailers. Manchester received year two funding for opioid safety in partnership with the CDC, NACCHO, and NaRCAD. Last year, Manchester was selected as one of 4 pilot sites across the country as part of this project, and received special funding to implement new strategies across the community to improve outcomes for patients who use opioids. The City was awarded a second year of funding to expand on this project. In partnership

with the Manchester Health Department, representatives from CMC, EHS, and Network4Health were trained in Academic Detailing and are focused on 8 key messages: (1) Offer Treatment for Opioid Use Disorder (OUD), including MAT, (2) Get Waivered to Prescribe Suboxone, (3) Use Non-Opioid Treatment, (4) If Opioids Must be Prescribed, Start Low, (5) Review the State Prescription Drug Monitoring Program (PDMP), (6) Behavioral Health Services, (7) Stigma Around Medication Assisted Treatment (MAT) and SUD Treatments, (8) Knowing where to refer. The 5 academic detailers in our region conducted 51 visits this quarter. This pilot project also required each of the four project sites to complete a community action plan focused on overdose prevention and response. The Network4Health Community Outreach Coordinator has been very involved to the implementation of this project including on detailer check-in calls and co-authoring the community action plan. Continuum of Care (CoC) will continue involvement in the year two planning and implementation.

7. Manchester submitted an application to the National League of Cities and was selected as one of six cities across the nation to send a team to the **Mayor's Opioid Institute**. The Manchester team traveled to Nashville in December 2018 to attend a second gathering of these cohorts from across the country. The team included Mayor [redacted], Community Outreach Coordinator [redacted], Fire Chief [redacted] and [redacted], the Mayor's Policy Advisor. Health Director [redacted] is also on the team but was unable to attend the Nashville trip. This institute helped the city team to frame current efforts, receive feedback, and learn about other communities' approaches to addressing addiction in their communities. A core faculty of experts were in attendance as well as philanthropic organizations. The city continues to engage in a 12-month technical assistance period with the institute which allows the team to utilize experts from around the country to help advice our efforts.

8. **Mobile Crisis SOR Grant** – Network4Health submitted a letter of support for a Mental Health Center of Greater Manchester grant application. The Community Outreach Coordination and other Network4Health staff attended a partner planning session for this grant and provided data to support the application as well.

9. The Network4Health Community Outreach Coordinator is a **NH Providers Association** board member. The provider's association represents alcohol and other drug service providers in New Hampshire through public policy, leadership, professional development, and quality member services.

10. The Community Outreach Coordinator is participating in **Leadership Greater Manchester** class of 2018 - 2019. This program has an excellent reputation for expanding knowledge of the resources and assets in the region as well as the greatest challenges and creating lasting connections across public, non-profit and business sectors. The program began with a retreat in September and has class days monthly. Since September the class has covered Chamber 101, History Day, Economic Development Day and Education Day.

11. **States Opioid Response (SOR) partner meetings:** Manchester hosted several partner meetings to help providers talk through challenges and prioritize efforts to best utilize potential state

funding. The City of Manchester submitted written public comment and [redacted] (in his former role as Health Director for the City) presented this at the public comment session in Concord.

Additional partner discussions over the past six months have included the development of a citywide data dashboard, technology solutions, implementation of hub and spoke model in our region, assessing sustainability of youth diversion program locally, investigating harm reduction strategies including syringe services, suicide prevention, and youth risk behavior survey trend data.

South Central Happenings:

1. **South Central Leadership group** - The South Central Regional Public Health Network Leadership Team met twice during the reporting period. The meetings were held on September 12th in Plaistow with 13 participants and on November 14th with 18 participants. Topics for meetings included the Young Adult Strategies program at the Upper Room, the Recovery Friendly Workplace initiative, Marijuana Policy (with assistance from New Futures), the upcoming open of the Hub and Spoke Model (Doorway NH), and time for cross-sharing. These meetings will continue to happen on a Bi-Monthly basis as weather allows.

2. **Mental health taskforce** – Dr. [redacted], a pediatrician at Londonderry Pediatrics, first began this group because of the strong response that was given for an event held in Derry. This event was held at one of the schools in Derry and included [redacted] speaking on his experiences. From this, Dr. [redacted] pulled together some of the participants from this event (Parkland Medical Center, Community Alliance for Teen Safety, Center for Life Management, and Hampstead Hospital) to create a taskforce of sorts to continue the conversation of who mental health services could be improved. Several other people have joined in since the first meeting including the Derry Town Council, Network4Health and the public health network. The first meeting was held in April and has continued monthly. There are usually twelve- fifteen people who come to each meeting. Much of the conversation has been centered on gaps and what some organizations are doing to combat that. At each meeting there is a guest speaker presenting on what their organizations can offer to help citizens struggling with mental health illnesses.

3. **Vaping 101 event-** in collaboration with Stand Up Salem. The Network4Health Community Outreach Coordinator led the planning committee to bring [redacted] from New England Poison Control to Salem High School for an informative event about vaping. The topics were where these products can be bought, what parents should look for as signs of youth use, and the dangers of using these products. There were 70 people present for the presentation. To increase its reach, it was also recorded and aired on the local public access channel and sent out to the parents of youth in the Salem School District.

4. **Addiction and the Brain Community Education-** The Network4Health Community Outreach Coordinator worked with [redacted] from Addiction Recovery Services to-provide a community education program focused on the role the brain plays in addiction. The event was hosted by the Plaistow Public Library. - [redacted] outlined what addiction is, how it can occur, and the role that

the brain plays in this process. He kept the neurology to the basics and left the participants with easy to understand information.

5. **Hub Accessing Meetings**- The Network4Health Community Outreach Coordinator brought [redacted] from Granite Pathways down to the region to host meetings explaining the new hub model to area stakeholders. This came about from the confusion among stakeholders about the new system. Three meetings were held in order to meet people where they are. One meeting was held in Plaistow with six participants, one was held in Salem with three participants, and one was held in Derry with eighteen participants. All meetings included an overview PowerPoint of the hub and spoke model, what services are going to be offered at the hub, and time for questions and answers. These meetings are likely to continue as there is still much left unanswered.

Public Awareness:

Network4Health continues to operate a **YouTube channel** that includes 7 videos describing Nework4Health and the six projects that have been implemented. We also continue to utilize social media through Facebook and Twitter.

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

- incorporating google translate to allow for translation to languages other than English;
- adding an activities calendar linking to both future and past events and links to all supporting documents or registrations;
- adding project pages with full project content and detail;
- adding staff bios, and a back-end employee site;
- including community outreach content and sound and video;
- improving partner links, search ability and contact us functionality; and,
- updating URL to support availability.

The website is continuously reviewed and will be updated as needed.

Network Development

Network4Health held its quarterly all network partners meetings in September and December 2018. Our September meeting included brief updates on implementation progress of the projects and a featured presentation by Mayor [redacted] on new and ongoing initiatives within the city of Manchester to address the opioid crisis. The mayor stressed the need for a collaborative and unified approach to addressing this crisis. She congratulated Network4Health for taking a lead role as a collaborator and community organizer in bringing key partners together with a unified approach to better care for patients and families experiencing behavioral health issues.

At the December meeting, Dr. [redacted] presented "Partnering for Community Wellness – Using Relational Coordination to Achieve Success" Dr. [redacted], is a professor of management at Brandeis University's Heller School for Social Policy and Management and an award winning author of High Performance Healthcare: Using the Power of Relationships to achieve Quality, Efficiency and Resilience.

In addition, several network partners provided updates including:

- Granite Pathways designation as the regional HUB for Greater Manchester and Nashua which is a key element of the planned NH Hub and Spoke Model to begin in January 2019. Granite Pathways will provide an implementation update at our March all partners meeting.
- The Partial Hospitalization Program at the Elliot has opened and is fully staffed.
- Pastoral Counseling Services noted that without the support of Network4Health, they would not be able to support the supervisory time necessary to advance three of their counseling staff in working to obtain a MLADC.
- On the Road to Wellness, a peer support agency, has relocated to 377 South Willow St.

Addressing the Opioid Crisis

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

Governance

The Network4Health Steering Committee met monthly throughout the reporting period and continues to provide oversight of project plan development, implementation and budgeting. There have been no changes in participating network partners. The Steering Committee has authorized the following changes in membership: [redacted], Hillsborough County Administrator, has replaced [redacted], Hillsborough County Commissioner. [redacted], Public Health Director for the City of Manchester, has replaced [redacted]. [redacted], President and CEO Mental Health Center of Greater Manchester, has been added as a voting member. [redacted], who retired from the City of Manchester Health Department, is now the Executive Director, Community Health & Mission at Catholic Medical Center. He has replaced [redacted] representing CMC as a non-voting member of the steering committee. [redacted] has been approved to work in a consultative role for Network4Health reporting to [redacted].

During the reporting period, the Steering Committee has dedicated significant time to discussing and planning for the sustainability of Network4Health and its projects following the termination of the NH Transformation Waiver. This effort has is being guided by our lead consultant at Bailit Health. The Steering Committee is supportive of capitalizing on the improved collaborations and communication amongst key community, health care and social service agencies that has been experienced. An ad hoc Strategic Planning subcommittee was formed to further investigate sustainability options for Network4Health and it met bi-weekly from October through December. An update has been provided to the full Steering Committee and continued planning will occur during the next six months. The release of the new NH Mental Health 10 Year Plan and the selection of Medicaid Care Organizations will be important considerations as we continue our sustainability planning.

Monitoring Progress

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

Implementation Activity/Milestone: Community Input	Responsible Party/Organization	Timeline	Progress Measure/Notes
In partnership with the Greater Manchester and South Central Regional Public Health Networks, Network4Health will coordinated and participate in community/ organizational meetings to elicit community input and engagement.	N4H Executive Director/N4H Community Outreach Coordinators	Attend 6 outreach meeting over the six month reporting period.	8 Community engagement sessions have been held during the reporting period. Results are summarized in the Soliciting Community Input section of this report.
Implementation Activity/Milestone: Network Development	Responsible Party/Organization	Timeline	Progress Measure/Notes
Continue to consider whether new partners should be invited to join Network4Health	N4H Executive Director	Quarterly	Quarterly review of partners and potential for new members. No new partners have been added to our Network. We continue to network with organizations in our network in an effort to enhance integrated care to our identified population. i.e. Brain Injury Association of New Hampshire (BIANH). Organizational members have changed secondary to position changes and needs of our partner organizations (see the governance section for details)
Hold quarterly all partner meetings	N4H Executive Director	Quarterly	Quarterly all partner meetings were held in September and December (see Project Plan Narrative for additional information)
Implementation Activity/Milestone: Addressing Opioid Crisis	Responsible Party/Organization	Timeline	Progress Measure/Notes
Participate in ongoing community activities and presentations on the Opioid crisis.	N4H Executive Director, N4H Community Engagement Coordinators, and N4H partner organizations	Quarterly	Network4Health was involved in several activities during the reporting period. Details are provided in the Soliciting Community Input section.

Participate in Continuum of Care Meetings	N4H Executive Director, N4H Community Engagement Coordinators, and N4H partner organizations	Monthly (Greater Manchester) and Quarterly (South Central)	Network4Health was represented at monthly and quarterly meetings by one or more representatives.
Implementation Activity/Milestone: Governance	Responsible Party/Organization	Timeline	Progress Measure/Notes
Hold monthly meetings of the N4H Steering Committee	N4H Executive Director	Monthly	Monthly meetings of the Network4Health Steering Committee were held.

Budget

Network4Health has adopted a fiscally conservative approach to utilization of Project Design and Capacity building funds received in the first year of operation. These funds support the salary and benefits of the Executive Director (1.0 FTE), a newly hired Associate Executive Director (.4 FTE), the Financial Coordinator (1.0 FTE), Project Managers (up to 1.4 FTE), Project Directors for Care Transitions, SUD Expansion PHP and Integrated Treatment of Co-occurring Disorders (up to 3.0 FTE) and Community Outreach Coordinators (up to 1.0 FTE).

Project plan funding continues to emphasize limited administrative overhead and maximum funding directed to impacting patient/client services. However, there are administrative expenses that are planned, budgeted and approved by the Steering Committee. These included but are not limited to consulting support, administrative support for leadership, implementation expenses associated with community engagement, website and other promotional development for the network, among others. As noted above, planned utilization of these funds may also be impacted by the resolution of the ongoing negotiations between NH DHHS and NH counties.

The following budget table reports expenses (actual and projected) for Project Design and Capacity Building Funds (PPI) as well as for all six projects implemented by Network4Health.

Project	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
PPI	**$67,559**	**$523,029**	**$279,933**	**$452,567**	**$1,616,429**	**$1,640,741**	**$636,632**
A1	**$0.00**	**$37,216**	**$79,451**	**$211,139**	**$2,612,987**	**$1,891,028**	**$360,512**
A2	**$0.00**	**$36,268**	**$262,798**	**$450,617**	**$1,543,465**	**$899,279**	**$355,675**
B1	**$0.00**	**$2,800**	**$67,267**	**$560,313**	**$5,039,055**	**$4,067,703**	**$2,146,802**
C	**$0.00**	**$11,121**	**$83,136**	**$167,115**	**$682,950**	**$674,649**	**$238,067**
D	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$2,160,716**	**$1,202,881**	**$638,941**
E	**$0.00**	**$8,329**	**$14,506**	**$51,789**	**$774,078**	**$768,419**	**$239,360**

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

- Community Engagement Coordinators were added beginning in February 2018 due to the discontinuation of the Regional Public Health Network Continuum of Care Coordinator funding. These two individuals have been instrumental in all N4H community engagement efforts. In July, funding for the Community Engagement Coordinators reduced from 2.0 FTE to 1.0 FTE.
- Additional consulting expenses were incurred due to needs in the areas of privacy, data sharing and data reporting.

The Steering Committee Project Team Support line item has been adjusted for purposes of rebalancing our full waiver term projections. Our total Project Design and Capacity Building (PDCB) expense for this reporting period was $452,567. Total invoiced and paid expenses for PDCB since inception is $1,323,081. An adjustment in the prior period expense line for Steering Committee Project Team Support increased the expense from $543 to $19,521 as a result of an invoice relating to disbursement to Network4Health partner, Makin It Happen.

PROJECT DESIGN AND CAPACITY BUILDING	**CY 2016 (Yr1) Actual (7/1/16 to 12/31/16)**	**CY 2017 (Yr2) Actual**	**CY 2018 (Yr3) January to June Actual**	**CY 2018 (Yr3) July to December Actual**	**CY 2019 (Yr4) Projected**	**CY 2020 (Yr5) Projected**	**CY 2021 (Yr6) 1/1/21 to 6/30/21 Projected**
Total Revenue (received in two payments)	$5,216,890						
Rollover		$5,149,331	$4,626,302	$ 4,346,369	$3,893,802	$2,277,373	$636,632
Total Revenue	$5,216,890	$5,149,331	$4,626,302	$4,346,369	$3,893,802	$2,277,373	$636,632
Salary & Benefits- Executive Director (1.0 FTE); Project Management (1.4 FTE); Finance Coordinator (1.0 FTE); Project Directors (3.0 FTE); Comm. Eng. Coordinators (1.0 FTE); Assoc. Exec. Director (.4 FTE)		$473,355	$247,793	$391,572	$810,429	$834,741	$429,892
Consulting							
Bailit Health	$67,559	$40,834	$11,066	$15,841	$45,000	$45,000	$15,000
UNH Law Health Practice & Policy Institute Privacy Consult		$5,500					
Privacy Legal Consult				$2,200			
Total Consulting	$67,559	$46,334	$11,066	$18,041	$45,000	$45,000	$15,000

Steering Committee Project Team Support and other N4H administrative support.		$1,826	$19,521	$38,747	$750,000	$750,000	$186,240
Quarterly Partner Meetings-refreshments		$1,226		$1,973	$6,000	$6,000	$3,000
Miscellaneous Office Supplies		$289	$1,553	$2,234	$5,000	$5,000	$2,500
Total Other		$3,340	$21,074	$42,954	$761,000	$761,000	$191,740
Subtotal	$67,559	$523,029	$279,933	$452,567	$1,616,429	$1,640,741	$636,632
Variation to Budget (Transfer Funds to Subsequent Year)	$5,149,331	$4,626,302	$4,346,369	$ 3,893,802	$2,277,373	$636,632	$0

Project A1: Behavioral Health Workforce Capacity Development

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

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

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

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

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

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

In this section we provide an overview of the significant work and progress that has occurred relative to our workforce development efforts during this reporting period.

Education

Network4Health had several initiatives that have come to fruition and several still underway to increase educational opportunities for behavioral health careers in our area. During this period, Network4Health initiated the following:

Behavioral Health Scholars Program: Manchester Community College

The Network4Health Behavioral Health Scholarship Program was initiated in August for the Fall, 2018 semester. It aims to increase participation and matriculation in behavioral health-oriented degree programs at Manchester Community College in order to increase the behavioral health workforce, and increase awareness of careers in human services and behavioral health. The scholarship supports students currently enrolled in these programs at MCC:

- Associate's Degree in Behavioral Science
- Associate's Degree in Human Services
- Direct Support Services Certificate
- Substance Misuse Prevention Certificate
- Recovery Support Worker Certificate

- Mental Health Support Certificate

Students can be FT or PT, in on-line or traditional programs with a GPA of 2.5 or higher. In addition, we asked that students live or work in a Region 4 town. Students were asked to submit an application, attach a 250 – 350 word essay on why they are choosing a career in behavioral health, and what they plan to do with their education.

$50,000 was allocated to this program for the 2018-2019 academic year, and N4H was prepared to make awards of up to $5,000.00. However, most awards were granted in smaller denominations since many students are receiving other types of financial aid, including scholarships and Pell grants, and the overall costs of community college are comparatively less. The awards given were based on the gap between current scholarship funding and full cost. Network4Health sought to reduce or eliminate the need for students to take out higher interest loans to finance the remainder of their education.

Results: Network4Health Workforce Capacity Funds were awarded to 12 students at Manchester Community College and the total award for fall semester 2018 was $22,000.00. The largest award was for $2,500. The remaining $28,000 is being allotted for the spring semester commencing in January 2019.

Additionally, President [redacted] of MCC publicly recognized and thanked Network4Health for their partnership during a scholarship fundraiser at the college in October.

<u>Behavioral Health Scholars Program: Granite State College</u>

Network4Health pursued a similar agreement with Granite State College to offer a scholarship program to increase participation and matriculation in behavioral health-oriented degree programs, increase the behavioral health workforce, and increase awareness of careers in human services and behavioral health.

Network4Health committed $100,000 to this effort for the 2019 school year. Students will be awarded up to $5,000 per year for full time enrollment, $2,500 for part time enrollment. Preference will be given to full time students. We will be looking to support students currently enrolled in these following programs:

- BS in Human Services
- BS in Psychology
- BS in Applied Studies – Human Services and Early Childhood Development
- AS in Behavioral Sciences

Students can be FT or PT, in on-line or traditional programs with a GPA of 2.5 or higher. Awards will be spread over GSC's 4 terms. In addition, we asked that students live or work in one of the Region 4 towns. Students must complete a FAFSA (Free Application for Federal Student Aid) and have exhausted grant and scholarship aid first. Pell eligible students are able to apply as well. Students will submit an application; attach a 250 – 350 word essay on why they are choosing a career in behavioral health, and what they plan to do with their education.

Granite State College is in the process of identifying eligible students and notifying them of the opportunity. Awards have not been made yet and will happen in January 2019.

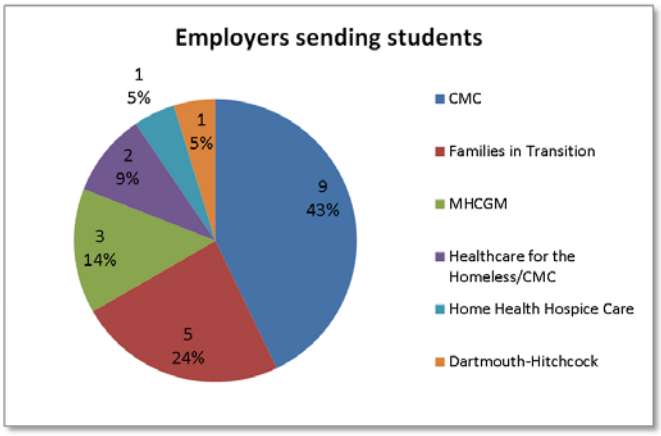
Fundamentals of Management Program with Granite State College:

Network4Health recognizes that retaining employees is just as important as hiring them. As a result, Network4Health committed $7,500 of funding to partner with Granite State College to offer a 'New Manager Development Program.' We feel it cannot be overstated the importance of strong and capable leadership – at all levels – as a driver of retention and engagement of employees across the organization. Plenty of studies have confirmed that large numbers of employees who turnover are leaving their manager, not their job.

The program began in September 2018 and ran for 3 months until November 2018. Students were in class 1 full day per month, and had approximately 2 hours of online work to do per week. In person classes were held at GSC's Manchester campus on 195 MacGregor Street and met on: September 27, October 25, and November 29, 2018. The chart below shows the breakdown of the class and the agencies the students came from:

25 applicants
24 starts
8 remained on waitlist
21 completed
84% completion rate

Drops:
- "Too much on plate"
- A direct report had unexpected LOA; had to cover job duties



Fundamentals of Management focused on developing high potential staff who have recently moved into managerial roles, or aspire to become managers/leaders. The program consisted of face-to-face and online modalities in the areas of management/leadership, communication, and conflict resolution. Program participants developed and enhanced skills and perspectives that are essential for managers and leaders. This was accomplished using interactive skill practice, engaged discussion, and other learning methods. All the content was delivered within the context of understanding some of the unique challenges that working for a mission-driven, non-profit and/or health provider can present. This course was not eligible for college credit or continuing education units. Candidates received a certificate of completion if all required assignments were met.

All candidates were required to fill out a basic Network4Health application for the program and indicate manager approval for taking the course and were processed on a first-come/first-served manner.

1. Program Content: The program included the following topics in each session.
    a. PART ONE: Fundamentals of Management and Leadership:
        i. Learn what effective management/leadership is and is not;
        ii. Identify tools for creating productivity and building morale;
        iii. Develop a personal action plan to improve your leadership skills.
    b. PART TWO: Effective Communication:
        i. Understand how to effectively communicate as a supervisor;

ii. Explore tools to help you set and communicate performance expectations;
iii. Gain techniques for giving constructive feedback without deflating moral;

c. PART THREE: Learn how to Confidently Handle Conflicts:
   i. Understand how to motivate your staff;
   ii. Identify how to avoid the problems that come with supervising your friends;
   iii. Learn tools for managing conflict situations pro-actively;
   iv. Build confidence in holding difficult conversations.

2. Survey Data

Network4Health and Granite State College measured data in two ways: First, Network4Health asked the referring manager to complete a qualitative survey for their employee prior to beginning the program and then right after the program. Similarly, Granite State College surveyed attendees prior to beginning the program and then right after.

<u>Student Opinion Results</u>

Pre- and post-evaluation data shows substantive gains in skills, confidence, and feelings of connectedness among practitioners in their fields. Of particular note – and demonstrated in the following data – include the following:

- Participants perceived that they gained substantive management skills as a result of this professional development offering.
- Presenters, the topics covered, and the learning environment were all rated highly favorably by respondents.
- Participants indicated that they gained real-world management skills that they could both apply in their own roles as well as with their workplace setting to extend and share their learning with others.

A full breakdown of responses and pre and post-course data is available in Attachment_A1.3a.

<u>Feedback Highlights</u>

Q: What Knowledge Did You Gain as a Result of this Program?

- *"While I am not yet in a managerial position, I feel like a gained a lot out of this program. One of the biggest things is that "you are not alone." I think this will be very important when I am in a position that will require me to use the skills I learned. I also think learning about how to manage friendships, conflict, and that performance reviews should not be a surprise will be very beneficial as well. Knowing these things before being in a role that requires all of these skills is an asset because I can start my position knowing these things rather than having to change and adapt."*
- *"One of the things that I learned was how to communicate with employees and that active listening is a huge part of that skill."*
- *"I loved meeting other managers who are in the same boat as I am. It was helpful to hear their experiences and their difficulties – that is the value in this program!"*
- *"Increased conflict resolution skills; greater ability to assess my strengths and areas for growth."*
- *"I learned a lot about conflict resolution as well as a lot about some of the biggest issues managers face (such as being promoted and now managing peers). I have learned not only how*

to deal with these situations, but it also gave me an idea of what some of my co-workers may be experiencing which allows me to do what I can to make it easier on them."

Q: How will you carry new knowledge and/or skills to your current employment?

- *"I plan to use my new knowledge in building a better team that works together, communicates effectively and resolves problems effectively."*
- *"I plan on using what I learned to continue to better myself and prove that I am management material. The more I am able to exhibit the skills I learned now, the more people will see that I am qualified and a good candidate for a position with more responsibilities."*

Q: Please share anything else you would like us to know about this program:

- *"I really enjoyed the program. As I previously mentioned the presenters were GREAT and the materials were awesome. I enjoyed getting to meet other people and the presenters did a great job of allowing us to get to know everyone and collaborate (which I think is an important skill as a manager). I really enjoyed this experience."*
- *"The program was very helpful in building my skills as a new manager. All of the materials, whether presented or online were excellent."*
- *"I really enjoyed the program! Both presenters were GREAT and provided excellent resources!"*

Based on the success and impact of this program, Network4Health is planning to offer this course again in September of 2019.

<u>Fundamentals of Leadership Program with Granite State College:</u>

Network4Health recognizes that there is a clear difference between management and leadership. While managers are often implementers and are focused on the day to day, leaders need to be change-agents, visionaries, have long-term views of things, be multi-taskers and work on building relationships. One cannot overstate the importance of strong and capable leadership as a driver of retention, recruitment, and engagement of employees across an organization. During this period, Network4Health partnered once again with Granite State College to offer a Fundamentals of Leadership program at no cost to partner employees.

This program will begin in March 2019 and run for 2 months until April 2019. Employees will be in class for 4 sessions over 2 months, and have approximately 2 hours of online work to do per week between March – April 2019. We began recruitment at the end of November, 2018 and by the end of this reporting period we already had 9 applicants (minimum 15, maximum 25).

This course will introduce students to the fundamentals of leadership development. The student will identify and gain awareness of their personal leadership style. In addition, they will examine leadership concepts, models and practices that lead to effective team and organizational performance. Topics will include: Leadership Essentials and Strategies, Team Building, and Coaching and Mentoring. A variety of interactive teaching methods will be employed during the course, to include: case studies, current business articles, in-class simulation exercises, interaction and small group projects.

Behavioral Health Education Roundtable:

Network4Health's Workforce Development Director partnered with Southern New Hampshire Area Health Education Center to host the 3rd Behavioral Health Educational Round Table on October 12, 2018.

The 19 attendees were representatives from colleges, IDN 4, IDN 7, community organizations, professional organizations, and employer partners from IDN regions 4 and 6 attended to discuss participate in the agenda which included:

- Welcome, Introductions, and Recap
- NH Health Care Sector Partnership - Guest speaker: [redacted]
- Group Dialogue on Internship/Clinical Placements Support
- Curriculum Enhancement Feedback: Expanding Bachelor of Science in Public Health to Include Addiction & Mental Health - [redacted], Keene State College
- Integrated Behavioral Health and Primary Care: What's Happening in Industry and how is Education Responding?
- NH Health Career Catalog Update and Review
- Next Steps

The Round Tables have been successful and participants are interested in continuing them. Our next Round Table is scheduled for February 8, 2019. Tentative agenda topics include:

- Curriculum Feedback: Psychology degree redesign – Rivier College
- NH Health Career Catalog update and review
- Guest speaker on integrated primary care and its effect on curricula – Cherokee Health Systems
- Special guest [redacted], Director of NH Department of Economic Development, on the workforce vision for New Hampshire
- Mapping K-12 engagement
- Articulation agreements
- SAMSHA competencies in behavioral health care

Additional items related to education efforts:

- *Networking Event for Granite State College (GSC) at Dover Chamber of Commerce*: Network4Health's Workforce Development Director was invited to speak to other healthcare employers at the Dover Chamber of Commerce about N4H's relationship with Granite State College and the professional development programs we are utilizing.
- *Granite State College meeting of the College's Business & Chamber and Healthcare Advisory Boards:* Network4Health's Workforce Development Director was asked to be part of this key advisory board at Granite State College. The board consists of other state, non-profit and business professionals who advise GSC on industry trends and help GSC plan relevant programs and curricula. .
- *New Hampshire Statewide Economic Development Plan Build Sessions - K-16 + Industry Alignment:* Network4Health's Workforce Development Director participated in a planning session which will contribute to the New Hampshire 10-year Economic Plan. This particular group focused on aligning industry with K-16 educational pathways.

- *Marketing MCC Programs in region:* During this period the Network4Health's Workforce Development Director has been helping Manchester Community College market their behavioral health programs directly to larger Network4Health partners. In data produced from our earlier education survey, coupled with data from the most recent survey by the NH Community BH Association, by volume the workforce need in behavioral health lies predominantly with the bachelor level workforce. We have tied this marketing in with the Behavioral Health Scholars program in hopes of driving employees who don't have degrees to consider re-entering the college pathway.
- The Director of Workforce Development met with the American Red Cross, the International Institute of New England, and the NH Charitable Foundation to explore the potential for being part of designing a healthcare career ladder program for non-native English speakers. Network4Health was particularly interested in funding Mental Health First Aid for students going through the LNA course at the American Red Cross to give more exposure to behavioral health issues and how to deal with them. As of this writing, progress has been halted due to staffing changes and funding cuts at IINE. We are hoping to develop this relationship further during the next reporting period.

Training

N4H Sponsored Trainings:

For this reporting cycle, Network4Health has supported 123 trainings across all projects, funding 343 individuals. With most trainings, we were able to offer continuing education unit (CEU) credits. In this period, trainings were held in support of the C1 (Critical Time Intervention) and E4 projects (Integrated Treatment for Co-Occurring Disorders) and the B1 Integrated Healthcare project. Specifically, through this project, Network4Health supported the following trainings during this reporting period:

- Trainings for the Care Transitions project include the 2nd CTI Coach Training, monthly Community of Practice (COP) meetings facilitated by Hunter College with all 5 regions participating in Care Transitions, and 1:1 coaching support as needed. COP conference call meetings were held July 25, 2018, August 22, 2018, October 24, 2018 and November 28, 2018. A face to face meeting was held on September 12, 2018 in Concord at the McAuliffe Center. The entire Network4Health Care Transition team consisting of 5 coaches, one Director and Administrative Assistant were in attendance for each of these meetings.

- The fifth coach completed CTI training November 1, 2018 – the entire CTI staff is now fully trained
- With the success and high satisfaction of the first Cherokee Healthcare Systems training in June 2018, Network4Health took the lead in organizing a second, 2-day Cherokee Health Systems training in collaboration with IDNs 1 and 6 in order to reach a wider group and spread the cost out. Approximately 86 staff participated in the training, including 37 staff from Network4Health partners. During this training, we hosted senior leaders of the Cherokee Health Systems to discuss the implementation challenges of integrated care. The training occurred September 27 and 28, 2018 at Saint Anselm College.
- Network4Health sponsored and filled 25 seats to the Annual NH Providers Behavioral Health Summit Conference in December 2018.

- Network4Health continues to offer its bi-weekly "Workforce Wednesday" newsletter. A sample is included as Attachment_A1.3b. It continues to be the primary tool Network4Health uses to communicate trainings being supported by Network4Health through the A1 project. It also includes articles on workforce topics, upcoming information sessions on emerging healthcare and workforce trends, and highlights tools for managers in an effort to promote engagement and retention of employees across the region. Our newsletter member base has grown to a viewership of 236. Many of those recipients forward the newsletter to employees and co-workers, however, so the number of viewers is actually much larger. Feedback on the newsletter continues to be very positive.

Emerging Healthcare Positions:

Community Paramedicine:

During this period, the Network4Health Workforce Development Director began studying the position of Community Paramedic (CP)_ as a way to understand potential roles for CPs in the region. After conversations with subject matter experts in Minnesota, and the head of Upper Valley Ambulance who has a small CP program happening in northern NH, the director decided to enlist Myers and Stauffer (M&S) to provide some technical assistance research on this subject. M&S was able to publish an 11 page document describing CPs and outlining some best practices. A larger challenge the work by M&S and Network4Health uncovered was the fact that New Hampshire laws and scope of practice for EMTs and Paramedics don't currently allow for reimbursement of typical CP roles.

The Workforce Development Director and the Executive Director of Network4Health spoke with Chris Stawasz, Regional Director for NH and ME for American Medical Response (AMR) about Community Paramedicine (CP).
Network4Health's learned that one of its clinical partner agencies is working with AMR on developing a CP pilot model for particular clients with cardiac heart failure to lower the readmission rates. While there may be a role for Network4Health to play in these discussions, as of this writing, no follow up has happened yet.

Occupational Therapy:

Network4Health has been in communication with the University of New Hampshire in promoting their Occupational Therapy (OT) program which received some funding under the HRSA Behavioral Health Workforce Education and Training (BHWET) Program grant a couple of years ago. Network4Health has promoted opportunities to host internships for this program and offered materials and workshops on utilizing Occupational Therapists as behavioral health care enhancers in integrated primary care settings. This reporting period, Network4Health was invited to hear a presentation by an OT intern from this program at the Center for Life Management (CLM) in Derry. This OT worked with clients individually and in one-on-one settings primarily around sensory integration. The internship was such a success that CLM is bringing on the OT as a staff member who will be billing under functional support services (FSS). CLM has already reached out to UNH to request another intern placement.

Behavioral Health Physician Assistant Fellowship

In the previous reporting period, the Network4Health Workforce Development Director began investigating a model for Behavioral Health Physician Assistant (PA) Fellowship in collaboration with

consultant Stephen Lee. During this reporting period, the Network4Health Workforce Development Director and the Integrated Health Director met with Catholic Medical Center and Healthcare for the Homeless to describe both the behavioral health PA model and the fellowship model to gauge interest. Since that time, CMC and HCH have progressed rapidly in implementing this model including:

- Identifying the Executive Medical Director, Population Health at CMC as the champion of this effort
- Identifying 2-3 PA's who are interested in participating
- Identifying a Psychiatrist who would be the preceptor for the fellowship
- Identifying possible foundation dollars to support implementation

Additional items related to training efforts:

- The A1 project partnered with the B1 project to look at funding a cross-collaborative effort by the Manchester Department of Public Health to build trauma sensitive school environments. Ultimately MDPH found alternate funding, but the process educated us about the need to address trauma in Manchester schools.
- During this period Network4Health looked at developing a partnership with the Alzheimer's Association (MA/NH) to deliver trainings on memory loss to providers and clinicians. Network4Health hosted them at the September N4H Workforce Committee meeting and asked members for more specific needs around memory loss training. The need didn't seem to present itself immediately and developing a further relationship has been put on hold.
- The Workforce Development Director attended the Career STAT national conference on healthcare workforce development in New Orleans, October 24 – 26, 2018.
- Leveraging the model used in IDN1, the Director of Workforce Development began to create a State Loan Repayment matching program in Network4Healthfor launch in early 2019.
- The Director of Workforce Development began work on developing an RFP to be released for giving all Network4Healthpartners access to offset productivity dollars. Currently, only B1 partners can access these funds. Our plan is to launch this effort in early 2019.
- The Director of Workforce Development remains an active partner with the NH Healthcare Workforce Stakeholders Group; the New Hampshire Children's Behavioral Health Workforce Development Network; and the Legislative Commission on Primary Care Workforce Issues.

Retention

Much of the work we are doing in our region has an overlapping effect with retention efforts. These include, but are not limited to the following:

- Providing career advancement opportunities through the scholarship programs
- Improving management and leadership skills through the programs with Granite State College
- Providing professional development opportunities through funding trainings and CEUs
- Providing funds to offer retention bonuses through the PRRI
- Providing scholarships for CRSW training

Recruitment

Network4Health has successfully recruited for 20 of 37 positions. The following describes the hiring by project during this reporting period:

- Positions associated with D3 Partial Hospitalization Program were delayed due to the receivership of Serenity Place but have made great strides and have a number of new hires beginning between July – September 2018 (see table in A1-5).
- C1 Care Transitions hired 3 CTI Coaches total, including one to replace staff based on a vacancy

Prescriber Recruitment and Retention Initiative (PRRI):

In early 2018 Network4Health introduced a Prescriber Recruitment and Retention Initiative. Through this initiative, Network4Health will reimburse 50% of allowable recruitment/retention costs up to $10,000 to any of our partners who hire or retain a MAT prescriber (MD, DO or APRN). Interest in this program has waned in this reporting period (no new applications received), but Network4Health is going to re-market it in the 1st quarter of 2019 with the hope of generating some new interest.

Scholarship Program for Training CRSWs:

Network4Health established a partnership with the Mental Health Center of Greater Manchester to establish scholarships to assist participants in affording the Certified Recovery Support Worker training.

Certified Recovery Support Workers (CRSW) play an important role in helping those in recovery stay on track and meet their recovery goals. In addition, the CRSW credential is often the first step on the career pathway for SUD professionals and these roles allow those in recovery to assist others in their journey through sharing personal experience. Network4Health is interested in supporting individuals who live or work in Network4Health's region and want to get this credential as a means for obtaining a job in SUD treatment, or as a means of 'upskilling' those that are already working in the field but would benefit from this credential.

Network4Health committed $2,550 towards this scholarship. This lowered the out-of-pocket costs to students from $200 to just $85. Results as of November 2018 below:

REGISTRANTS FOR ACADEMY: 21 RESIDENTS: 16 - Manchester 1 – Allenstown 1 – Exeter 1 – Hooksett 1 – Candia 1 - Milford TOTAL GRADUATES FROM ACADEMY: 20	Paid by other agencies: 6 – Families in Transition 1 – Groups Recover Together 2 – New Hampshire Healthy Families	TOTAL N4H SCHOLARSHIPS: 12 Scholarship = $2040.00 CRSW Manuals (8 at $44.00/per person) = 352.00 Total investment from N4H = $2392.00	OUTCOMES POST TRAINING: 3 – Employment Applications were distributed 1 – Registrant from the modules (Connect Suicide, HIV/AIDS, Ethics) was hired by MHCGM for the Continuous Treatment Team (CTT)

			1 – Registrant was interviewed by MHCGM

Additional items related to recruitment efforts:

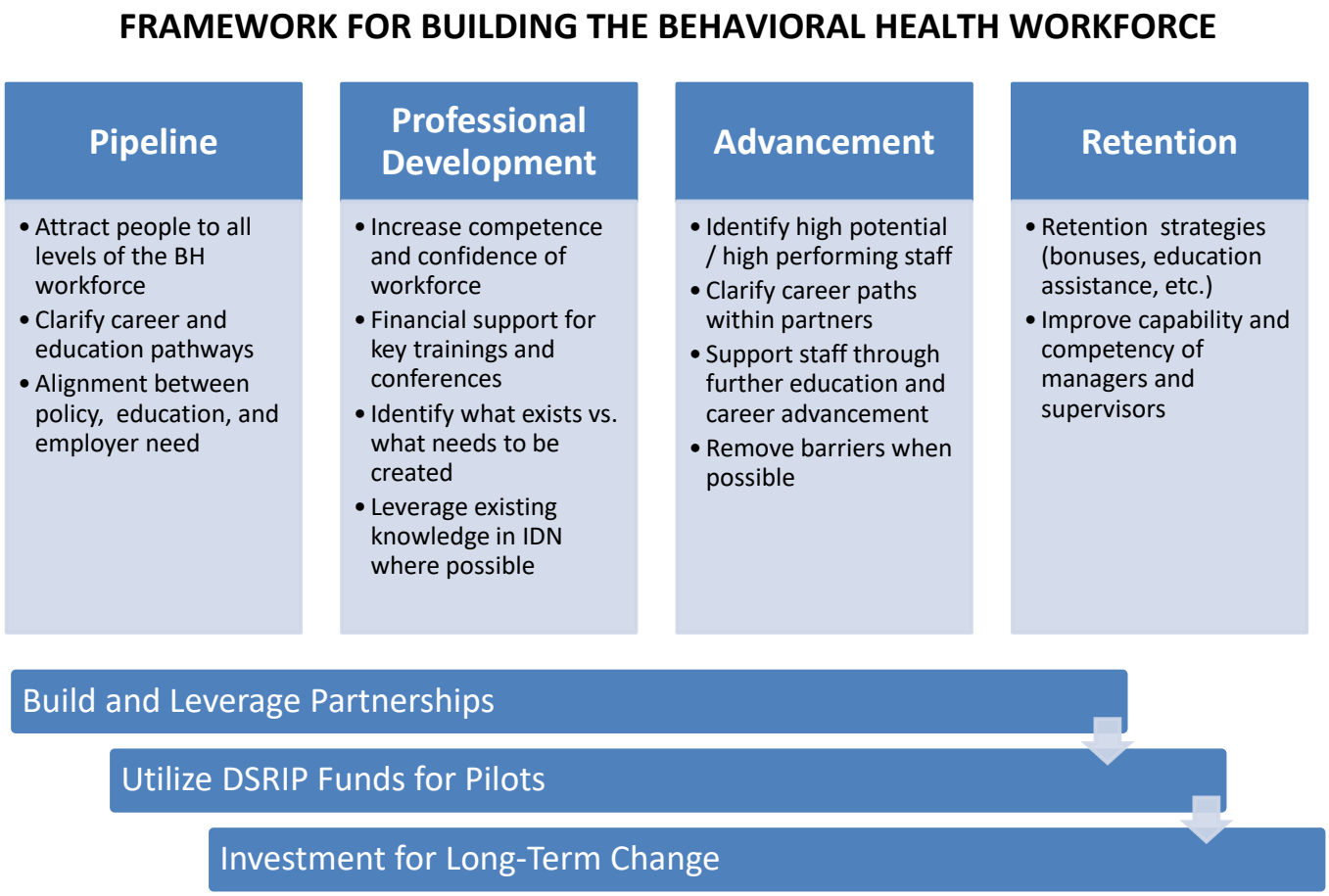
- The Director of Workforce Development met with Southern New Hampshire Services (SNHS), a N4H partner, to learn more about a $5M National Emergency Grant that the state received to help expand the recovery workforce and get those in recovery into training for new careers. This is a natural partnership because it is focused on workforce development. We also recommended that SNHS connect with other IDNs at the statewide workforce committee meeting to talk more about the grant and look for ways to partner with the IDNs. While there was some interest on the part of SNHS to develop a partnership with IDN4, follow-up emails have not been returned to date.
- The Director of Workforce Development has been regularly attending planning committee meetings for the development of the next edition of the Health Careers Catalog published by the NH Area Health Education Council (AHEC). The book will contain a greatly expanded section on behavioral health careers.
- The Director of Workforce Development attended Race and Equity New Hampshire Economic Development Workgroup Meetings organized by the NH Division of Economic Development.

Other Progress and Accomplishments

Network4Health has been active in other workforce development-related initiatives across the state and within their region:

- The Director of Workforce Development is the co-chair of the Recruitment and Hiring Sub-committee of the Statewide Workforce Development Committee. During this period, he worked with the new chair from Region 3 to re-evaluate project targets, recruit new members and re-launch the group.
- The Director of Workforce Development organized calls with colleagues from the Massachusetts Department of Public Health' DSRIP waiver group specifically around how they were implementing workforce development efforts in that state. It was an excellent learning opportunity for the Director and Executive Director
- The Director of Workforce Development organized calls for the Executive Director with an agency in Boston called Social Finance (SF). SF has experience with fundraising through 'Pay for Success' social impact bonds. As Network4Health looks towards sustainability past the waiver, Social Finance may be a good contact to engage with.
- In order to improve attendance and engagement at the Network4Health Workforce Development Committee, the Director of Workforce Development recruited new members to the Committee and has moved the meeting to an every other month schedule.

- During this period Network4Health redesigned its Workforce Development framework model, as pictured below, to better reflect the reality of the work we are doing and where we are focusing our efforts.



The updated project plan for this project is included as Attachment_A1.3c.

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

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

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

As described above, and shown below, Network4Health has been extremely successful in offering trainings across projects to maintain and improve the skills of our Network4Health partners and their staff. We have provided 50% more trainings than initially anticipated.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Recruit N4H Workforce positions	Up to 37 positions	15	17	**33**
Offer a variety of different trainings across the projects to maintain/improve skills	Up to 144	5	112	227

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.

(*write-back responses in bold)*

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Application Analyst	Up to 2	0	1	1	1
Integrated Healthcare Clinical Director	Up to 1	0	1	1	1
Innovation Consultant	Up to 2	0	0	0	1
Community Health Workers	**Up to 10**	**0**	**0**	**0**	**5[1]**
Peer Support Specialist	**Up to 1**	**0**	**0**	**0**	**2[2]**
Nurse	**Up to 1**	**0**	**0**	**0**	**1[3]**
Clinical Case Manager, BSW, LMA, RN	**Up to 1**	**0**	**0**	**0**	**5[4]**
Co-Occurring Disorders Clinical Director	Up to 1	0	1	1	1
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	4 per diem	4 per diem	4 per diem
Program Coordinator	Up to 1	0	1	1	1
Mental Health Clinician	Up to 1	0	0	0	1
Substance Use Disorder Clinician	Up to 1	0	0	0	1
Critical Time Intervention Director/Supervisor	Up to 1	0	1	1	1
Critical Time Intervention Coach	Up to 6	0	4	5	5
Care Transitions Administrative Support Worker	Up to 1	0	1	1	1

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

[1] 4 CHW's and 1 CHW supervisor were hired at Manchester Community Health Center
[2] 1 Peer Specialist was hired at MHCGM and 1 was hired at Families in Transition - New Horizons, Willows Treatment Program
[3] 1 Nurse Care Navigator was hired at CMHC CLM
[4] 4 ITT Case Managers were hired by MHCGM; and 1 by Fusion Health Services

These positions were either hired in the last period or they already worked for the organization and were "transferred" from other grants to the waiver program in this SAR period.

The following positions have been removed from A1-5 IDN-level Workforce: Staffing Targets section:

Psychiatric Nurse Practitioner or Psychiatrist	Up to .06	0	0	0	0
Outreach Worker	Up to 1	0	0	0	0

Initially, Network4Health anticipated that the B1 project would hire the above positions directly. However, through strategic planning with Network4Health partners and guidance from the Network4Health Steering Committee, the decision was made that individual organizations would hire additional multi-disciplinary team members needed in their organization through their approved Integration Enhancement Plans (IEPs). Encouraging partners to include various roles as part of their multi-disciplinary team helps an organization to see the "value add." The downstream effect of improved patient and provider satisfaction and potential reduced costs, in turn, should help with sustainability for such positions by partner organizations beyond the waiver period. None of our partners made the decision to utilize Network4Health funds to hire for the Psychiatric Nurse Practitioner or Psychiatrist positions, and outreach is being done as a subset function of other roles.

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

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

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

Revenue- All project budgets have been adjusted to reflect the actual receipt of funding. During the reporting period, anticipated funding was not received due to ongoing negotiations between NH DHHS and NH counties. The anticipated, but not yet received, 2018 funding for the Workforce budget totals $1,009,555. These expected funds have been added to revenue in 2019. If anticipated revenue is reduced as a result of State negotiations, Network4Health will revise budgets and project plan deliverables, subject to Steering Committee and NH DHHS approval.

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

Reported actual expenses continue to be below budget due in part to expense reporting that includes only invoiced and paid expenses. Significant training and development funding has been committed to the B1 Integrated Healthcare "Integration Enhancement Plans" that have been negotiated with network partners.

TRANSFORMATON FUNDS	**CY 2017 (Yr2) Actual**	**CY 2018 (Yr3) January to June Actual**	**CY 2018 (Yr3) July to December Actual**	**CY 2019(Yr4) Projected**	**CY 2020 (Yr5) Projected**	**CY 2021 (Yr6) Projected**
A1: BH Workforce (New)	$ 862,544	$ 483,025	$ 172,509	$2,449,626	$ 875,316	$ 357,796
A1: BH Workforce (Rollover)		$ 825,328	$1,228,902	$1,190,272	$1,026,911	$ 11,199
Total Revenue	$ 862,544	$1,308,353	$1,401,411	$3,639,898	$1,902,227	$ 368,995
Recruit			$ 5,000	$ 950,000	$ 610,000	$ 120,000
Training/Development	$ 20,527	$ 28,109	$ 100,365	$1,438,362	$1,050,000	$ 125,000
Salaries and benefits- Workforce Director (1.0 FTE) and Workforce Coordinator (1.0 FTE)	$ 14,768	$ 48,509	$ 99,656	$ 213,442	$ 219,845	$ 109,922
Occupancy		$ 2,300	$ 4,025	$ 6,900	$ 6,900	$ 3,450
Technology (Computer, phone, software)	$ 1,921	$ 533	$ 2,093	$ 4,283	$ 4,283	$ 2,140
Subtotal	$ 37,216	$ 79,451	$ 211,139	$2,612,987	$1,891,028	$ 360,512
Variation to Budget (Transfer Funds to Subsequent Year)	$ 825,328	$1,228,902	$1,190,272	$1,026,911	$ 11,199	$ 8,483

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.

There were no changes this period.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Catholic Medical Center (Lead) including Health Care for The Homeless.	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center- Amoskeag Family Practice	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center – Behavioral Health Practice	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center – Family Health & Wellness at Bedford	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center – Willowbend Family Practice	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
American Medical Response of MA	**Other**	**A1, A2**
Ascentria Care Alliance	**Community-Based Organization providing social and support services**	**A1, A2**
Building Community in NH	**Community-Based Organization providing social and support services**	**A1, A2**
Catholic Charities NH	**Other, *Non CMHC mental health provider***	**A1, A2**
Center for Life Management – Behavioral Health	**MHC*, SUD***	**A1, A2, B1, *C1*, E4**
Child and Family Services	**Social Services**	**A1, A2, B1, *C1*, E4**
City of Manchester Health Department	**Public Health Organization**	**A1, A2**
Community Crossroads	**Home and Community Based Care Provider**	**A1, A2**
Crotched Mountain	**Community-Based Organization providing social and support services**	**A1, A2**
Dartmouth Hitchcock - Adult Primary Care	**Primary Care Provider**	**A1, A2, B1**
Dartmouth Hitchcock – Pediatric Primary Care	**Primary Care Provider**	**A1, A2, B1**
Derry Friendship Center	**Other**	**A1, A2**
Easter Seals NH, including Farnum Center	**Community-Based Organization**	**A1, A2, B1, E4**

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
	providing social and support services and SUD Treatment	
Elliot Health Systems – Doctors Park Pediatrics	Hospital, Primary care provider, Non CMHC Mental health provider, SUD	A1, A2, B1, *C1,* D3, E4,
Elliot Health System – Partial Hospitalization Program	Hospital, Primary care provider, Non CMHC Mental health provider, SUD	A1, A2, B1, *C1,* D3, E4,
Families in Transition – Family Willows Treatment center	Community-Based Organization providing social and support services, SUD	A1, A2, B1, E4
Fusion Healthcare Services	Primary Care	A1, A2, B1
Goodwill Industries of Northern New England	Community-Based Organization providing social and support services	A1, A2
Granite Pathways	Community Based Organization providing social services and supports	A1, A2, E4
Granite State Independent Living	Home and Community Based Care Provider	A1, A2
Granite United Way	Host Agency for the South Central Public Health Network, Administrative Lead for 211-NH	A1, A2
Greater Derry Community Health Services, Inc.	Non Profit H&HS	A1, A2
Hillsborough County	County Corrections; Nursing Facility	A1, A2, *C1*
Home Health and Hospice Care	Home and Community Based Care Provider	A1, A2, B1
Hope for NH Recovery	Community Based Organization providing social and support services	A1, A2
International Institute of New England	Other	A1, A2
Life Coping Inc.	Home and Community Based Care Provider	A1, A2
Makin' It Happen	Public Health Organization	A1, A2
Manchester Community Health Center – Hollis Street	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Tarrytown	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Westside Neighborhood Health center	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Child Health Services	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Housing and Redevelopment Authority	Other	A1, A2
Manchester School District	Other	A1, A2

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Mental Health Center of Greater Manchester-	**MHC, SUD**	**A1, A2, B1, C1, E4**
NAMI NH	**Community Based Organization providing social services and supports**	**A1, A2**
New Hampshire Hospital*	**Hospital**	**A1, A2, *B1, C1***
New Horizons for NH	**Community Based Organization providing social services and supports**	**A1, A2**
NH Legal Assistance/NH Medical Legal Partnership	**Other**	**A1, A2**
On the Road to Wellness	**Non-CMHC Mental Health Provider**	**A1, A2, B1**
Parkland Medical Center	**Hospital**	**A1, A2, B1**
Pastoral Counseling Services	**Non-CMHC mental health provider, SUD**	**A1, A2**
Rockingham County	**County Corrections; Nursing Facility**	**A1, A2, *C1***
ServiceLink Aging and Disability Resource Center of Rockingham County	**Community Based Organization providing social services and supports**	**A1, A2**
Southern New Hampshire Services	**Community Based Organization providing social services and supports**	**A1, A2, E4**
St. Joseph Community Services, Inc.	**Community Based Organization providing social services and supports**	**A1, A2**
The Moore Center	**Community Based Organization providing social services and supports**	**A1, A2**
The Upper Room	**Community Based Organization providing social services and supports**	**A1, A2**

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

Project Scoring: IDN Workforce Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A1-3	IDN-level Workforce Capacity Development	Narrative & Microsoft Project or similar platform				

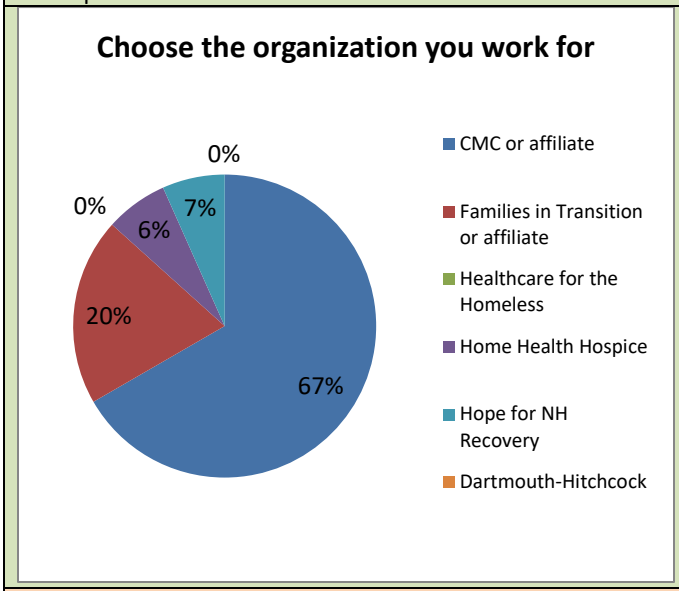
Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Implementation Plan					
A1-4	Evaluation Project Targets	Table				
A1-5	IDN-level Workforce Staffing Targets	Table				
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet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

Attachment_A1.3a Results of rated questions

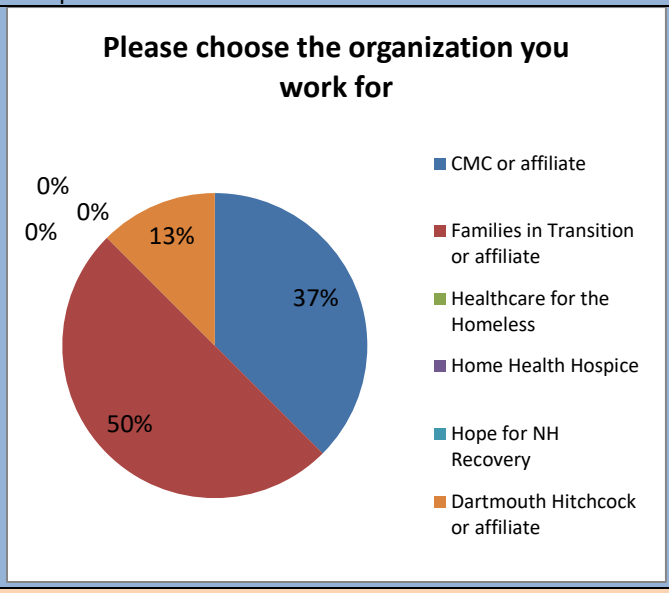
Q1: The following components of the program were effective and met my needs:

Q: Please review the following topics. Please choose the response that resonates with your feelings at this time.

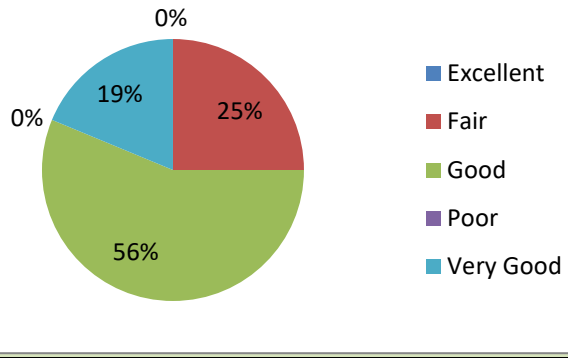
Pre-Course Survey
16 responses

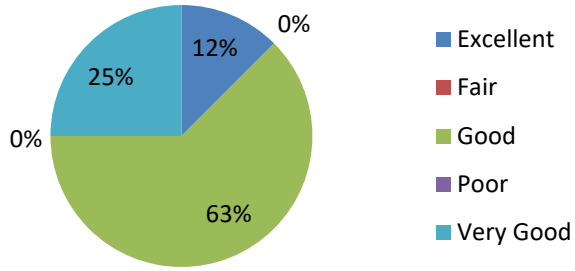


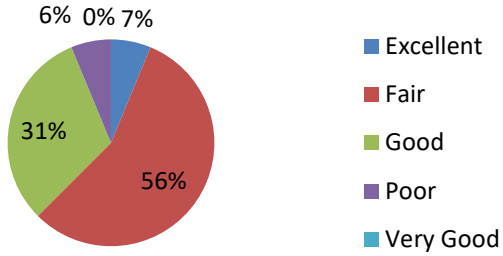
Post-Course Survey
8 responses

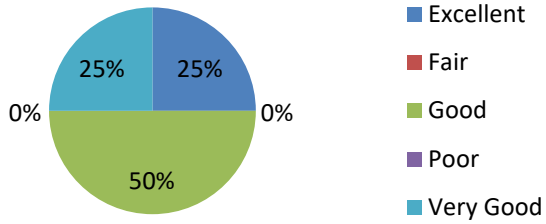


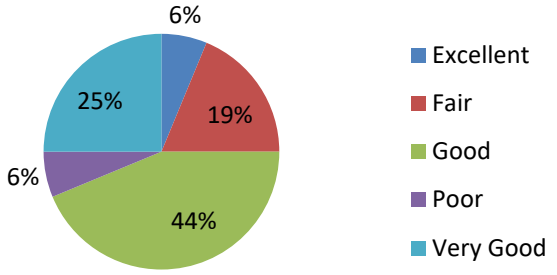
Rating scale: Poor / Fair / Good / Very Good / Excellent

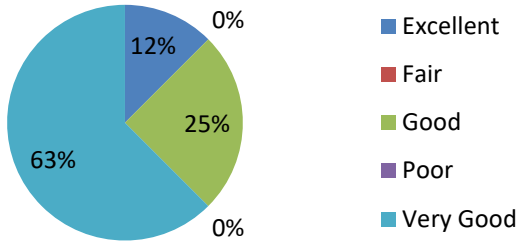

Overall management skills
0%
19%
25%
0%
56%
Excellent
Fair
Good
Poor
Very Good

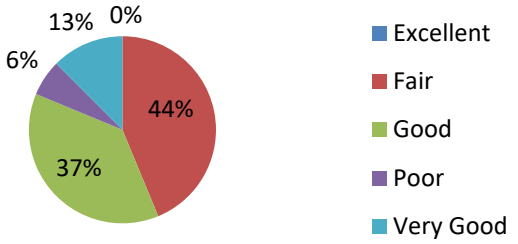

Overall management skills
0%
12%
25%
0%
63%
Excellent
Fair
Good
Poor
Very Good

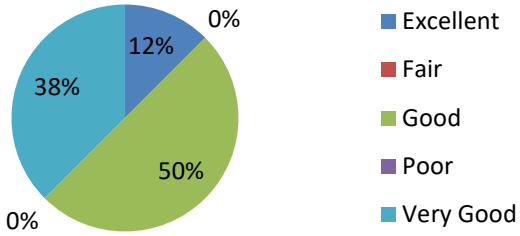

Confidence as a manager
6%
0%
7%
31%
56%
Excellent
Fair
Good
Poor
Very Good

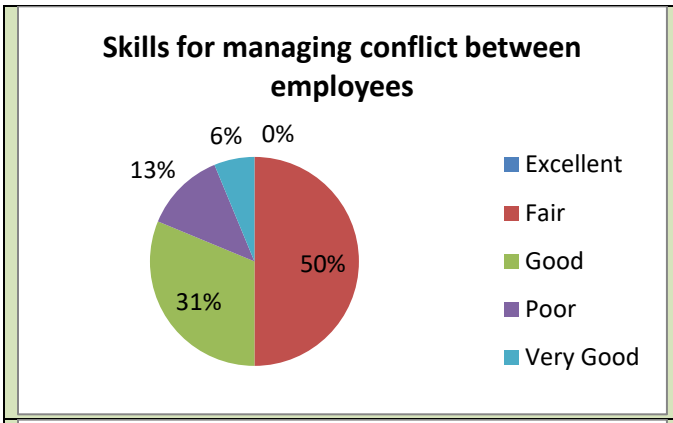

Confidence as a manager
25%
25%
0%
0%
50%
Excellent
Fair
Good
Poor
Very Good

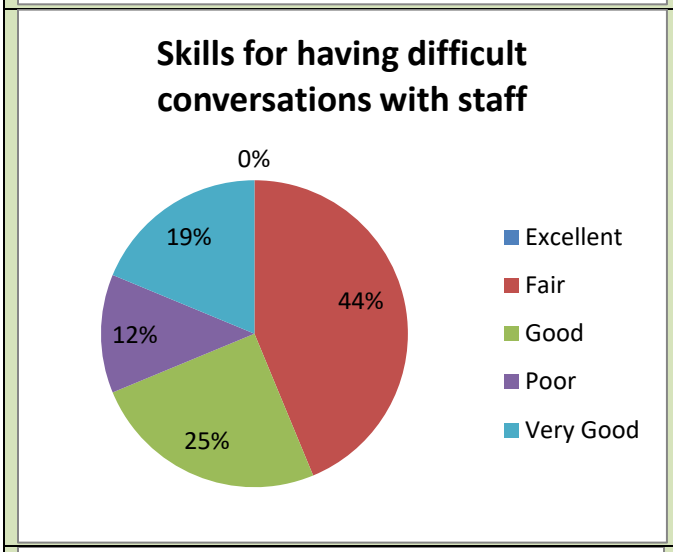

Skills for buildng morale
6%
25%
19%
6%
44%
Excellent
Fair
Good
Poor
Very Good

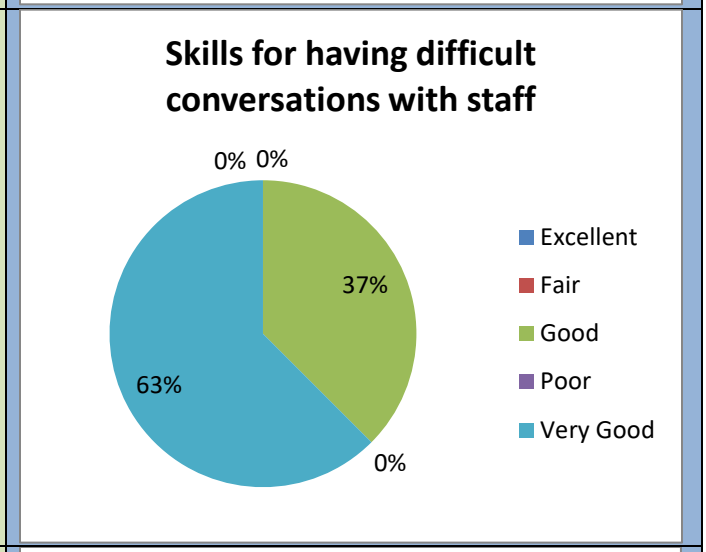

Skills for buildng morale
0%
12%
25%
63%
0%
Excellent
Fair
Good
Poor
Very Good

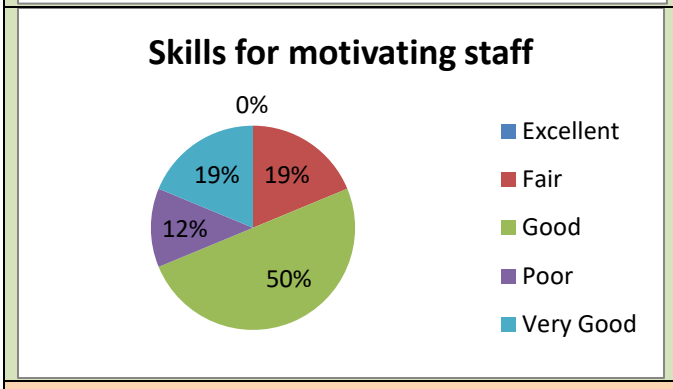

Skills for enhancing productivitiy
13%
0%
6%
44%
37%
Excellent
Fair
Good
Poor
Very Good

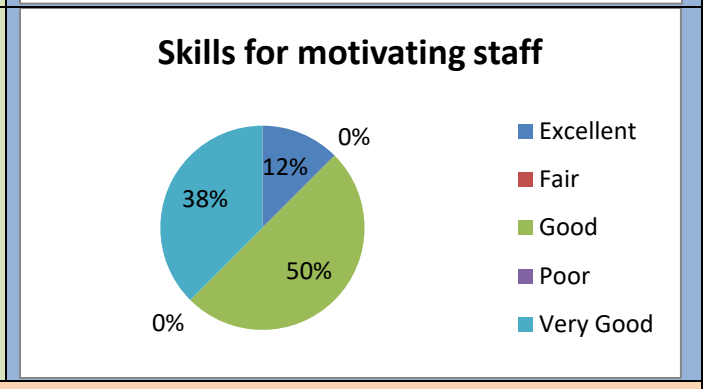

Skills for enhancing productivitiy
0%
12%
38%
50%
0%
Excellent
Fair
Good
Poor
Very Good



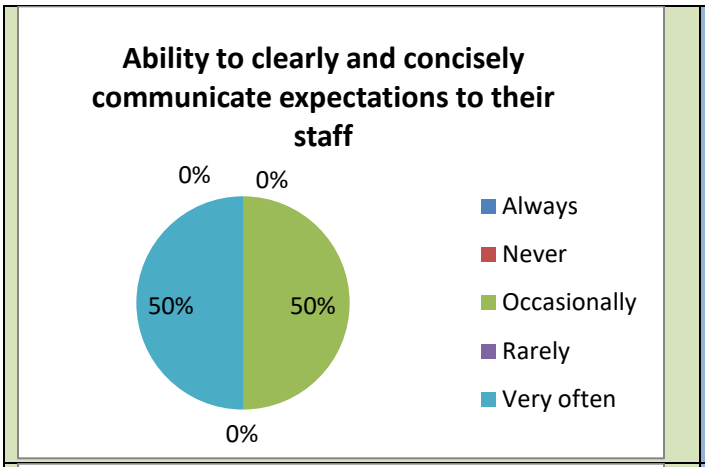




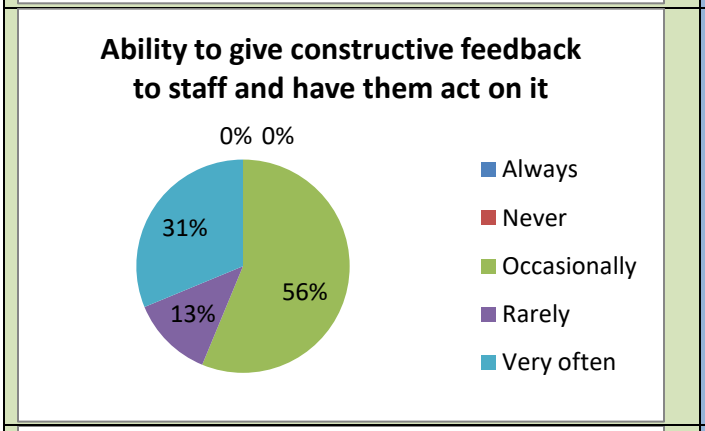


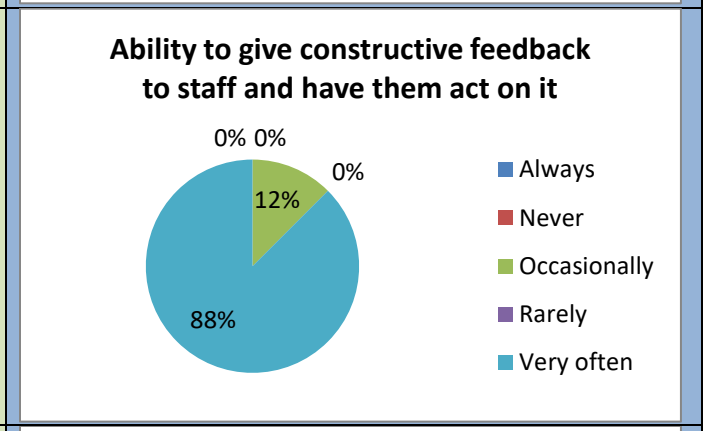


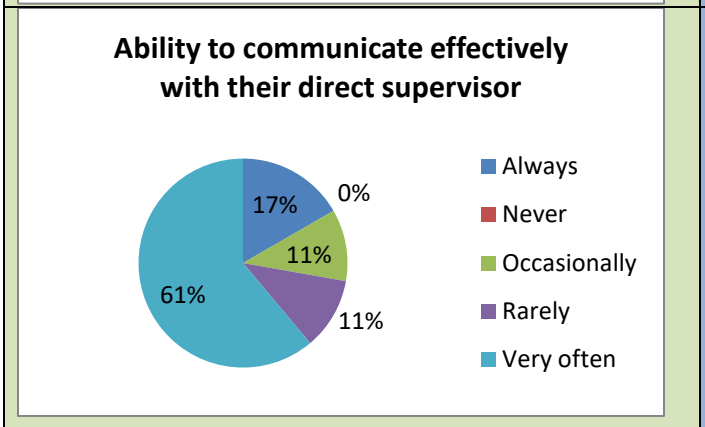
Rating scale: Never / Rarely / Occasionally / Very often / Always

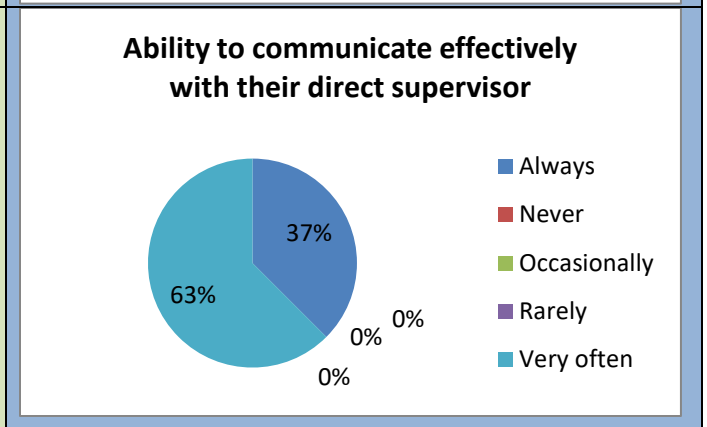

Ability to clearly and concisely communicate expectations to their staff
0%
0%
50%
50%
0%
Always
Never
Occasionally
Rarely
Very often

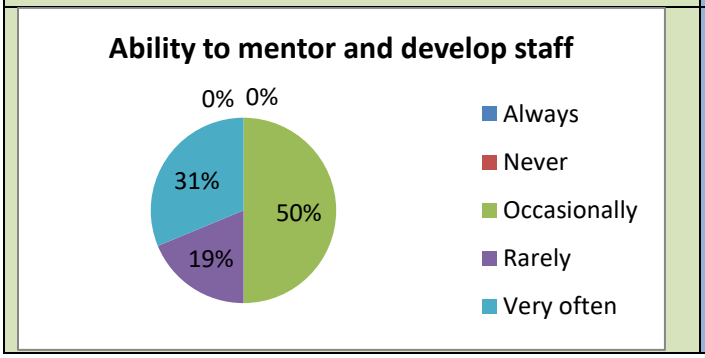
Ability to clearly and concisely communicate expectations to their staff
100%
Always
Never
Occasionally
Rarely
Very often

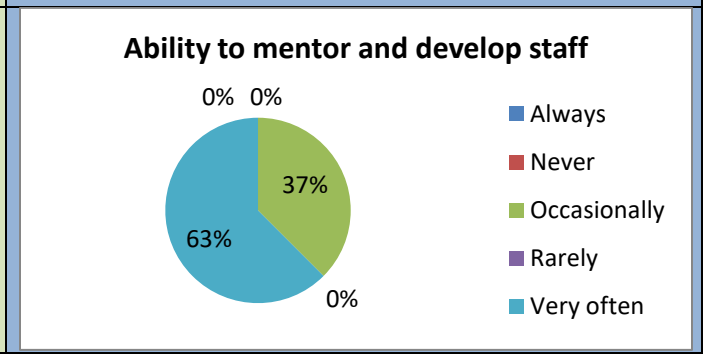

Ability to give constructive feedback to staff and have them act on it
0% 0%
31%
56%
13%
Always
Never
Occasionally
Rarely
Very often

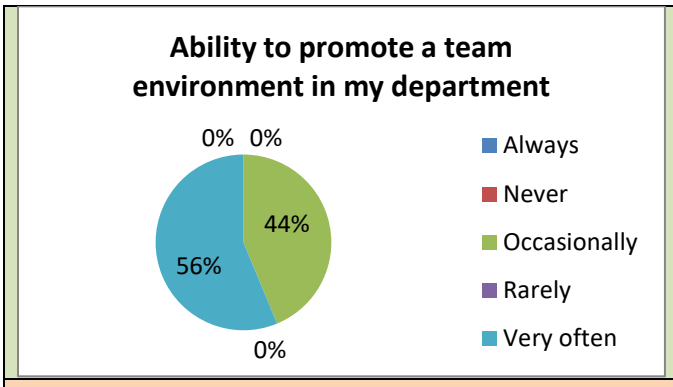

Ability to give constructive feedback to staff and have them act on it
0% 0%
0%
12%
88%
Always
Never
Occasionally
Rarely
Very often

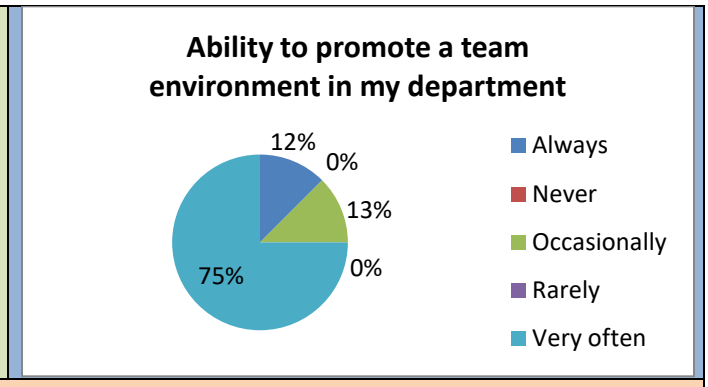

Ability to communicate effectively with their direct supervisor
17%
0%
11%
61%
11%
Always
Never
Occasionally
Rarely
Very often


Ability to communicate effectively with their direct supervisor
37%
63%
0%
0%
0%
Always
Never
Occasionally
Rarely
Very often

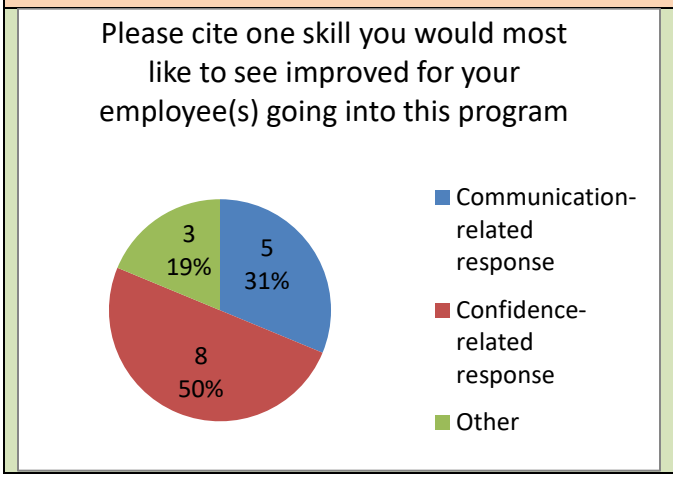

Ability to mentor and develop staff
0% 0%
31%
50%
19%
Always
Never
Occasionally
Rarely
Very often

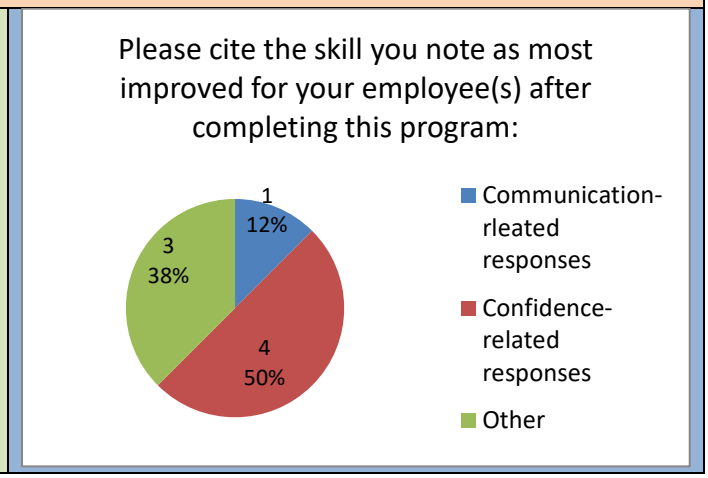

Ability to mentor and develop staff
0% 0%
37%
63%
0%
Always
Never
Occasionally
Rarely
Very often





Rating scale: Open ended responses





Workforce Wednesdays

December 5th, 2018

NETWORK 4 HEALTH

Topics in This Issue:

Cliff Effects Page 1

Foundations of Leadership – now accepting applications Page 3

MATCH Training Page 4

Grant and Funding Opportunities Page 4

Scholarship and Fellowship Opportunities Page 5

CMC Medical Assistant Apprenticeship Program Page 5

Your Opinion Matters Page 6

Know Your Career Path: LDAC's – Associate Level Page 6

Circle of Security Parenting (COSP) Training Opportunity Page 7

Sponsored and Free Trainings List Page 8

Management Corner: Showing Gratitude in Management Page 10

Cliff Effects

The National Fund for Workforce Solutions does a lot of great work on studying the challenges faced by the low-wage, entry level, and middle skilled workforce in climbing out of poverty and obtaining good jobs. They oftentimes write excellent policy pieces and research briefs that get to the root of some of the challenges these groups face and offer solutions on what can be done.

In early November, Janice Urbanik, Senior Director for Innovation and Strategy wrote a blog piece called "Falling Off a Cliff: When Workers Can't Afford to Take a Job." (https://nationalfund.org/falling-off-a-cliff-when-workers-cant-afford-to-take-a-job/). Please see the text from that piece below.

"Pick up the business section of any paper, and you're bound to read an article about employers struggling to fill their open positions. We are swamped with messaging about the skills gap and the failures of workforce development systems and training programs. We also hear about the need to "get people off the bench," meaning those who are able to work, but aren't.

While there is plenty of room for improvement in how training and education services are provided, and while it's true that the skills required to get a good job are changing rapidly, there are many other factors preventing employers from filling their open positions.

With the unemployment rate below 4 percent, we are in a "full employment" economy, and job seekers have lots of choices. But not all choices are equal. Many of the available jobs tend to be lower-wage positions; some of them part-time with no benefits and with unpredictable schedules. In some cases, people literally can't afford to take those jobs. How can that be?

For people who access public benefits such as SNAP, Medicaid, and child care or housing vouchers, a key consideration when accepting a job, working more hours, or taking pay raise, is "What will this mean for my benefits?" It's known as "the cliff effect," and it's what happens when a person experiences a relatively small increase in income, only to lose some of the critical public benefits they were receiving. The value of the benefits lost can sometimes exceed the gain in income, and dropping them off a "cliff" in terms of the net resources they bring home. In other words, a new job or raise can actually make them worse off.

Here's an example. In northern Kentucky, if a person gets a pay increase from $13 to $15 an hour, that equates to a $4,000 annual increase.[1] At that income level, they lose their housing and child care public assistance. The value of these benefits is about $15,000. Ouch!

What does a job seeker do when confronted with this choice? They do what we all

do and choose what is best for their families, and often that means turning down the raise. Just about every employer I have talked to has seen this happen.

The Kentucky example above is typical. In Ohio, the cliff effect for a family of three (a single parent and two children) starts when a person's annual income is about $25,000. They progressively lose more benefits as their income increases to about $35,000. In hourly terms, which is how most low-wage workers are paid, the two poles of this income range equate to about $12.50 to $17 an hour.

At this point, you might be thinking, "Wait, you're saying that people working full time for $15 an hour still receive public benefits?" That is exactly what I am saying. Here's why:

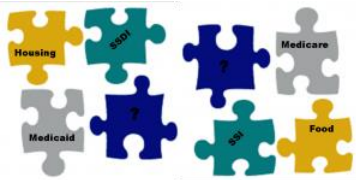
Most lower-skill, entry-level positions pay $12-15 an hour. A family of three needs about $20 just to be able to afford the basics of food, clothing, rent, utilities. A family of four needs $24 (or $50,000 per year) for just the basics. That's why they need public benefits if they are only earning $15.

"Okay, but people just need to work harder and get a better job, right?"

Let's look at that. How many jobs in the greater Cincinnati region pay over $50,000? Only one in four. Said another way, three out of four jobs pay less than household-sustaining wages per year. And even at that wage, there is no money left to handle a car breakdown, or a medical emergency, or to save for the future.

So while it seems to make sense to remove public benefits as a person earns more, the current way that income levels are tied to benefits creates a disincentive to work or to pick up more hours. And even though that person is working hard, doing all they can to make ends meet, they can never get ahead because the jobs available to them, even with more training and skills, pay less than what it costs to provide for their families.

At some point, there are no public benefits available to assist them. And they are one medical emergency or car breakdown away from falling back into poverty.



If this sounds absurd, that is because it is, and yet it's the current policy across the country. A number of states have been studying this issue and introducing legislation to fix it, with Colorado leading the charge. Unfortunately, in many cases, the proposed legislation just died – for a variety of reasons, but mostly due to lack of funding.

Until policies change, what can employers do, especially if they can't raise wages? Well, they can talk to their employees and find out what would help them the most. Solutions might be providing assistance with transportation expenses, such as providing bus passes or a shuttle. It might be more predictable schedules that would even out their incomes week-to-week or month-to-month. It could be small emergency loans to cover a car breakdown. All of these options, and more, are provided in the National Fund's Job Design Framework and in an employer's toolkit compiled by the Women's Fund of the Greater Cincinnati Foundation.

Employers can also talk to their legislators. They can explain to them how crazy it is to disincentivize people to work or accept a raise. We need reforms that will help

people move off of public benefits in a more rational way that supports them as they are working hard and trying to get ahead. At the same time, employers should be doing all they can to think about how they can make their jobs even better (see NFWS's Job Design Framework). And yes, pay more."

[1] Wage data is from the Women's Fund of the Greater Cincinnati Foundation's Pulse Report: Outlining the Disincentives and Opportunity Costs for Working Mothers.

Thanks for reading!

[redacted]
Director of Workforce Development - Network4Health

FOUNDATIONS OF LEADERSHIP – NOW ACCEPTING APPLICATIONS

Network4Health is happy to partner with **Granite State College** to offer this program to leaders or aspiring leaders at no cost to employees of N4H partners.

This course will introduce participants to the fundamentals of leadership development. Participants will identify and gain awareness of their personal leadership style, examine leadership concepts, models and practices that lead to effective team and organizational performance. Topics will include Leadership Essentials and Strategies, Team Building, and Coaching and Mentoring. A variety of interactive teaching methods will be employed during the course, to include: case studies, current business articles, in-class simulation exercises, interaction and small group projects.

We are now accepting applications and the program will begin in March 2019 and run for 2 months until April 2019. Employees will be in class for 4 sessions over 2 months, and have approximately 2 hours of online work to do per week. In person classes will be held at GSC's Manchester campus on 195 MacGregor Street and are scheduled for:

Workshop 1: Leadership Essentials Tue., March 5th, 2019; 9 – 3:30pm
Workshop 2: Leadership Strategies Tue., March 26th, 2019; 9 – 3:30pm
Workshop 3: Team Building Tue., April 9th, 2019; 9 – 3:30pm
Workshop 4: Coaching & Mentoring Tue., April 30th, 2019; 9 – 3:30pm

Informational Call:

Have questions or want more information? We will have an open informational call on December 14th from 1p – 2p. Dial in number: (701) 801-1211; Access Code: 149-550-560

How to Apply:

If you are interested in an application and more information, please **CLICK HERE** to send an email to request it.

MATCH Training in Manchester*

Costs for this program will not be reimbursed and will not be covered by IDN funds.

The Manchester Community Health Center has contacted the Harvard Judge Baker Children's Center to enlist them to deliver the Modular Approach to Therapy for Children (MATCH) training program in Manchester. February 25 - March 1, 2019 are being held as the New Hampshire Training dates. **Currently there are 14 slots open for clinicians at a cost of $3067.00 each.**

This is a terrific opportunity to learn a high quality, evidence-based counseling program for children experiencing multiple problems related to anxiety, depression, posttraumatic stress, and disruptive conduct, including conduct problems associated with ADHD. Please visit: https://jbcc.harvard.edu/match-trac for more information.

For more information about the training before securing a spot, please contact Katy Burchett, Director of Social Services, Manchester Community Health Center, kburchett@childhealthservices.org

Grant Opportunities

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Workforce Readiness and Vocational Training Programs for Individuals with Opioid Use Disorder - Due December 13th, 2018

https://www.dhhs.nh.gov/business/rfp/rfp-2019-bdas-12-workf.htm

This Request For Proposals (RFP) is for vendors who can design and implement vocational training supports and workforce readiness programming for individuals with Opioid Use Disorders (OUD) in treatment and recovery settings seeking to join or re-join the workforce. This procurement will require vendors to integrate workforce readiness programming into treatment and recovery settings, including conduct vocational profiles in order to determine an individual's skill level, their strengths and readiness to gain employment and a course of action to link the individual to appropriate vocational trainings with the provision of training stipends and other resources to aid the individual on the path to employment. Vocational training may include, but is not limited to assistance with resume writing, job applications and improving interviewing skills.

HRSA
Health Resources & Services Administration

Advanced Nursing Education Workforce (ANEW) – **January 8.** HRSA's Bureau of Health Workforce will make 53 awards to accredited schools of nursing, nursing centers, academic health centers, and state or local governments. The ANEW program supports academic clinical partnerships to educate and graduate primary care Nurse Practitioners, clinical nurse specialists and nurse midwives (NM) who are academically and clinically prepared for the unique challenges of transitioning from nursing school to practice in rural and underserved communities, thereby increasing access to needed primary medical care for these populations.

Office of the Assistant Secretary for Health (OASH)

Rural Primary Care SBIRT for Maternal Opioid Use – March 29. The U.S. Department of Health & Human Services Office of the Assistant Secretary for Health (OASH) will grant $2 million to support the implementation and evaluation of screening, brief intervention, and referral to treatment services (SBIRT) for maternal opioid misuse. Although SBIRT is an evidence-based intervention shown to decrease substance use that is covered by both Medicare and Medicaid, it is not yet widely used in rural primary care settings for women's health. Rural providers can find guidance on implementing SBIRT services from the Substance Abuse and Mental Health Services Administration and the U.S. Preventive Services Task Force.

Scholarship and Fellowship Opportunity

The National Board of Certified Counselors (NBCC) Foundation awards scholarships, fellowships and capacity-building grants to increase mental health resources in rural and urban minority communities. Minorities include but are not limited to racial, ethnic, cultural, religious, gender, sexual orientation, rural, or military groups. While these fellowships are not limited to individuals from minority populations, priority will be given to individuals from the following communities: African American, Alaska Native, Asian American, Hispanic/Latino, Native American, Native Hawaiian, and Pacific Islander. *Deadline for all - December 15th!*

The NBCC Minority Fellowship for Addictions Counselors will grant up to 40 master's degree-level counseling fellowships of $15,000 for addictions counseling students in exchange for work in underserved communities in inner city or rural areas.

The NBCC Minority Fellowship for Mental Health Counselors will grant up to 30 master's or doctoral level counseling fellowships of $10,000 in exchange for a commitment to teach, administer services, conduct research, and/or provide direct mental health counseling in an underserved minority community. **Find out more at:** https://www.nbccf.org/programs/scholarships

Apprenticeship Program for Medical Assistants

Please feel free to share this with any friends, colleagues, or clients you have who would benefit from this terrific career opportunity.

CMC is preparing to start another class of 8 students in January 2019 for the **Medical Assistant Apprenticeship** in partnership with Manchester Community College (MCC) and ApprenticeshipNH.

Participants in the apprenticeship are full-time, benefited CMC employees from the start of the program, as well as receiving 60% of their tuition paid by CMC. The participants are eligible for additional grant funding toward tuition through ApprenticeshipNH and receive increases to their base pay as they meet milestones throughout the program. Completion of the

apprenticeship earns the participant a National Occupational Credential through the Department of Labor. The program consists of:

- 12 weeks of classroom instruction at MCC
- Preparation and eligibility to sit for the Certified Clinical Medical Assistant (CCMA) national exam
- Placement after classroom education into a full-time open medical assistant position at one of our Primary Care or specialty practices
- Completion of 3,600 on-the-job training hours with a mentor

To learn more about this opportunity and have your questions answered, please visit the CMC Careers webpage at: https://careers.catholicmedicalcenter.org/

N4H Needs Your Help

We've recently come across a nursing credential we are interested in hearing your opinion about. ANCC (American Nurses Credentialing Center) is a well recognized credentialing body for nursing and nursing practice, and they offer a **Psychiatric-Mental Health Nursing Certification (RN-BC).** https://www.nursingworld.org/our-certifications/psychiatric-mental-health-nursing-certification/

The ANCC Psychiatric–Mental Health Nursing board certification examination is a competency based examination that provides a valid and reliable assessment of the entry-level clinical knowledge and skills of registered nurses in the psychiatric–mental health specialty after initial RN licensure.

Eligibility:

- Hold a current, active RN license in a state or territory of the United States.
- Have practiced the equivalent of 2 years full-time as a registered nurse.
- Have a minimum of 2,000 hours of clinical practice in psychiatric–mental health nursing within the last 3 years.
- Have completed 30 hours of continuing education in psychiatric–mental health nursing within the last 3 years.

As part of our effort to have a well-trained, competent and confident workforce, we are interested in finding out if we should financially support attainment of this credential. If you are a nurse, nurse supervisor, or a leader of an organization that employs nurses who interact with patients with a behavioral health diagnosis, we'd like to hear from you on this. **Please take this very brief survey to share your opinion so that we can continue to deliver relevant trainings and credentials to our workforce:** https://www.surveymonkey.com/r/M65KYSB

Know Your Career Path

Licensed Alcohol and Drug Counselors (LADC): Associate's level

Substance Use Counselors are trained professionals who offer support, rehabilitation, and guidance. They work closely with people with substance use disorders to help them better understand and overcome their addictions.

The scope of a substance abuse counselor's support can vary from crisis intervention to long-term management issues, procuring immediate medical attention to assisting with ongoing treatment. Counselors will evaluate their clients' mental and physical health, the scope and severity of their addictions, and help develop treatment goals and plans. They teach clients coping mechanisms, help

them rebuild relationships, and assist them in reestablishing their careers.

Note: This position can only work in an agency under weekly supervision. For more on the scope of practice, please see: http://www.gencourt.state.nh.us/rsa/html/XXX/330-C/330-C-11.htm

Licensure/Education Needed	***Local Education Programs***
The foundation for a LADC license is a qualifying degree and examination and documented experience (http://www.gencourt.state.nh.us/rsa/html/XXX/330-C/330-C-mrg.htm). If the degree is at the associate's level, it should be in **addiction studies or substance abuse counseling**. Candidates must complete 300 hours of education in drug and alcohol use. These hours may or may not be earned in conjunction with the qualifying degree. Additional requirements: • 6,000 hours of supervised work experience • 300 hours of supervised practical training within the degree-granting program, as part of the supervised work experience or separately • Pass IC & RC ADC exam See: http://www.gencourt.state.nh.us/rules/state_agencies/alc100-500.html - PART Alc 306	**NHTI:** AS in Addiction Counseling https://www.nhti.edu/academics/programs-study/human-service-programs/addiction-counseling-degree

CIRCLE OF SECURITY PARENTING (COSP) TRAINING

Circle of Security Parenting training is being held **January 21 – 24, 2019 at Dartmouth-Hitchcock in Lebanon, NH** and is being organized through Dartmouth-Hitchcock Moms in Recovery Program. Please note: There needs to be a minimum number of registrants before the date is confirmed in order for things to move forward and, as of this writing, it has not been met yet.

Circle of Security® Parenting™ is a parent-reflection program offering the core components of the evidence-based and internationally acclaimed COS protocol. This 4-Day training teaches professionals to use an eight-chapter DVD to educate parents and caregivers. The program presents video examples of secure and problematic parent/child interaction, healthy options in care giving, and animated graphics designed to clarify principles central to COS. Circle of Security Parenting implements decades of attachment research in an accessible step-by-step process for use in group settings, home visitation, or individual counseling. Target Audience: Community Family Resource Centers, Early Intervention Specialists, DCYF, anyone working with children and families.

Network4Health is supporting 2 slots for this event for participants to become COSP Facilitators. Interested partners need to sign up before 12/24. Anyone who signs up must agree to offer the training to the region at least once during 2019. Network4Health will work with facilitators to arrange, coordinate and market this.

For more information on COSF:
https://www.circleofsecurityinternational.com/circle-of-security-parenting

To indicate your interest in a Network4Health slot, please begin by completing this form: **https://www.eventbrite.com/e/cosp-circle-of-security-parenting-4-day-facilitator-training-121-thru-1242019-tickets-52720112275**

FREE SPONSORED TRAININGS – COSTS COVERED BY NETWORK4HEALTH*

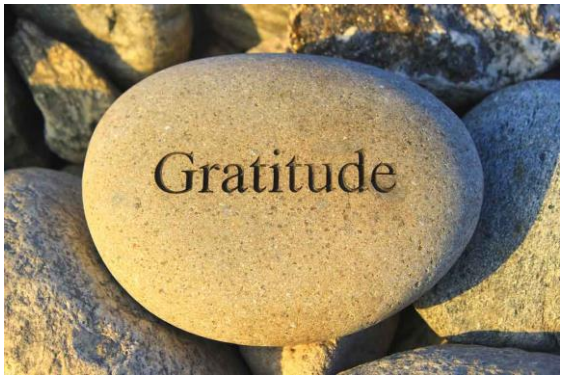
**** Applies only to employees of Network4Health partners in IDN4***

Have a training or a conference you would like to attend personally or want to send staff to?
Please email us the information and we will consider sponsoring seats at the event.

NHADACA ~ NHTIAD			
12/7/18	8:30 am – 4:00 pm: **Substance Use Counseling Skills and Core Functions** *130 Pembroke Road Suite 100, Concord NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/14/18	8:30 AM - 4:00 PM: **HIV Trends and Treatments** *130 Pembroke Road Suite 100, Concord, NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/17/18	8:30 am - 4 pm: **Certified Recovery Support Worker (CRSW) Performance Domains,** *130 Pembroke Road Suite 100, Concord, NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/19 & 12/20/18	8:30 am - 4 pm: **Ethics for Peer Recovery Support Workers,** *130 Pembroke Road Suite 100, Concord, NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/19/18	8:30 am - 4 pm: **Supervising Peer Recovery Support Workers,** *130 Pembroke Road Suite 100, Concord, NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/21/18	8:30 am - 4 pm: **Prevention Ethics,** *130 Pembroke Road Suite 100, Concord, NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
1/31/19	8:30 am - 4 pm: **Confidentiality and Ethical Practices: Issues for Substance Use, Mental Health and other Healthcare Providers,** *130 Pembroke Road Suite 100, Concord, NH*	CEU's Available!	Click to Learn More & Sign Up for a Seat
MHCGM Trainings			
12/6/18 9am-4:30pm	**Integrated Treatment of Co-Occurring Disorders (IDDT)** MHCGM Blodget St. Training Room 5 Blodget St. Manchester, NH	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/12/18 9am-4:30pm	**Stages of Change** 401 Cypress Street, Board Room, Manchester, NH	CEU's Available!	Click to Learn More & Sign Up for a Seat
1/18/19 and 1/25/19	**Youth Mental Health First Aid -** designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. *Manchester Health Department, 1528 Elm Street, Manchester, NH*	Two-day training!	Click to Learn More & Sign Up for a Seat
PESI Workshops			
12/6/18 8 to 4pm	**Over 75 Quick "On-The-Spot" Techniques for Children and Adolescents with Emotional and Behavior Problems** Manchester Downtown Hotel, 700 Elm Street, Manchester, NH	CEU's Available!	Click to Learn More & Sign Up for a Seat
University of New Hampshire			
1/11/19 9 – 4pm	**Ethics and Boundaries in Coaching Youth Affected by Substance Abuse -** Portsmouth/Pease, Great Bay Community College	CEU's Available!	Click to Learn More & Sign Up for a Seat

Other Training Vendors			
12/6 – 12/7 9am-4:30pm	**FY19 WRAP Seminar (session 3) -** Steppingstone and Next Step Peer Support and Respite Centers Doloff Building, DHHS, 117 Pleasant Street, Concord, NH	CEU's Available!	Click to Learn More & Sign Up for a Seat
12/11/18 8:30am – 5pm	**Assessing and Managing Suicide Risk -** AMSR's research-informed risk formulation model helps clinicians feel confident navigating challenging conversations and offers key strategies for providing compassionate care to people at risk for suicide. *Education Development Center, 43 Foundry Ave., Waltham, MA*	CEU's Available	Click to Learn More & Sign Up for a Seat
Free Trainings & Easy Registrations			
12/10/18 3-4:30p	**National Re-Entry Resource Center:** Webinar - *Foundations of an effective familiar face framework*		FREE - Click to register
12/12/18 1p – 2p	**Manatt Health:** *Information Sharing During the Opioid Crisis: Challenges and Solutions*		FREE - Click to register
12/12/18 2-3pm	**Collaborative Family Healthcare Association**: Webinar - *At Home, But Not Welcome: Frameworks to Use When Working With Undocumented Latino Patients & Families*		FREE - Click to register
12/12/18 3:30pm	**ASAM:** How to Track Treatment Progress and Adherence with the ASAM Criteria for Drug Court Team Members		FREE - Click to register
12/13/18 3pm	**The Weitzman Institute:** Webinar - *Behavioral Health Workforce Development Training Across the Various Behavioral Health Disciplines*		FREE - Click to register
01/09/19 3p – 4p	**NAADAC:** Webinar - *Implementing SBIRT in Rural Clinics: A How-to Guide*		FREE - Click to register
Free Self-Paced Online Trainings			
Ongoing	**Introduction to Behavioral Health in Schools: Supports for Students** - The Clough Foundation Training and Access Project (TAP) is a part of the Boston Children's Hospital Neighborhood Partnerships Program (BCHNP) in the Dept. of Psychiatry at Boston Children's Hospital. This training uses an ecological model that takes into account development, environment, and cultural considerations to help build a context for understanding student behavior.		FREE - Click to register
	Optum Health - Webinar Education Series:		
Ongoing	Establishing Effective Communication with Patients with Intellectual Disabilities: R.A.F.T. Part 1	CEU's Available!	FREE - Click to register
Through 11/21/19	Non-pharmaceutical Management of Behavioral Issues in Older Adults	CEU's Available!	FREE - Click to register
Through 05/04/20	The Relationship Between Physical and Behavioral Health	CEU's Available!	FREE - Click to register
Through 05/30/20	Management of Comorbid Behavioral and Physical Illness Near the End of Life	CEU's Available!	FREE - Click to register

SHOWING GRATITUDE IN MANAGEMENT



Your Most Powerful Forgotten Weapon: Gratitude by David Horsager
https://www.forbes.com/sites/forbesleadershipforum/2012/11/28/your-most-powerful-forgotten-weapon-gratitude/#16c51ff16c29

We just celebrated a holiday that's all about giving thanks for what we have (including turkey and football). But if we think about gratitude only once a year, we overlook the immense power of practicing it daily, especially in a business context.

A recent study by Bersin & Associates underscores the bottom-line implications of saying thank you in the workplace. It reveals that companies that "excel at employee recognition" are 12 times more likely to enjoy strong business results. If you aren't already a believer in the thank you economy, just think about what it can mean to your business if you embrace the power of gratitude.

My own academic research on trust has revealed not only that gratitude makes a difference but that people don't require big gestures, just heartfelt ones. Simple but genuine thank-you's or small, handwritten notes of appreciation can mean the world to people. So if it's so easy, why don't we do it more often?

When it comes to business, I think we fall into the trap of not seeing people when we work with them. We take them for granted and just assume they don't need a show of gratitude. This oversight can have huge consequences, particularly if you're the boss.

For instance, my friend Tony completed a project that saved his company tens of thousands of dollars a month. It also cut a process that used to take almost two days down to three hours. Considering the bottom-line significance of Tony's project, you can imagine his confusion when nothing was said after its successful implementation. At the first staff meeting afterward, his manager quietly slid him a box that held a standard item the company gave to recognize a job well done. But no one said anything, then or later.

Tony told me that as little as a handshake, a word of appreciation in private, or a pair of movie tickets would have meant more. But the silence hurt. He responded by leaving the company and starting his own successful business. I doubt that many organizations can afford to lose their 'Tonys' simply because they've fostered a culture of silence instead of gratitude.

On a personal level, what are the qualities that attract you to another person? When I ask this question during speaking sessions, I often hear words like charisma, kindness, or physical appearance. The audience is usually surprised when I tell them that the most magnetic trait is not charisma or even a smile but gratitude. In fact, if you think about it, chances are good that the people you like and respect the most—both personally and professionally—have no problem showing their appreciation.

In business we're drawn to people who acknowledge our contributions. When those people hold leadership positions, you can see the trickle-down effect on the company as a whole—all the way down to customers. When managers and employees know that company leaders value gratitude, those who serve customers on the front line show appreciation more readily. And we know that the customer who feels appreciated won't hesitate to return.

Knowing that gratitude comes with so many benefits, why do we still struggle to express it? I think we often assume that we do more than we do, or we tell ourselves that it's not worth the effort. If that's where you're coming from, then I have three suggestions to help get you out of your gratitude rut.

1. Take a few minutes each morning to make a list of three to five things you appreciate. This requires only a moment and it helps you cultivate a habit of gratitude. When we're caught up in our day-to-day routine, we easily overlook the people and things we appreciate. A daily reminder can give us a much needed happiness boost while also putting us in the gratitude mindset.

2. If you deal with employees, find ways to personalize your appreciation. The method of appreciation or the person who extends the gratitude can make a big difference. For example, some people value acknowledgement before a group, while others prefer a one-on-one thank you. This extra effort demonstrates that showing gratitude isn't just a routine for you. It makes a difference when people see that you care about what matters to them.

3. Leave yourself open to feedback. Part of expressing gratitude means also hearing what the other person has to say. One of the reasons we get frustrated with gratitude is because when we do show appreciation we don't always get the response we expected. An underwhelmed response to your display of gratitude can have several causes. The primary one might surprise you: lip service. If you show gratitude to someone who feels it's not genuine, the gesture will fall flat. If I as a manager thank an employee for doing a great job but ignore his feedback about ongoing issues, it rings a little hollow.

When we make the effort to adopt gratitude year-round, the results can prove astonishing. Few things stick in our minds like those moments when we learn that people appreciate our efforts or we acknowledge how others have helped us. I promise that when you make the effort to make gratitude a central part of how you think and act, you won't be disappointed with the results.

Network4Health

Learn more at:
https://www.network4health-nh.org/

Want to change how you receive these emails?
You can unsubscribe from this list.
Want to be added to this mailing list?

Questions? Comments? Suggestions?
Please reach us at N4H.WorkforceDevelopment@cmc-nh.org

		Task Mode	Task Name	Duration	Start	Finish	Resource Names
1			**BH Workforce**	**1,066 days**	**Sat 7/1/17**	**Thu**	
2			**Recruit**	**1 day**	**Sat 7/1/17**	**Thu**	
3	✓		Recruit 1 BH Workforce Director	132 days	Sat 7/1/17	Mon 1/1/18	BH Workforce Team,Catholic
4	✓		Recruit 1 BH Workforce Administrative Support Worker	132 days	Sat 7/1/17 8:00 AM	Mon 1/1/18 5:00 PM	BH Workforce Team,Catholic Medical Center
5	✓		Recruit 1 HIT Analyst/Trainer	132 days	Sat 7/1/17	Mon 1/1/18	HIT Team,Catholic
6	✓		Recruit 1 Integrated Healthcare	132 days	Sat 7/1/17	Mon 1/1/18	Integrated Healthcare
7	✓		Recruit 1 Critical Time Intervention Director	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
8	✓		Recruit 1 Care Transitions Administrative Support Worker	132 days	Sat 7/1/17 8:00 AM	Mon 1/1/18 5:00 PM	Care Transitions Team,MCHGM
9			Recruit 6 Critical Time	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
10	✓		Recruit 1 Co-occurring Disorders	132 days	Sat 7/1/17	Mon 1/1/18	Integrated TX COD
11	✓		Recruit 3 Dual Diagnosis	132 days	Sat 7/1/17	Mon 1/1/18	Integrated TX COD
12	✓		Recruit Program Coordinator (D3)	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD
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 8:00 AM	Sat 6/30/18 5:00 PM	Geoff Vercauteren
15	✓		Assess need to recruit 1.5 Innovation	131 days	Mon 1/1/18	Sat 6/30/18	Integrated Healthcare Team
16	✓		Assess need to recruit 5 Community Health Workers	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	Integrated Healthcare Team
17	✓		Assess need to recruit Mental	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD
18	✓		Assess need to recruit Substance Use Disorder Clinician	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	Expansion of SUD SVCS,Serenity Place
19	✓		Assess need to recruit Clinical	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD
20	✓		Assess need to recruit Nurse	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD
21	✓		Assess need to recruit Nurse Practitioner or Psychiatrist	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	Expansion of SUD SVCS,Serenity Place
22	✓		Recruit 1 additional HIT Analyst/Trainer	130 days	Mon 1/1/18	Fri 6/29/18	Laurie Diggins
23	✓		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
24			Assess turnover and additonal recruitment needs of N4H teams	132 days	Sun 7/1/18 8:00 AM	Mon 12/31/18 5:00 PM	Geoff Vercauteren
25			Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Sun 7/1/18 8:00 AM	Mon 12/31/18 5:00 PM	BH Workforce Director
26	✓		Milestone reporting period	0 days	Sat 7/1/17	Sat 7/1/17	
27	✓		Revise recruitment plan to include additonal positions needed based on most current assessment	130 days	Tue 1/1/19 8:00 AM	Sun 6/30/19 5:00 PM	BH Workforce Director

		Task Mode	Task Name	Duration	Start	Finish	Resource Names
28			Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
29			Assess turnover and additonal recruitment needs of N4H teams	132 days	Mon 7/1/19 8:00 AM	Tue 12/31/19 5:00 PM	BH Workforce Director
30			Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Mon 7/1/19 8:00 AM	Tue 12/31/19 5:00 PM	BH Workforce Director
31			Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
32	✓		Assess turnover and additonal recruitment needs of N4H teams	130 days	Wed 1/1/20 8:00 AM	Tue 6/30/20 5:00 PM	BH Workforce Director
33	✓		Revise recruitment plan to include additonal positions needed based on most current assessment	130 days	Wed 1/1/20 8:00 AM	Tue 6/30/20 5:00 PM	
34			Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
35			Assess turnover and additonal recruitment needs of N4H teams	132 days	Wed 7/1/20 8:00 AM	Thu 12/31/20 5:00 PM	Wed 7/1/20
36			Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Wed 7/1/20 8:00 AM	Thu 12/31/20 5:00 PM	Wed 7/1/20
37			Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	
38			**Trainings**	**1 day**	**Sat 7/1/17**	**Thu**	
39	✓		Confirm training needs of N4H teams	131 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
40	✓		Survey N4H partners to idenify which partners currently offer trainings needed	131 days	Sat 7/1/17 8:00 AM	Sun 12/31/17 5:00 PM	BH Workforce Director
41	✓		Develop training plan based on needs, requests and retention efforts	131 days	Sat 7/1/17 8:00 AM	Sun 12/31/17 5:00 PM	BH Workforce Director
42	✓		Begin implementation of training plan	131 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
43	✓		Critical Time Intervention worker training for Coaches	131 days	Sat 7/1/17 8:00 AM	Sun 12/31/17 5:00 PM	Care Transitions Team
44	✓		Critical Time Intervention training	131 days	Sat 7/1/17	Sun 12/31/17	Care Transitions Team
45	✓		Critical Time Intervention Community of Practice meetings	131 days	Sat 7/1/17 8:00 AM	Sun 12/31/17 5:00 PM	Care Transitions Team
46	✓		Case Western Reserve training	131 days	Sat 7/1/17	Sun 12/31/17	Integrated TX COD Team
47	✓		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
48	✓		Critical Time Intervention Worker training for Coaches	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	Care Transitions Team
49	✓		Critical Time Intervention Community of Practice meetings	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	Care Transitions Team
50			HIT training in CMT	305 days	Mon 1/1/18	Fri 3/1/19	HIT Team

		Task Mode	Task Name	Duration	Start	Finish	Resource Names
51	✓		Case Western Reserve training	131 days	Mon 1/1/18	Sat 6/30/18	Integrated TX COD Team
52	✓		Milestone reporting period	0 days	Sat 7/1/17	Sat 7/1/17	
53	✓		Critical Time Intervention Train-the-Trainer	132 days	Sun 7/1/18	Mon 12/31/18	Care Transitions Team
54			Critical Time Intervention Community of Practice meetings	132 days	Sun 7/1/18 8:00 AM	Mon 12/31/18 5:00 PM	Care Transitions Team
55			Milestone reporting period	0 days	Sat 7/1/17	Sat 7/1/17	
56			Critical Time Intervention Community of Practice meetings	130 days	Tue 1/1/19 8:00 AM	Sun 6/30/19 5:00 PM	Care Transitions Team
57			Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
58			Reasses training needs and participation	132 days	Mon 7/1/19	Tue 12/31/19	BH Workforce Director
59			Revise training plan based on most current assessment	132 days	Mon 7/1/19 8:00 AM	Tue 12/31/19 5:00 PM	BH Workforce Director
60			Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
61			Reasses training needs and participation	130 days	Wed 1/1/20	Tue 6/30/20	BH Workforce Director
62			Revise training plan based on most current assessment	130 days	Wed 1/1/20 8:00 AM	Tue 6/30/20 5:00 PM	BH Workforce Director
63			Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
64			Reasses training needs and participation	132 days	Wed 7/1/20	Thu 12/31/20	BH Workforce Director
65			Revise training plan based on most current assessment	132 days	Wed 7/1/20 8:00 AM	Thu 12/31/20 5:00 PM	BH Workforce Director
66			Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	
67			**Gap Analysis Assessment**	**1 day**	**Sat 7/1/17**	**Thu**	
68	✓		Obtain accurate account of open positions for targets found in most recent Gap	132 days	Sat 7/1/17 8:00 AM	Sun 12/31/17 5:00 PM	BH Workforce Director
69	✓		Align recruitment plan with	132 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
70	✓		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
71	✓		Assess and revise recruitment plan based on feedback from N4H partners	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	BH Workforce Director
72	✓		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
73	✓		Discontinue gap analysis	1 day	Sat 6/30/18	Sat 6/30/18	
74			**Statewide BH Workforce**	**915 days**	**Sat 7/1/17**	**Thu**	
75	✓		Approve Statewide Implementation Plan	1 day	Mon 7/3/17	Mon 7/3/17	Tina Sharby,Lisa
76	✓		Sign attestation agreeing to Statewide Implementation Plan	20 days	Tue 7/4/17 8:00 AM	Mon 7/31/17 5:00 PM	Alex WAlker
77	✓		Participate in establishing monthly work team meetings	46 days	Sat 7/1/17 8:00 AM	Fri 9/1/17 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
78	✓		Attend monthly work team meetings as appropriate	132 days	Sat 7/1/17 8:00 AM	Mon 1/1/18 5:00 PM	BH Workforce Director,Tina Sharby,Peter Janelle

		Task Mode	Task Name	Duration	Start	Finish	Resource Names
79	✓		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop	132 days	Sat 7/1/17 8:00 AM	Mon 1/1/18 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
80	✓		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
81	✓		Reasses particpation requested by the Statewide BH Workforce and adjust	23 days	Mon 1/1/18 8:00 AM	Wed 1/31/18 5:00 PM	Peter Janelle,BH Workforce Director
82	✓		Attend monthly work team meetings as appropriate	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	BH Workforce Director
83	✓		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop	131 days	Mon 1/1/18 8:00 AM	Sat 6/30/18 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
84	✓		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
85			Reasses particpation requested by the Statewide BH Workforce and adjust	22 days	Sun 7/1/18 8:00 AM	Mon 7/30/18 5:00 PM	Peter Janelle,BH Workforce Director
86			Attend monthly work team meetings as appropriate	132 days	Sun 7/1/18 8:00 AM	Mon 12/31/18 5:00 PM	BH Workforce Director
87			Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop	132 days	Sun 7/1/18 8:00 AM	Mon 12/31/18 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
88			Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
89	✓		Reasses particpation requested by the Statewide BH Workforce and adjust	23 days	Tue 1/1/19 8:00 AM	Thu 1/31/19 5:00 PM	Peter Janelle,BH Workforce Director
90			Attend monthly work team meetings as appropriate	130 days	Tue 1/1/19 8:00 AM	Sun 6/30/19 5:00 PM	BH Workforce Director
91			Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Tue 1/1/19 8:00 AM	Sun 6/30/19 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
92			Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
93			Reasses particpation requested by the Statewide BH Workforce and adjust	22 days	Mon 7/1/19 8:00 AM	Tue 7/30/19 5:00 PM	Peter Janelle,BH Workforce Director
94			Attend monthly work team meetings as appropriate	133 days	Sun 6/30/19 8:00 AM	Tue 12/31/19 5:00 PM	BH Workforce Director
95			Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	133 days	Sun 6/30/19 8:00 AM	Tue 12/31/19 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
96			Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
97			Reasses particpation requested by the Statewide BH Workforce and adjust	23 days	Wed 1/1/20 8:00 AM	Fri 1/31/20 5:00 PM	Peter Janelle,BH Workforce Director

		Task Mode	Task Name	Duration	Start	Finish	Resource Names
98			Attend monthly work team meetings as appropriate	130 days	Wed 1/1/20 8:00 AM	Tue 6/30/20 5:00 PM	BH Workforce Director
99			Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Wed 1/1/20 8:00 AM	Tue 6/30/20 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
100			Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
101			Reasses particpation requested by the Statewide BH Workforce and adjust	22 days	Wed 7/1/20 8:00 AM	Thu 7/30/20 5:00 PM	Peter Janelle,BH Workforce Director
102			Attend monthly work team meetings as appropriate	132 days	Wed 7/1/20 8:00 AM	Thu 12/31/20 5:00 PM	BH Workforce Director
103			Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	132 days	Wed 7/1/20 8:00 AM	Thu 12/31/20 5:00 PM	Tina Sharby,Lisa Desceneau,Peter Janelle
104			Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	

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 January submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

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

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

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

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

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

- An Event Notification System (ENS) through Collective Medical (CM) 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 CM, Network4Health will also develop a system to allow for the sharing of multi-disciplinary Care Plans across Network4Health partners and visibility to recommended care suggestions to all providers associated with the identified patient. This effort will support improved transitions, integration and implementation of alternative payment models;
- The incorporation of a direct secure messaging platform to support the secure sharing of patient information throughout the Network4Health community. In conjunction with other technologies this will have significant impact to the accuracy and follow up of referrals to support integration of primary care, behavioral providers and community-based organizations;
- Joining IDNs statewide in the implementation of a data aggregation tool through the Massachusetts eHealth Collaborative to support statewide data collection and performance reporting; and,
- Robust data collection software and data storage strategies through the use of PatientLink.
- Patient centered access to individualized comprehensive health records through the use of My Links

DIRECT Secure Messaging (DSM)

Network4Health currently has 31 partners (including all B1 participants) 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.

For those organizations that did not have DSM integrated in their EMR, our current strategy is to implement a sustainable and cost-effective solution through the use of MedAllies Mail. This application will provide a secure method for providers and community organizations to securely communicate with health care organizations across the community.

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.

Although traditionally used for HIPAA regulated organizations, Network4Health has identified that DSM has significant advantage for our community service organizations as a streamlined way to communicate to HIPAA regulated groups. Allowing community service providers to incorporate their communication into existing provider workflows within the EMR provides a streamlined and timely approach to send information. Network4Health has offered DSM services to all of our partners. Currently ninety two percent of our partners have completed or are in process with implementation.

We are on the verge of a new era of healthcare, with patients taking a more active role in their care and health decisions. MY LINKS allows patients to aggregate their own medical record into a centralized location and offers patients the ability to send and send/receive secure direct messages, thus allowing patients to share their medical record, remote patient monitoring results and questions with providers.

Network4Health has also established a project to build a Community Directory of secure messaging addresses to support the accuracy and maintenance of referral systems. Network4Health recognizes that organizations are limited in their ability to collect address data and keeping this data updated is a resource intensive task. With the development of this Community Directory, Network4Health will provide quarterly updates to our partners ensure information within their organizations is easily accurate and comprehensive. The first directory will be published on March 31, 2019.

As shown in our Project Plan (Attachment_A2.3a) implementation of direct secure messaging is ongoing for Network4Health.

Collective Medical - Event Notification and Shared Care Planning

As indicated in our project plan, we have made significant strides in the implementation of Collective Medical across the IDN. Currently all B1 Partners have contracted with Collective Medical for both event notification and Shared Care Planning. We have 3 additional partners who have joined our CM implementation to support their patients.

The changes and development activities of CM provided our partners with the necessary requirements to move forward with implementations. With a focus first on event notification services with each partner we were able to provide timely implementation and a period of “software success” that led to a confidence level for our partners related to security, privacy and software support. It was this level of confidence that has allowed an easy transition to shared care planning through CM.

Network4Health works with the Catholic Medical Center's Emergency Department (ED)to implement event notification has had significant impact. Initial data prompted CMC to develop an ED utilization task force that identifies high risk ED utilizers through the use of the CM Portal. In addition, it has brought realization to the ED team that overutilization is not limited to their four walls, and collaboration with primary care providers and other emergency departments is imperative to improvement.

Elliot Health System has completed the CM User Agreement and will be fully implemented in Q1 of 2019. Continued success stories of the value of CM being communicated to various departments within the Elliot System drove their decision to move forward. Despite multiple meetings and communications, Network4Health has received limited response from Parkland Medical Center regarding their intent to participate in the CM implementation. Network4Health with the support of CM will continue to attempt to engage Parkland Medical Center and other state HCA hospital organizations.

MAeHC Data Aggregator Service

As indicated in our project plan, Network4Health has continued to engage B1 partners in data reporting through Massachusetts eHealth Collaborative (MAeHC). The Network4Health HIT team is still working towards full understanding of the performance measurement reporting requirements to support implementation with MAeHC. Significant issues, such as a cross-IDN policy on the included reporting population, and common definitions of completion criteria for a Comprehensive Core Standardized Assessment are still being reviewed. As indicated and in-alignment with other IDNs, Catholic Medical Center as the Network4Health administrative lead executed a contract with MAeHC for IDN data aggregator services. Network4Health has created a subcontract data sharing agreement and Business Associates Agreement for review and signatures with each of our key data partners in order for them to move forward with MAeHC implementation. In January 2019, Network4Health will successfully submit data to MAeHC from all B1 partner organizations.

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 has made two options available to partners implementing a CCSA as part of their B1 Integration Enhancement Plan. They may either choose to modify their EHR to support data collection based on screening questions across all required CCSA domains or they may choose to implement Patient Link. Patient Link is a tool that provides organizations the ability to capture and send discrete, structured patient data into the electronic health record. It can also produce a PDF formatted document to support our non EHR partners thus reducing the time and resources needed to support manual data entry. Network4Health has executed a contract which allows access to Patient Link for those partners who chose to implement it.

Data Collection Support

Patient Link has also supported multiple other innovative projects within Network4Health. While the main initiative was CCSA collection many partners have found innovative ways to expand it's use. Multiple organizations our collecting assessment data, and developing SBIRT tools in addition to the CCSA.

The Center for Life Management has developed a referral registry using this technology. By using Patient Link to collect referral intake data they are quickly able to determine their ability to accept referrals based on the facility criteria.

Child Health Services in cooperation with the Manchester department of Public Health will be using Patient Link to screen students at local schools through evidence-based assessments beginning in September of 2019. This enhances a current program in place to provide social work to students in high risk home situations. Currently the program works with students through teacher recommendation, however this data capture provides the ability to screen all students and electronically calculate risk levels per student to determine need for services.

Families in Transition/New Horizons will use the patient link tool to register individuals at their shelters and food pantries. This system will allow for accurate counts of individuals using services as well as providing data on individuals last known address. The data will help to support current studies being done to determine homeless population demographics and will also provide an online dashboard for local EMS, police, fire and outreach workers to determine if space is available.

Closed Loop Referral Support

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

In reviewing our implementation plan for this endeavor, we had to consider funding uncertainties prior to committing to a contract. In our analysis we determined that a centralized system could be more cost effective. Currently Network4Health is working in conjunction with Granite Pathways and other IDNs to determine a collaborative solution to closed loop referral to accommodate multiple providers in the state. Network4Health still believes that Par8o offers the best available and sustainable solution and continues to support this product in discussions. In conjunction with Granite Pathways we will work towards a common solution to support the needs of our partners in IDN4.

Until these discussions are complete, Network4Health has worked with all partners to develop an interim workflow to insure closed loop referral functionality.

Workforce

Network4Health has determined that due to the vast types of support needed by our community that we would be better served by contracting with an IT consulting firm that can support the various needs including EMR Build, project management, implementation support, training plan development and interface development, instead of hiring an internal HIT analyst. Network4Health has contracted with KEA Associates for ongoing services beginning in July 2018.

Network4Health has updated and streamlined the HIT implementation plan (see Attachment_A2.3a) to align with our current program needs. Attachment_A2.3b provides an overview of HIT accomplishments by B1 partners to date. 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 CM		X	
Aim 3: Enroll ENS subscribers, train, and transmit notifications via CM		X	X
Aim 4: Design and Build SCP process and workflow based on available CM functionality (in alignment with B1 team)		X	X
Aim 5: Comprehensive Core Standardized Assessment rollout: Patient Link Rollout or Partner EHR Modifications		X	X
Aim 6: Train staff on solutions			X
Aim 7: Roll out solutions			X

A2-4. IDN HIT: Evaluation Project Targets

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

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

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 contribute to Event Notification System (ENS)	14 of 18 practices by 12/31/18	0	0	16
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 18 practices By 12/31/19	0	0	16
The number of participating partner organization who use DIRECT Secure Messaging	17 of 18 practices by 12/31/19	0	16	18
The number of participating partners who use an Event Notification System (ENS)	14 of 18 practices by 12/31/19	0	0	14
The number of participating partners who use a Shared Care Plan (SCP)	10 of 18 practices By 12/31/19	0	0	16

A2-5. IDN HIT: Workforce Staffing

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

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
HIT Director	Up to 1	0	1	1	1
IT Consultants	Up to 4000 hrs	0	0	Contracted	Utilized 867 hrs in reporting period

A2-6. IDN HIT: Budget

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

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

Revenue- All project budgets have been adjusted to reflect the actual receipt of funding. During the reporting period, anticipated funding was not received due to ongoing negotiations between NH DHHS and NH counties. The anticipated, but not yet received, 2018 funding for the HIT budget totals $1,009,555. These expected funds have been added to revenue in 2019. If anticipated revenue is

reduced as a result of State negotiations, Network4Health will revise budgets and project plan deliverables, subject to Steering Committee and NH DHHS approval.

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

Reported actual expenses continue to be below budget due in part to expense reporting that includes only invoiced and paid expenses. Significant training and development funding has been committed to the B1 Integrated Healthcare "Integration Enhancement Plans" that have been negotiated with network partners. Also, please note the following changes were made to January – June 2018 actuals: The distribution of expenses under the "Event Notification and Shared Care Plan" and "Data Aggregator" headings were updated to correctly reflect the split of payments across the sub-categories as per the invoices paid. The HIT Salary has been updated to reflect the correct salary figure paid between January–June 2018. The June 2018 salary payment was added twice in error on the previous SAR budget.

Transformation Funds	**CY 2017 (Yr2) Actuals**	**CY 2018 (Yr3) January to June Actual**	**CY 2018 (Yr3) July to December Actual**	**CY 2019 (Yr4) Projected**	**CY 2020 (Yr5) Projected**	**CY 2021 (Yr6) Projected**
A2 HIT Revenue (New)	$862,544	$483,025	$172,509	$2,449,626	$875,316	$357,796
A2 HIT Revenue (Rollover)		$ 826,276	$1,046,503	$ 189,501	$ 26,106	$ 2,143
Total Revenue	$862,544	$1,309,301	$1,219,012	$1,569,571	$ 901,422	$ 359,939
Event Notification System and Shared Care Plan						
Premanage ED - annual Subscription for CMC, Elliot, Parkland		$ 12,242	$ 24,356	$ 83,181	$ 85,677	$ 43,000
Premanage Primary/Community ($0.12 per Medicaid member per month) - Software License		$ 51,363	$ 34,242	$ 90,000	$ 90,000	$ 45,000

Premanage PMDP ($50 / provider/yr, ~200 providers) - Software License		$ -	$ -	$ 10,609	$ 10,927	$ 10,000
B1 Integration Enhancement Plan Support Funds						
Integrated Care IEP Implementation Support (care planning tool licensing, other HIT tool licensing, implementation fees, HIT Training, HIT consulting, existing tool development or customization costs, etc.			$ 62,616	$ 625,000	$ 225,000	
Secure Messaging						
Direct secure messaging ($750*30) - Software License			$ -	$ 25,000	$ 25,000	$ 25,000
Data Aggregator						
Data aggregator implementation		$ 91,895	$ 65,520			
Data aggregator Annual Service Fees		$ 62,675	$ -	$ 62,675	$ 62,675	$ 62,675
Data Aggregator Customizations, Consulting, Custom Reporting		$ -	$ -	$100,000	$ -	
Secure Data Storage						
Referrals						
Closed Loop Referral System			$ -	$ 100,000	$ 75,000	

CCSA Implementation						
Patient Link Implementation and Licensing Costs			$ 109,310	$ 100,000	$ 75,000	$ 50,000
EMR Integration (Technical Assistance Fund)			$ -	$ 45,000	$ 25,000	
Other						
Contingency Fund	$ 2,170	$ 532	$ 11,345	$ 50,000	$ 25,000	
Internet Connectivity		$ 148	$ -	$ 12,000	$ -	
HIT Salary	$ 34,098	$ 43,943	$ 143,228	$ 240,000	$ 200,000	$ 120,000
Subtotal	$ 36,268	$ 262,798	$ 450,617	$1,543,465	$899,279	$ 355,675
Variation to Budget (Transfer Funds to Proceeding Year)	$826,276	$1,046,503	$ 768,395	$ 26,106	$ 2,143	$ 4,264

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

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

B1 Organizations	Type
The Mental Health Center of Greater Manchester	CMHC
Center for Life Management	CMHC
Dartmouth Hitchcock Clinic- Manchester and Bedford Adult	PCP
Dartmouth Hitchcock Clinic- Manchester and Bedford Pediatric	PCP
Catholic Medical Center: Amoskeag Family Practice	PCP
Catholic Medical Center : CMC Behavioral Health	BH/SUD
Catholic Medical Center: Willowbend Family Practice	PCP
Catholic Medical Center: Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	PCP
Catholic Medical Center - Healthcare for the Homeless	FQHC/PCP
Elliot Health System: Doctors Park Pediatrics, Manchester	PCP
Elliot Health System: Partial Hospitalization Program	BH
Families in Transition/New Horizons	Res/SUD
Fusion	SUD
Easter Seals NH (Farnum Center)	SUD/CBSSO
Manchester Community Health Center: Hollis Street	FQHC/PCP/BH
Child Health Services at MCHC	FQHC/PCP/BH

MCHC East Side (Tarrytown Rd)	FQHC/PCP/BH
West Side Neighborhood Clinic	FQHC/PCP/BH
Ancillary HIT Participants	**Type**
Hope for NH Recovery	Recovery/ Peer
Makin It Happen	PREV/PH
City of Manchester Health Department	PH/PREV
Bhutanese Community of NH	CBSSO
Community Crossroads	CBSSO
Granite Pathways (FedCap)	CBSSO
Greater Derry Community Health Services	CBSSO
Life Coping Inc.	CBSSO
Pastoral Counseling Services	CBSSO
The Moore Center	CBSSO
The Upper Room	CBSSO
Granite United Way	CBSSO
On the Road to Wellness	CBSSO

A2-8. IDN HIT. Data Agreement

In order to initiate reporting submissions from IDN partners Network4Health initiated three individual agreements with B1 participants:

* BAA agreement to support the sharing of data for purposes of state reporting

** Service agreement to support the incentive funding and scope of work for participation

*** Data sharing agreement to support IDN data access to support analytics and performance evaluation

The status of these agreements for B1 partners is listed below:

B1 Organizations	BAA*	Service Agreement **	Data Sharing Agreement***
The Mental Health Center of Greater Manchester	Yes	Yes	Yes
Center for Life Management	Yes	Yes	Yes
Dartmouth Hitchcock Clinic- Manchester and Bedford	Yes	Yes	Yes
Catholic Medical Center: Amoskeag Family Practice	Yes	Yes	Yes
Catholic Medical Center : CMC Behavioral Health	Yes	Yes	Yes
Catholic Medical Center: Willowbend Family Practice	Yes	Yes	Yes

Catholic Medical Center: Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	Yes	Yes	Yes
Catholic Medical Center - Healthcare for the Homeless	Yes	Yes	Yes
Elliot Health System: Doctors Park Pediatrics, Manchester	Yes	Yes	Yes
Elliot Health System: Partial Hospitalization Program	Yes	Yes	Yes
Families in Transition/New Horizons	Yes	Yes	Yes
Fusion	Yes	Yes	Yes
Easter Seals NH (Farnum Center)	Yes	Yes	Yes
Manchester Community Health Center: Hollis Street	Yes	Yes	Yes
Child Health Services at MCHC	Yes	Yes	Yes
MCHC East Side (Tarrytown Rd)	Yes	Yes	Yes
West Side Neighborhood Clinic	Yes	Yes	Yes

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 Overview and Timeline	Narrative & Spreadsheet (Microsoft Project or similar platform)				
A2-4	Evaluation Project Targets	Table				
A2-5	IDN HIT Workforce Staffing	Table				
A2-6	IDN HIT Budget	Narrative and Spreadsheet				
A2-7	IDN HIT Key Organizational and Provider Participants	Table				
A2-8	IDN HIT Data Agreement	Table				

Project Timeline A2 December

smartsheet

	Task Name	Duration days	Start	Finish	Predecessors	% Complete
1	**HIT Implementation Plan**	1488	01/02/17	01/29/21		**100%**
2	**State Level HIT Planning**	728	01/02/17	12/31/18		**100%**
3	Participate in Statewide HIT Planning	149	01/02/17	05/31/17		100%
4	Receive Statewide HIT Report (informs IDN 4 Implementation Plan)	395	06/01/17	07/01/18		100%
5	Create IDN 4 HIT Implementation Plan	179	01/01/18	06/29/18		100%
6	**Network 4 Health/IDN 4 HIT Implementation Plan**	851	09/01/17	12/31/19		**77%**
7	**Event Notification and Shared Care Planning (CMT)**	618	09/20/17	05/31/19		**100%**
8	Sign IDN Support Contract w/ CMT (Network 4 Health/CMC Admin lead)	1	09/20/17	09/21/17		100%
9	**CMT Master Service Agreement and PreManage Service Orders**	345	09/20/17	08/31/18		**66%**
10	CMC Signed Agreement	0	09/20/17	09/20/17		100%
11	Elliot Signed Agreement	332	12/04/17	11/01/18		100%
12	Parkland Signed Agreement	270	12/04/17	08/31/18		0%
13	**ADT Feed Implementation to NH CMT PreManage Platform**	466	09/21/17	12/31/18		**59%**
14	CMC ADT feed Implementation, Testing and Go-Live	345	09/21/17	09/01/18	10	100%
15	Elliot ADT feed Implementation, Testing and Go-Live	333	04/02/18	03/01/19	11	75%
16	Parkland ADT feed Implementation, Testing and Go-Live	425	04/02/18	06/01/19	12	0%
17	**Emergency Department Event Notifications (CMT PreManage EDIE)**	154	01/29/18	07/02/18		**44%**
18	**CMC Emergency Department**	63	01/29/18	04/02/18		**100%**
19	Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	11	01/29/18	02/09/18	14FS -45d	100%
20	Implementation and Testing	32	02/12/18	03/16/18	19	100%
21	Emergency Department Training	29	08/01/18	08/30/18	20	100%
22	Go-Live	1	08/30/18	08/31/18	21	100%
23	**Elliot Emergency Department**	305	04/30/18	03/01/19		**32%**
24	Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	124	04/30/18	09/01/18	15FS -45d	75%
25	Implementation and Testing	61	10/01/18	12/01/18	24	40%
26	Emergency Department Training	29	12/01/18	12/30/18	25	10%
27	Go-Live	1	12/30/18	12/31/18	26	0%
28	**Parkland Emergency Department**	397	04/30/18	06/01/19		**0%**
29	Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	124	04/30/18	09/01/18	16FS -45d	0%
30	Implementation and Testing	61	10/01/18	12/01/18	29	0%
31	Emergency Department Training	29	12/01/18	12/30/18	30	0%
32	Go-Live	1	12/30/18	12/31/18	31	0%
33	**Primary Care and BH Providers Event Notification (PreManage Community)**	364	04/02/18	04/01/19		**65%**

	Task Name	Duration days	Start	Finish	Predecessors	% Complete
34	**Cohort 1 Participants - B1 Integrated Care Project**	638	04/02/18	12/31/19		**95%**
35	Sign CMT User Agreements	35	07/27/18	08/31/18	14	100%
36	Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	308	07/27/18	05/31/19	35FS -15d	90%
37	**Shared Cared Planning Implementation**	578	06/01/18	12/31/19		**0%**
38	Workflow	39	06/25/18	08/03/18	35	0%
39	Training	90	10/01/18	12/30/18	38	0%
40	Go Live	62	10/29/18	12/30/18	39	0%
41	**Cohort 2 Participants - B1 Integrated Care Project**	638	04/02/18	12/31/19		**60%**
42	Sign CMT User Agreements	35	07/27/18	08/31/18		100%
43	Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	65	07/27/18	09/30/18	42	75%
44	**Shared Cared Planning Implementation**	212	06/01/18	12/30/18		**0%**
45	Workflow	39	06/25/18	08/03/18	42	0%
46	Training	90	10/01/18	12/30/18	45	0%
47	Go Live	62	10/29/18	12/30/18	46	0%
48	**Cohort3 Participants - B1 Integrated Care Project**	364	04/02/18	04/01/19		**40%**
49	Sign CMT User Agreements	-213	09/01/18	01/31/18		100%
50	Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	246	07/27/18	03/30/19	42	15%
51	**Shared Cared Planning Implementation**	333	06/01/18	04/30/19		**62%**
52	Workflow	158	06/25/18	11/30/18	42	100%
53	Training	43	02/15/19	03/30/19	45	75%
54	Go Live	183	10/29/18	04/30/19	46	10%
55	**Comprehensive Core Standardized Assessment (PatientLink or EHR Build)**	445	12/11/17	03/01/19		**93%**
56	**PatientLink**	445	12/11/17	03/01/19		**93%**
57	Proof of Concept (N4H and PatientLink - CMC existing contract)	216	12/11/17	07/15/18		100%
58	Sign IDN Support Contract w/ PatientLink (Network 4 Health/CMC Admin lead)	160	02/05/18	07/15/18		100%
59	**B1 Cohort 1**	326	02/05/18	12/28/18		**96%**
60	Identify Cohort 1 Integrated Care Patientlink Participants	116	02/05/18	06/01/18		100%
61	B1 Cohort1 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	178	03/05/18	08/30/18	51	100%
62	Site Level Implementations: Requirements, Build, Testing, Training	129	06/25/18	11/01/18	54	100%
63	Go-Live(s) and Data Collection (Modifications and Lessons Learned)	152	09/30/18	03/01/19	55	85%
64	**B1 Cohort 2**	389	02/05/18	03/01/19		93%
65	Identify Cohort 2 Integrated Care Patientlink Participants	116	02/05/18	06/01/18		100%
66	B1 Cohort2 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	178	03/05/18	08/30/18	58	100%
67	Site Level Implementations: Requirements, Build, Testing, Training	240	06/25/18	02/20/19	59	85%
68	Go-Live(s) and Data Collection (Modifications and Lessons Learned)	152	09/30/18	03/01/19	60	85%

	Task Name	Duration days	Start	Finish	Predecessors	% Complete
69	**Data Aggregator Services (MAeHC)**	483	09/01/17	12/28/18		**84%**
70	Identify capable vendors	0	09/01/17	09/01/17		100%
71	Sign IDN Support Agreement	83	11/03/17	01/25/18	63FS +45d	95%
72	CMC Denominator Submission	490	01/26/18	05/31/19	64	75%
73	Sign Data Sharing Sub-Contracts with Network4Health Partners (begin implementation as contracts are signed)	247	01/26/18	09/30/18	64	75%
74	Implementation, Testing, Go-Live (as contracts are signed)	284	03/09/18	12/18/18	66SS +30d	75%
75	**Closed Loop Referral Tool (Par8o)**	516	01/01/18	06/01/19		8%
76	Validate vendor selection	423	01/01/18	02/28/19		25%
77	Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	365	03/01/18	03/01/19	69	0%
78	Identify Partner Organizations for Implementation	365	03/01/18	03/01/19	70SS	20%
79	Configuration, Workflow and Implementation	237	09/06/18	05/01/19	72	0%
80	Training	139	12/27/18	05/15/19	73	0%
81	Go-Live(s)	100	02/21/19	06/01/19	74	0%
82	**Direct Secure Messaging (MedAllies)**	371	01/01/18	01/07/19		100%
83	Validate vendor selection	81	01/01/18	03/23/18		100%
84	Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	39	03/26/18	05/04/18	77	100%
85	Identify Partner Organizations for Implementation (B1 Project - Cohort 2)	39	05/07/18	06/15/18	78	100%
86	Sign Participant Agreements (Partner Orgs)	4	06/18/18	06/22/18	79	100%
87	Configuration, Workflow and Implementation	127	06/25/18	10/30/18	80	100%
88	Training	71	08/20/18	10/30/18	81	100%
89	Go-Live(s)	15	10/15/18	10/30/18	82	100%

Attachment A2-3b

HIT PROJECT OVERVIEW (B1 Participants)									
Organization	CMT contract	CMT Kickoff	CMT File transmission	CMT Live Alerts	MAEHC Submission July	MAEHC Submission December	Direct messaging	Design and Build SCP process and workflow	CCSA Roll out
CMC Amoskeg Family Practice	X	X	X	X	X	X	X	X	X
CMC Willowbend Family Practice	X	X	X	X	X	X	X	X	X
CMC Bedford Center Internal Medicine and Pediatrics	X	X	X	X	X	X	X	X	X
CMC Behavorial Health	X	X	X	X	X	X	X	X	X
Catholic Medical Medical - Healthcare for the Homeless	X	*X*	*X*	X		X	X	X	X
Dartmouth Hitchcock Adult	X	X	X	*X*	X	X	X	X	X
Dartmouth Hitchcock Pediatric	X	X	X	*X*	X	X	X	X	X
Elliot Hospital PHP	X	X	X			X	X	X	X
Elliot Health Pediatric	X	X	X			X	X	X	X
Mental Health Center of Greater Manchester	X	X	X	X	X	X	X	X	X
Center for Life Management	X	*X*	*X*	X	X	X	X	X	X
Manchester Community Health Center	X	*X*	*X*	X	X	X	X	X	X
Manchester Community Health Center Child Health Services	X	*X*	*X*	X	X	X	X	X	X
Manchester Community Health Center East side	X	*X*	*X*	X	X	X	X	X	X
Manchester Community Health Center West side Neighborhood clinic	X	*X*	*X*	X	X	X	X	X	X
Families in Transition	X	*X*	*X*	In progress		X	X	In Progress	X
Easterseals / Farnum Center	In Process	X	In Process			In Progress*	X	In progress	X

Attachment A2-3b

Fusion	X	X	X	X	No data new Org	X	X	X	X

Project B1: Integrated Healthcare

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

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

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

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

The Coordinated Care Practice must include:

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

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

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

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

Progress Narrative

During this reporting period, Network4Health's B1 Integrated Healthcare project participants made significant progress towards coordinated, and, for two partners, integrated care designation. Culture change and change management continue to pose the biggest challenge, but the level of networking and collaboration among partners, especially through development of joint workflows and protocols has mitigated that challenge. One helpful change management and measurement tool continues to be the Site Self-Assessment (SSA) used by the IDNs state-wide. The SSA tool will continue to provide a standardized assessment of a practice's progress along the continuum of integrated care. Two baseline SSAs, and the second SSA for thirteen B1 partners were completed during this reporting period, and results were provided back to members by the Citizens Health Initiative (NH CHI) at the October B1 Advisory Board Meeting. We anticipated that the results of the second SSA would show little to no movement along the continuum, as partners gained a more critical eye around what defines integrated healthcare delivery. However, improvement was seen across both SSA domains.

B1 partners report that the SSA is valuable as they obtain insight from staff across departments, identify opportunities for improvement, measure progress which also provides a measure of accountability, and determine action steps. NH CHI reported the following lessons learned from the SSA:

- Overestimation of the level of "buy-in" for change from the practices
- The importance of providing refreshers to the practices on the "How To" take an SSA
- The SSA provides an opportunity for organizations to foster a culture of trust and move toward improved data transparency
- Having a provider champion is key

Implementation of the Integration Enhancement Plans (IEPs) has begun with most partners. IEPs were submitted by all but two B1 partners in the last reporting period, and submitted by the final two partners, Easterseals NH/Farnum Center, and Elliot Health System's Partial Hospitalization Program (as described in our D3 project update). this reporting. Regular meetings were held by the B1 Network4Health team with partners to provide support, guidance and some project management, but the bulk of the work to move integration forward was done internally by each partner to develop the strategies and tactics within the primary care and behavioral health practices to define how communication flows among the multi-disciplinary team, and how to operationalize integration at a particular site. To further support these efforts, the B1 team coordinated with the Network4Health A1 workforce director to bring Cherokee Health Systems back for a second conference on September 27th and 28th, 2018. Cherokee Health Systems is considered a gold standard in evidence-based integrated healthcare delivery model. Network4Health plans to continue to partner with Cherokee throughout the course of the waiver to bring best practices to our partners.

All partners worked toward and achieved Coordinated Care Practice Designation. The Network4Health B1 IEP project required each organization to achieve the following:

- Integrated healthcare delivery that enhances both collaboration and integration;
- Comprehensive Core Standardized Assessment with required domains;
- Multi-disciplinary Core Teams;
- Information sharing: care plans, treatment plans, case conferences, closed loop referrals; and,
- Standardized workflows and protocols

We are seeing what one partner called "the synergistic effect of the waiver." During a December meeting where Network4Health presented to Mental Health Center of Greater Manchester leadership, their COO remarked about the B1 Integration Enhancement Plan process and implementation, "Everything has opened a window to something else. It's had a synergistic effect." Seeing the value in integrated care, some partners are working on components of Integrated Care Practice Designation:

- Fusion and Dartmouth-Hitchcock: adoption of MAT and enhanced use of technology for shared care planning and closed loop referral
- Both CMC primary care and Dartmouth-Hitchcock primary care have allowed electronic medical record (EMR) access to MHCGM to improve care coordination of shared patients/clients

The two Federally Qualified Health Center (FQHC) partners, Manchester Community Health Center and Healthcare for the Homeless, worked towards and achieved Integrated Care Practice Designation. Network4Health B1 IEP project required these two partners to achieve the following:

- Implementation of Medication-Assisted Treatment (MAT)
- Implementation of evidence-based treatment of mild to moderate depression
- Use of technology to identify at risk patients, plan their care, monitor progress toward goals and ensure closed loop referrals
- Shared interoperable EHR or electronic care coordination system that incorporate the CCSA and Care Plan

- Documented workflows, joint service protocols and communication channels with social service providers
- Closed loop referral capabilities

Hiring

Network4Health continues its contract with the University of New Hampshire (UNH) for support from their New Hampshire Citizen's Health Initiative team (NH CHI) to provide practice level facilitation to our project participants, and provide subject matter expertise. UNH/NH CHI is also contracted to manage the continued collection of the Site Self-Assessment (SSA) Evaluation Tool from the Maine Health Access Foundation Integration Initiative for all participating practices for the duration of the waiver. No additional hires or staff augmentation related to the B1 project team are anticipated at this time.

The following table provides the completed and in-progress hiring of all Network4Health Integration Enhancement Plan (IEP) partners.

Organization	IEP Hiring Completed and Anticipated
FQHC s & CMHCs	**(Hired staff unless noted)**
FQHC - Healthcare for the Homeless	• APRN and per diem provider (anticipated Q1/Q2 2019)
FQHC - Manchester Community Health Center	• Case Manager 1 (WSNHC) • Case Manager 2 (TT) • Community Health Worker 1 (TT /WSNHC) • Community Health Worker 2 (Hollis) (32 hrs) • Community Health Worker 3 (Hollis) • Community Health Worker 4 (Hollis) • Community Health Worker Supervisor • Behavioral Health Consultant
CMHC - Center for Life Management	• Nurse Care Navigator

CMHC - Mental Health Center of Greater Manchester	• Intensive Transition Team (ITT)
	  • ITT Coordinator
	  • ITT Case Manager 1
	  • ITT Case Manager 2
	  • ITT Case Manager 3
	  • ITT Case Manager 4
	  • ITT Peer Specialist
	  • ITT Program Assistant/Office support
	  • APRN (.2) (anticipated Q1/Q2 2019)
	• Intake Clinician - School Liaison (partial funding)

Primary Care	

PC & BH - Catholic Medical Center	• 3 x Behavioral Health Patient Navigators (interviews in progress) • Therapist (anticipated hiring in Q1/Q2 2019)
PC - Dartmouth-Hitchcock -Adult / Pediatric	• 2 x Licensed Mental Health Clinician – Adult Primary Care • Licensed Mental Health Clinician - Pediatrics • Family Support Specialist (Social Worker/Navigator)
Elliot Health Pediatrics Manchester IEP Accepted, SOW Pending	• Therapist (anticipated Q2 2019) • Social Worker (anticipated Q2 2019)
BH / SUD	
Fusion Health Services MAT and Primary Care Services	• Behavioral Health Clinician • Care Manager
Families in Transition- New Horizons Willows Treatment Program	• Director of Operations • Therapist • 2 x Certified Recovery Support Worker (1 hired, 1 in recruitment)

Participant Implementation Process: General

Partners understand the importance and value proposition of integrated care delivery, but find at times that it is difficult to prioritize the B1 project given the competing demands for their engagement, such as demands from payers other than Medicaid, mergers, acquisitions, EMR implementations, leadership changes, and competing grant initiatives, such as the Hub and Spoke grant. Network4Health appreciates this and works closely with partners to ensure successful implementation of the B1 project IEPs. Network4Health's executive director and the Steering Committee have been instrumental in escalating engagement issues when needed. NH DHHS Medicaid and Bureau of Drug and Alcohol Services staff have also worked with the B1 team to move reluctant partners forward with IEP planning and implementation.

The regular B1 Integrated Care workgroup meetings helped to improve networking and strengthen relationships across IDN partners. One IEP lead from one of the larger primary care practices remarked, "Now I know people from other organizations through the workgroup. We never used to talk to each other and now we do! When I need something, I know who to call."

We have also observed that the development of joint intra-organization workflows has a synergistic effect, with the stronger partners motivating and speeding up the level of progress for some of the less mature organizations. The proactive culture from one organization also spreads as they work closely together to address issues. The waiver requirements have drawn attention, too, to the fact that while many organizations use evidence-based best practices, they're not always used consistently. That's

where the training and protocol requirements help to move along the continuum – SBIRT implementation is a good example.

In this reporting period, the B1 workgroup meetings were used to present, discuss and collaboratively develop recommended strategies and tactics to advance integrated healthcare delivery. For instance, the recommended CCSA questions were developed by the B1 workgroup; implementation strategies were shared. Each partner submitted as part of their IEP the CCSA screening tool, covering all required domains, which their organization chose, along with an implementation plan. We expect that the implementations will bring to light other best practices and perhaps changes in evidence-based screenings. In 2019, the B1 workgroup will review the CCSA as part of an annual review, and develop revisions as needed to share with partners as well as the other IDNs.

All B1 pediatric providers continue to ensure that all children receive standardized, validated developmental screenings. This was part of their care delivery prior to the waiver, but the IEP provided an opportunity to look at their process, and how to more effectively share related information with the multi-disciplinary core team.

Multiple evidence based screenings practices are included in the CCSA recommendations, including the PHQ 2 and PHQ 9 depression screenings. To align with NH's Zero Suicide initiative, Network4Health recommended the use of what our partners now refer to as the PHQ 3 from Zero Suicide (https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk):

Over the past two weeks, have you been bothered by:

- *Little interest or pleasure in doing things?*
- *Feeling down, depressed, or hopeless?*
- *Thoughts that you want to kill yourself, or have you attempted suicide?*

To ensure brief intervention and referral to treatment in primary care practice sites Network4Health contracted with the John Snow, Inc. (JSI) to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) trainings to those practice sites not yet trained. One of the CMC primary care sites had a PCP concerned that SBIRT "was just another thing to add onto our already full day." Now, after implementation, she is a strong advocate for SBIRT. Two of our partners, Elliott and Dartmouth Hitchcock implemented SBIRT prior to the waiver. However, the B1 project offers additional training if any site would like a refresher for staff, and we are also discussing with JSI the possibility of an SBIRT Train-the Trainer course.

Multi-disciplinary core teams (MDCT), as defined by the 1115 waiver, were created by B1 partners either internally where integrated staff resources are available on site or within a given organization, or through partnerships with external provider organizations. Each of our partners has primary care and behavioral health providers, including a psychiatrist, available on their MDCTs. Meeting the MDCT requirement has helped to drive collaborative relationships and joint workflows, such as those formed between the Mental Health Center of Greater Manchester, and Catholic Medical Center Primary Care and Dartmouth-Hitchcock Manchester/Bedford Primary Care.

The MDCT has case conferences that inform an individual care plan of a target population. Network4Health's B1 project's recommended target population is individuals of recently diagnosed with co-occurring disorders. We encourage B1 partners, as they progress and strengthen the capacity of

multi-disciplinary core teams, to consider including the broader population of individuals with mental health and/or substance use disorders, with a particular focus on those with newly diagnosed behavioral health issues and/or with newly diagnosed or existing chronic medical conditions, e.g., diabetes, hypertension and hyperlipidemia.

Participant Implementation Process: Integration Enhancement Plans (IEPs) Cohort 1, 2 and 3

Implementation planning and roll-out sessions began after IEP submission for all participants. The creation, negotiation and dissemination of approved Statements of Work (SOWs) to provide access to IEP funding, and the invoicing process continue to be a labor intensive and lengthy process. Network4Health is looking at ways to streamline this process and make it more "user-friendly" for our partners while still ensuring it meets the needs and requirements of the partners, Catholic Medical Center as the lead agency, and NH DHHS/CMS. In spite of SOW-related delays, all organizations moved forward with project planning and implementation during this reporting period. Significant progress was made on workflow development, job descriptions and recruiting/hiring new staff. The NH CHI practice facilitation team works as an integral part of the B1 team's work with partners during this implementation phase.

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

Organization	IEP Highlights
FQHC s & CMHCs	
FQHC - Healthcare for the Homeless	• Expansion of integrated PC/BH team model, to include Manchester Recovery and Treatment Center • Implementation of MAT program; recently completed MAT planning grant • Implement Institute for Clinical Systems Improvement (ICSI) shared decision making model to treat mild to moderate depression • BH provider(s) to attain ADA Diabetes Recognition (would be 1st in NH to have this designation)
FQHC - Manchester Community Health Center	• Expansion of current integrated PC/BH team model (Cherokee model) to all 4 practice sites • Shift from current treatment of mild to moderate depression to another evidence-based model to further enhance capabilities, e.g., Improving Mood: Providing Access to Collaborative Treatment (IMPACT) or Institute for Clinical Systems Improvement (ICSI) shared decision making model to treat mild to moderate depression • Expand collaborative efforts with several social service agencies to support vulnerable populations
CMHC - Center for Life Management	• Implement enhanced care management team model that includes a Nurse Care Manager targeting clients with co-occurring mental illness and chronic medical condition(s) • Develop an automated registry for high risk clients with identified co-morbidities

CMHC - Mental Health Center of Greater Manchester	• Implement Intensive Transition Team (ITT) to support the identification, assessment and transition of high-risk individuals in the ED & PC settings (based on Oregon ITT model) • Implement BH clinician in 4 Manchester middle schools • Development of joint workflows with PC & SUD partners
Primary Care	
PC & BH - Catholic Medical Center	• Expand multidisciplinary team to include Behavioral Health Patient Navigators at 3 practices and an in-practice therapist at one practice • Increase SUD capacity; implement SBIRT; potentially implement MAT in 2019 • Psychiatric consultation for primary care • Development of joint workflows w/MHCGM for closed loop referral and shared care planning
PC - Dartmouth-Hitchcock -Adult / Pediatric	• Introduce integrated onsite Primary Care/Behavioral Health teams at 2 adult and 1 pediatric DH practice sites including Behavioral Health Consultants and Family Support Specialists/Social Workers • Collaboration for mental health services w/MHCGM and for MAT with Fusion
Elliot Health Pediatrics Manchester (IEP Accepted, SOW Pending)	• Implementing integrated behavioral health in primary care, utilizing a BHC and psychiatric consultation
BH / SUD	
Partial Hospitalization Program and Drug Court	• PHP/ Enhanced care management model addressing co-occurring disorders
Fusion Health Services MAT and Primary Care Services	• Support PCP & CMHC practices expanding MAT capabilities through education, coaching, suboxone inductions, and vivitrol administration • Start up of new integrated primary care & behavioral health practice for complex patients, specializing in SUD, chronic pain, and neurologically impaired patients
Families in Transition- New Horizons Willows Treatment Program	• Enhanced internal integration between Willows Treatment Program and other FIT-NH services (workflows, enhanced coordination and communication, enabling HIT) • Enhanced coordination and documented workflows with community partners, particularly those within the new Manchester Recovery and Treatment Center • Expand SUD treatment services to include men who are homeless or at risk of homelessness
Easterseals NH Farnum Center (IEP Accepted, SOW Pending)	• Expand care coordination capacity • Develop joint workflows with Elliot and Healthcare for the Homeless

Core Deliverables, Workflows and Protocol Support

B1 partners were made aware of the purpose and need to adopt workflows/protocols to address the waiver protocol requirements during B1 workgroup meetings, and with each partner at individual IEP meetings. Network4Health developed a document, "*Integrating Healthcare Delivery – Recommended Protocols and Best Practices*" (Attachment_B1.8h) which was shared during the 12/19/18 B1 workgroup meeting, via email, and is also be available on Network4Health website (https://idn4-network4health-nh.org/integrated-healthcare). In the spirit of collaboration these recommended protocols and best practices were shared with the other IDNs.

B1 partners submit protocols/workflows as part of their IEP milestones. The B1 team worked closely with partners to refine workflows and create Visio documents to use for internal on-boarding, training and process improvement. We also used this requirement as an opportunity to introduce partners to Plan Do Study Act (PDSA) cycles. The NH CHI team presented a PDSA training at the 10/12/18 B1 Integrated Care Workgroup, which was well received. PDSA support, along with other change management strategies are provided at individual meetings as needed or requested by partners.

Shared care planning across through the use of Collective Medical (CMT) continues to progress and work out privacy and other concerns for this as well as the other IDNs. Partners, however, continue to look at and implement ways to share information, care plans and better coordinate care between organizations. For example, workflows and protocols have been changed to obtain consent during registration or intake to share information with an integrated care team; information sharing varies with the use of e-fax, CCDs, access to EMRs at partner site, etc. Our partners have embraced the challenge of finding better ways to work with one another.

Trainings

In addition to the trainings detailed in sections B1-8c and B1-8d below, Network4Health supported partners' progress toward improved integrated care delivery with the following activities:

- The B1 Integrated Care Workgroups and Advisory Board Meetings included the following:

Date	• Topics Presented & Discussed
July 2018	• Direct Messaging • Update Privacy Issues, including 42CFR and event notification • Reporting requirement and MAeHC • CMT demonstration
September 2018	• IEP Project Management - Quarterly Project Status Report Timeline • HIT Updates, including direct messaging, CMT and MAeHC
October 2018	• NH CHI team presented de-identified group results for the second round of IDN 4 SSA surveys • Quality Improvement / Plan-Do-Study-Act (PDSA) Cycle • HIT Updates, including Patient Link, My Link, and Referral Management Solution
November 2018	• Social Determinant of Health/Legal, presentation by Manchester Family Justice Center • Referral Management Systems

December 2018	• Value Based Care and Risk Stratification

Cherokee Integrated Care Team Training – September 27-28, 2018, in collaboration with the A1 project, and IDNs 1 and 6. Network4Health plans to have Cherokee Health System provide trainings through the remainder of the waiver to communicate a consistent message and reinforce the principles of integrated care and the CHS model; various activities will be offered that address the needs of frontline staff as well as leadership.

Chronic Conditions Lunch and Learns – Sessions delivered during the fall of 2018, with plans to continue in the spring of 2019, through a collaboration with Rivier University's APRN program and their FNP Program Director, [redacted] (also a B1 partner at Fusion). The target audience was Network4Health behavioral health partners, but we opened it up to all Network4Health partners, and also extended the invitation to all of the other IDNs. The lunch and learn recordings will be posted on the Network4Health website for partner access.

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

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

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

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

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

- Targets were updated last reporting period to reflect the total number of practices to be 18
- The Target date for "The number of participating partners who implement and receive training for the Event Notification System (ENS)" was moved last reporting period to 3/31/19 (formerly 12/31/18) due to issues documented above regarding delays in our ability to implement the Collective Medical Technologies (CMT) PreManage tool with our primary care and behavioral health partners.
- The target for performance measure "The number of participating partners who implement and receive training for the Shared Care Plan (SCP)" and "The number of participating partners who use a Shared Care Plan (SCP)" was changed last reporting period to 10 due to the significant pushback from partner agencies around the consent requirements to utilize CMT for Shared Care Planning.
- In addition, the target for the Performance Measure: "The number of participating partners who contribute to Event Notification System (ENS)" was modified last reporting period from 17 to 14

due to a lack of interest by some primary care and behavioral health practices to go live on Event Notification without all hospitals contributing ADT records to CMT.

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

B1-4. IDN Integrated Healthcare: Workforce Staffing

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

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

As designed, Network4Health partners identified and hired additional multi-disciplinary team members through their approved Integration Enhancement Plans (IEPs).

The following table provides the completed and in-progress hiring of all Network4Health Integration Enhancement Plan (IEP) partners.

Organization	IEP Hiring Completed and Anticipated
FQHC s & CMHCs	**(Staff have been hired unless noted)**
FQHC - Healthcare for the Homeless	• APRN (anticipated Q1/Q2 2019) • Per Diem Provider (anticipated Q1/Q2 2019)
FQHC - Manchester Community Health Center	• Case Manager 1 (WSNHC) • Case Manager 2 (TT) • Community Health Worker 1 (TT /WSNHC) • Community Health Worker 2 (Hollis) (32 hrs) • Community Health Worker 3 (Hollis) • Community Health Worker 4 (Hollis) • Community Health Worker Supervisor • Behavioral Health Consultant
CMHC - Center for Life Management	• Nurse Care Navigator

CMHC - Mental Health Center of Greater Manchester	• Intensive Transition Team (ITT)
	  • ITT Coordinator
	  • ITT Case Manager 1
	  • ITT Case Manager 2
	  • ITT Case Manager 3
	  • ITT Case Manager 4
	  • ITT Peer Specialist
	  • ITT Program Assistant/Office support
	  • APRN (.2) (anticipated Q1/Q2 2019)
	• Intake Clinician - School Liaison (partial funding of the role)

Primary Care	
PC & BH - Catholic Medical Center	• 3 x Behavioral Health Patient Navigators (interviews in progress) • Therapist (anticipated hiring in Q1/Q2 2019)

PC - Dartmouth-Hitchcock -Adult / Pediatric	• 2 x Licensed Mental Health Clinician – Adult Primary Care • Licensed Mental Health Clinician - Pediatrics • Family Support Specialist (Social Worker/Navigator)
Elliot Health Pediatrics Manchester IEP Accepted, SOW Pending	• Therapist (anticipated Q2 2019) • Social Worker (anticipated Q2 2019)
BH / SUD	
Fusion Health Services MAT and Primary Care Services	• Behavioral Health Clinician • Care Manager
Families in Transition- New Horizons Willows Treatment Program	• Director of Operations • Therapist • 2 x Certified Recovery Support Worker (1 hired, 1 in recruitment)

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

B1-5. IDN Integrated Healthcare: Budget

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

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

Revenue- All project budgets have been adjusted to reflect the actual receipt of funding. During the reporting period, anticipated funding was not received due to ongoing negotiations between NH DHHS and NH counties. The anticipated, but not yet received, 2018 funding for the Integrated Healthcare budget totals $1,283,466. These expected funds have been added to revenue in 2019. If anticipated revenue is reduced as a result of State negotiations, Network4Health will revise budgets and project plan deliverables, subject to Steering Committee and NH DHHS approval.

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

Reported actual expenses continue to be below budget due in part to expense reporting that includes only invoiced and paid expenses. Another significant factor has been the delay of finalizing services agreements and other legal documentation needed for funds disbursements to network partners who are implementing Integration Enhancement Plans. Significant funding has been committed to partners implementing these plans.

TRANS-FORMATON FUNDS	**CY 2017 (Yr2) Actual**	**CY 2018 (Yr3)January to June Actual**	**CY 2018 (Yr3) July to December Actual**	**CY 2019 (Yr4) Projected**	**CY 2020 (Yr5) Projected**	**CY 2021 (Yr6) Projected**
B1: Integrated Healthcare Revenue (New)	$1,035,053	$ 579,630	$ 207,010	$4,043,607	$3,871,864	$2,146,776
B1: Integrated Healthcare Revenue (Rollover)		$1,032,253	$1,544,616	$1,191,313	$ 195,865	$ 26
Total Revenue	$1,035,053	$1,611,883	$1,751,626	$5,234,920	$4,067,729	$2,146,802
Salaries and benefits-Integrated Healthcare Clinical Director (1.0 FTE)		$ 35,779	$ 74,041	$ 163,635	$ 167,869	$ 86,452
Technology (Laptops, phones, software)		$ 593	$ 255	$ 4,000	$ 4,000	$ 2,000
UNH Institute on Health Policy and Practice/Citizen Health Initiative Baseline and Follow-up Assessments.	$ 2,800	$ 2,800	$ 1,980	$ 3,744	$ 5,606	
UNH IHPP/CHI Integration Enhancement Project plan development.		$ 10,257	$ 20,515			

UNH Law IHPP/CHI Integration coaching.		$ 15,538	$ 166,812	$ 159,716	$ 131,118	
Practice level Integrated Healthcare Enhancement Project plan funding.		$ -	$ 293,260	$4,701,060	$3,752,210	$2,054,900
Occupancy		$ 2,300	$ 3,450	$ 6,900	$ 6,900	$ 3,450
Subtotal	$ 2,800	$ 67,267	$ 560,313	$5,039,055	$4,067,703	$2,146,802
Variation to Budget (Transfer Funds to Subsequent Year)	$1,032,253	$ 1,544,616	$1,191,313	$ 195,865	$ 26	$ -

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

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

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

Organization/Provider	Agreement Executed (Y/N)
Manchester Community Health Center • Manchester Community Health Center – Hollis Street Practice • Child Health Services at MCHC • MCHC East Side – Tarrytown Road Practice • West Side Neighborhood Health Center	Y
Mental Health Center of Greater Manchester	Y

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

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

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

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

Name	Title	Organization	Sign Off Received (Y/N)

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

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

As mentioned previously, the strength of this B1 workgroup is the impact it has had on breaking down silos between primary care and behavioral health stakeholders. The waiver in IDN 4 is creating a more trusting collaborative effort to approach integrated healthcare. Primary care is particularly motivated as they are encountering higher numbers of behavioral health issues with their patients. We continue to

have strong engagement, and broad representation of our partners, including NH's two managed care organizations (MCOs), NH Healthy Families and Well Sense.

B1-8a

CCSA: Partners were provided with the Network4Health recommended CCSA process and care plan for positive screens that was developed in collaboration with B1 stakeholders. Some partners adopted the recommended CCSA; others adapted it to leverage their current screenings, and augmenting where there were gaps to address all domains of the CCSA. For partner status, see Attachment_B1.8a. Many partners have chosen to pilot the CCSA with full implementation roll-out plans to progress in 2019. The Mental Health Center of Greater Manchester has made the greatest progress in integrating the CCSA into their EMR with an organization-wide implementation, and is payer agnostic - something that has been recommended to all partners as they progress further along in their implementation and capacity. Some of the barriers to implementation our partners have encountered include:

- EMR implementations at three of the B1 partners have impacted the roll-out time line-in some cases extending the pilot phase.
- Competing initiatives both internally and externally at a given organization, e.g., merger, grants and other program requirements, e.g. HRSA Uniform Data System (UDS)
- Concern for impact on provider workload to address positive screens

B1-8b

Multi-disciplinary core team: **The multi-disciplinary core teams identified in the table below have been modified from previous SARs to align with MDCTs that have further developed and refined to better address the IEPs and training plans.**

B1 partners have grown their multi-disciplinary teams to meet the integrated level as required in the special terms and conditions of the waiver. Partnering with other organizations to include an available psychiatrist or primary care provider to the core team was a solution that evolved naturally as partners, through their IEP work, developed joint workflows related to shared patients/clients. Throughout this reporting period, Network4Health staff continued to educate partners about the concept of multi-disciplinary core teams in primary and behavioral health settings and integrated care at the B1 workgroup, the B1 Advisory Committee meetings, the Network4Health All-Partners quarterly meetings, and individual partner meetings.

Organization/Provider	Multi-Disciplinary Team Identified	Team List
Catholic Medical Center - Amoskeag Family Practice	Yes	Physician/Associate providers (APRNs, PAs) RN Care coordinator CMC BH Psychiatrist and BH clinicians MHCGM Psychiatrist and BH clinicians
Catholic Medical Center - CMC Behavioral Health (BH)	Yes	Psychiatrist and/or Associate providers (APRNs) Therapist(s): LICSW, LCMHC, MLADC or MA CMC PCPs CMC Primary Care Coordinators
Catholic Medical Center - Willowbend Family Practice	Yes	Physician/Associate providers (APRNs, PAs) RN Care coordinator

		CMC BH Psychiatrist and BH clinicians MHCGM Psychiatrist and BH clinicians
Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	Yes	Physician/Associate providers (APRNs, PAs) RN Care coordinator CMC BH Psychiatrist and BH clinicians MHCGM Psychiatrist and BH clinicians
Catholic Medical Center - Healthcare for the Homeless	Yes	Physician/Associate providers (APRNs, PAs) RN Care Coordinator BH provider on call (either the MLADC, LMHW or SW) Psychiatric APRN (shared resource) MHCGM Psychiatrist and BH clinicians
Center for Life Management	Yes	Medical provider (MD or APRN) and RN BH Clinician (provided by LICSW, LCMHC, MLADC, MSW. MA, or MS) Nurse Care Navigator Case Manager Primary Care Provider available at Derry Medical PC and other local PC practices
Dartmouth-Hitchcock Bedford/Manchester Adult	Yes	Primary Care Provider and/or Associate Provider RN Medical Assistant Family Support Specialist Behavioral Health Clinician Clinical Secretary D-H Dept. of Psychiatry Psychiatrist MHCGM Psychiatrist and BH clinicians
Dartmouth-Hitchcock Bedford/Manchester Pediatric	Yes	Primary Care Provider and/or Associate Provider RN Medical Assistant Family Support Specialist Behavioral Health Clinician Psychiatrist MHCGM Psychiatrist and BH clinicians
Easterseals NH/ Farnum Center	Yes	Providers: Psychiatrist(s) Primary Care APRN(s) (rounds 3hr daily in clinic) Nurse(s) Therapist Social Worker/Care Manager Peer Support
Elliot Health System - Doctors Park Pediatrics, Manchester	Yes	Primary Care Provider(s) Nurse(s) Therapist/Behavioral Health Consultant Medical assistant(s) Social Worker/Care Manager EHS Psychiatrist and BH staff

Elliot Health System – Partial Hospitalization Program	Yes	MLADC Clinical Case Manager Licensed Social Worker CRSW RN EHS Psychiatrist Client's primary care provider (external)
Families in Transition New Horizons (FITNH) / Family Willows Treatment Center	Yes	Program Manager Intake Coordinator Therapist(s) Treatment Coordinator(s) Peer Recovery Support Worker - CRSW Primary Care Physicians – external, e.g., CMC-Healthcare for the Homeless, CMC, Elliot, Dartmouth-Hitchcock Psychiatrists- external, e.g., Mental Health Center of Greater Manchester, CMC, Elliot
Fusion Health Services, LLC	Yes	Waivered APRNs Clinical Case Manager Behavioral Health Consultant Mental Health Center of Greater Manchester Psychiatrist Consult and BH Clinicians (external) CMC Psychiatrist referral available (external)
Manchester Community Health Center – Hollis Street	Yes	Provider(s) Medical Assistant(s) Team Nurse Behavioral Health Consultant Case Manager Community Health Worker Psychiatry consult with MHCGM
Manchester Community Health Center – Child Health Services	Yes	Provider(s) Medical Assistant(s) Team Nurse Behavioral Health Consultant Case Manager Community Health Worker Psychiatry consult with MHCGM
Manchester Community Health Center –East Side Tarrytown Road Practice	Yes	Provider(s) Medical Assistant(s) Team Nurse Behavioral Health Consultant Case Manager Community Health Worker Psychiatry consult with MHCGM
Manchester Community Health Center –West Side Neighborhood Health Center	Yes	Provider(s) Medical Assistant(s) Team Nurse

		Behavioral Health Consultant Case Manager Community Health Worker Psychiatry consult with MHCGM
Mental Health Center of Greater Manchester	Yes	Intensive Transition Team: • Coordinator • Case Managers • Peer Support Specialist/Recovery Coach MHCGM Psychiatrists, APRNs and BH Clinicians available for consults and treatment recommendations Primary Care Providers – Coordination and case consultation with external providers (e.g. CMC, Elliot, Dartmouth-Hitchcock, etc) Primary Care Nurse Coordinators (at CMC) – Facilitate case consultation and closed loop referral Primary Care based Family Support Specialists and Behavioral Health Clinicians at Dartmouth Hitchcock Manchester/Bedford - Facilitate case consultation and closed loop referral

B1-8c

Multi-disciplinary core team training:

The training plan, included as **Attachment_B1.8c**, provides a detailed look at completed trainings for multi-disciplinary core team and non-clinical staff trainings for participating practices. **Network4Health worked with each of our B1 primary care and behavioral health organizations to create a training plan of desired courses and those required for coordinated care designation for their multi-disciplinary core teams and non-clinical staff. Network4Health has updated the table to align with the creation of multi-disciplinary teams for each B1 Integration Enhancement Plan. Confirmation of completion of the required trainings for Coordinated Care and Integrated Care Designation prior to December 31, 2018 per the NH DSRIP waiver program can also be found in section B1-10.**

We also worked closely with Network4Health staff to provide training opportunities from the A1 Workforce and E4 Integrated Treatment of Co-occurring Disorders projects respectively.

Network4Health B1 core training offerings in 2018 included:

Network4Health Core Trainings	
Chronic Conditions • Define the latest guidelines for diabetes, hypertension and dyslipidemia • Understand the intersection of behavioral health and chronic disease management • Identify barriers to the integration of	**On-site chronic conditions training** delivered to each B1 behavioral health partner, this course was developed for Network4Health by an RN educator at Healthcare for the Homeless' RN, who is also a certified diabetes educator and quality improvement expert. Netwrok4Health and the NH

behavioral health care and chronic disease management • Identify and utilize strategies to overcome identified barriers	Division of Public Health/Chronic Conditions collaborated to support this training. This training was also presented at the December 2018 NH Behavioral Health Summit, and has been offered to and delivered in other IDNs. A recording will be available on the Network4Health website in 2019. **Webinar training**, ½ hour lunch and learn course created for Network4Health by Rivier University's Nurse Practitioner program and presented by their APRN students and program director
Integrated Care Delivery • The Cherokee Health System Integrated Care Model is considered a nationally recognized, evidence-based gold standard integrated health care delivery model. • BH Integration and Practice Transformation Facilitator Training	**1 ½ day conference**, the second 2018 Cherokee Health System training was held September 27-28, 2018 in cooperation with IDN's 1 and 6, with seats opened to other IDNs. **A 5-part training** Hosted by B1 partner, the Mental Health Center of Greater Manchester with 10 attendees from 6 partner organizations (1st session started in June 2018) aimed at strengthening the multidisciplinary core team offered through the New Hampshire Primary Care Behavioral Health Workforce Project (https://sites.google.com/view/nhpcbhworkforce/training/facilitator-training).
Stigma Reduction / Behavioral Health 101	**On site Behavioral Health 101training** delivered to each B1 primary care partner; this course was developed for IDN 4 by one of Manchester Community Health Center's LICSW **Mental Health First Aid** - Network4Health continues to offer this course on a quarterly basis.
Comprehensive Core Standardized Assessment (CCSA)	Each organization tailored their CCSA training to meet their needs and align with their organization's CCSA implementation plan as documented in their Integration Enhancement Plan.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	On-site and computer-based SBIRT trainings were offered to all B1 partners. JSI/NH Center for Excellence provided the onsite trainings for partners in 2018 and will provide additional trainings in 2019

B1-8d

Training for staff not providing direct care: The training plan, included as **Attachment_B1.8c**, provides a detailed look at completed trainings for multi-disciplinary core team and non-clinical staff trainings for participating practices. **Network4Health worked with each of our B1 primary care and behavioral health organizations to create a training plan of desired courses and those required for coordinated care designation for their multi-disciplinary core teams and non-clinical staff. Confirmation of completion of the required trainings for Coordinated Care and Integrated Care Designation prior to December 31, 2018 per the NH DSRIP waiver program can be found in section B1-10.**

Network4Health B1 core training recommendations and offerings in 2018 included:

Network4Health Core Trainings	
Chronic Conditions • Define the latest guidelines for diabetes, hypertension and dyslipidemia • Understand the intersection of behavioral health and chronic disease management • Identify barriers to the integration of behavioral health care and chronic disease management • Identify and utilize strategies to overcome identified barriers	**On-site chronic conditions training** delivered to each B1 behavioral health partner, this course was developed for IDN 4 by an RN educator at Healthcare for the Homeless' RN, who is also a certified diabetes educator and quality improvement expert. Netwrok4Health and the NH Division of Public Health/Chronic Conditions collaborated to support this training. This training was also presented at the December 2018 NH Behavioral Health Summit, and has been offered to and delivered in other IDNs. A recording will be available on the Network4Health website in 2019. **Webinar training**, ½ hour lunch and learn course created for IDN 4 by Rivier University's Nurse Practitioner program and presented by their APRN students and program director
Integrated Care Delivery • The Cherokee Health System Integrated Care Model is considered a nationally recognized, evidence-based gold standard integrated health care delivery model. • BH Integration and Practice Transformation Facilitator Training	**1 ½ day conference**, the second 2018 Cherokee Health System training was held September 27-28, 2018 in cooperation with IDN's 1 and 6, with seats opened to other IDNs. **A 5-part training** Hosted by B1 partner, the Mental Health Center of Greater Manchester with 10 attendees from 6 partner organizations (1st session started in June 2018) aimed at strengthening the multidisciplinary core team offered through the New Hampshire Primary Care Behavioral Health Workforce Project (https://sites.google.com/view/nhpcbhworkforce/training/facilitator-training).
Stigma Reduction / Behavioral Health 101	**On site Behavioral Health 101 training** was offered all B1 primary care partners; this custom

	course was developed for Network4Health by one of Manchester Community Health Center's Behavioral Health Consultants. Fusion Health Services received this training in Q4 2018. Network4Health hopes to expand delivery in early 2019. **Mental Health First Aid** - Network4Health continues to offer this course on a quarterly basis.
Comprehensive Core Standardized Assessment (CCSA)	Each organization tailored their CCSA training to meet their needs and align with their organization's CCSA implementation plan as documented in their Integration Enhancement Plan.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	On-site and computer-based SBIRT trainings were offered to all B1 partners. JSI/NH Center for Excellence provided the onsite trainings for partners in 2018 and will provide additional trainings in 2019

B1-8e

Network4Health partners identified a schedule for core team case conferences as part of their Integration Enhancement Projects. Case reviews are currently done by each B1 partner. These core team case conferences vary from daily to monthly, some are focused internally, and others are with external core team members. Families in Transition, Manchester Community Health Center, Catholic Medical Center Primary Care, Healthcare for the Homeless and the Mental Health Center of Greater Manchester participate in Manchester's Continuum of Care meetings, which also has community based service organizations and payers, including Well Sense and NH Healthy Families, in attendance. Network4Health encourages all partners to participate. A barrier for some organizations has been gaining organizational approval for the release of information. Dartmouth-Hitchcock Manchester/Bedford primary care is currently discussing this matter with their legal department and leadership.

The table below represents the current case conference schedule for each Network4Health B1 partner:

Organization/Provider	Case Conference Schedule
Catholic Medical Center - Amoskeag Family Practice	• Monthly FACE UP (Framing Addiction Care Effectively) Meetings with CMC Psychiatry, Addiction Medicine and Primary Care. Focused on patients with substance use disorders and/or mental illness. • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester • Consultative case conferences with CMC Behavioral Health Services or Behavioral Health teams at the Mental Health Center of Greater Manchester, as required
Catholic Medical Center - CMC	• Monthly FACE UP (Framing Addiction Care Effectively) Meetings with

Behavioral Health (BH)	Psychiatry, Addiction Medicine, Primary Care. Focused on patients with substance use disorders and/or mental illness. • Consultative case conferences with CMC Primary Care as required • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Catholic Medical Center - Willowbend Family Practice	• Monthly FACE UP (Framing Addiction Care Effectively) Meetings with CMC Psychiatry, Addiction Medicine and Primary Care. Focused on patients with substance use disorders and/or mental illness. • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester • Consultative case conferences with CMC Behavioral Health Services or Behavioral Health teams at the Mental Health Center of Greater Manchester, as required
Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	• Monthly FACE UP (Framing Addiction Care Effectively) Meetings with CMC Psychiatry, Addiction Medicine and Primary Care. Focused on patients with substance use disorders and/or mental illness. • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester • Consultative case conferences with CMC Behavioral Health Services or Behavioral Health teams at the Mental Health Center of Greater Manchester as required
Catholic Medical Center - Healthcare for the Homeless – FIT Clinic	• Weekly multi-disciplinary core team case conferences, also attended by representatives from the Mental Health Center of Greater Manchester to discuss shared high-risk clients • Monthly MAT ECHO case reviews • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Catholic Medical Center - Healthcare for the Homeless – New Horizons Clinic	• Weekly multi-disciplinary core team case conferences, also attended by representatives from the Mental Health Center of Greater Manchester to discuss shared high-risk clients • Monthly MAT ECHO case reviews • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Center for Life Management	• Individual case conferences for 6 adult patients and 4 children were completed in November/December 2018. Focus on patients with co-occurring mental illness and chronic diseases • Monthly Case Conferences with CLM core team and representatives from Derry Medical Center primary care will begin January 2019.
Dartmouth-Hitchcock Bedford/Manchester Adult	• Daily rounding case conferences between primary care providers, Behavioral Health Consultant and Family Support Specialist, D-H psychiatry available as required • Monthly case conference with D-H Lebanon Psychiatrist and Behavioral Health Consultants
Dartmouth-Hitchcock Bedford/Manchester Pediatric	• Weekly multi-disciplinary core team case conferences

Easterseals NH/ Farnum Center	• Daily Multi-disciplinary care team round on unit
Elliot Health System - Doctors Park Pediatrics, Manchester	• Weekly combined behavioral health education and case conferences
Elliot Health System – Partial Hospitalization Program	• Weekly case conferences
Families in Transition New Horizons (FITNH) / Willows Substance Use Treatment Center	• Consultative case conferences with multiple primary care practices for Willows Treatment Program participants • Weekly Willows Substance Use Treatment Center Case Conferences • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Fusion Health Services, LLC	• Daily case conferences • Monthly MAT ECHO case reviews • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Manchester Community Health Center – Hollis Street	• Monthly Case Conference with Psych Nurse NP and Behavioral Health Team for unstable MH/SUD Dx, med seeking behavior, lack of improvement, minimal participation behavior and no shows • Bi-weekly medical/BH/SUD high-risk prenatal patients case conferences • Weekly MAT new and high risk patient case conferences • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Manchester Community Health Center – Child Health Services	• Monthly complex/high risk adolescent patient case conferences • Monthly Medically, Behaviorally, or SDOH (DCYF, other agency involvement) case conferences. Inclusion of other agencies such as Waypoint (FKA Child and Family Services) • Monthly Medically, Behaviorally, or SDOH (DCYF, other agency involvement) case conferences with school clinicians • Monthly Case Conference with Psych Nurse NP and Behavioral Health Team for unstable MH/SUD Dx, med seeking behavior, lack of improvement, minimal participation behavior and no shows • Consultative case conferences with MHCGM psychiatry
Manchester Community Health Center –East Side Tarrytown Road Practice	• Monthly Case Conference with Psych Nurse NP and Behavioral Health Team for unstable MH/SUD Dx, med seeking behavior, lack of improvement, minimal participation behavior and no shows • Bi-weekly medical/BH/SUD high-risk prenatal patients case conferences • Weekly MAT new and high risk patient case conferences • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester
Manchester Community Health Center –West Side Neighborhood Health Center	• Monthly Case Conference with Psych Nurse NP and Behavioral Health Team for unstable MH/SUD Dx, med seeking behavior, lack of improvement, minimal participation behavior and no shows • Bi-weekly medical/BH/SUD high-risk prenatal patients case conferences • Weekly MAT new and high risk patient case conferences • Monthly Manchester Continuum of Care Community Care Team case

	conference meetings facilitated by the Mental Health Center of Greater Manchester
Mental Health Center of Greater Manchester	• Daily Intensive Transition Team(ITT) huddles • ITT Team attends weekly CMC Healthcare for the Homeless case conferences to discuss high-risk shared patients. • ITT staff attends the monthly Manchester Continuum of Care Community Care Team case conference meetings • MHCGM psychiatrist attends monthly case conference at Dartmouth-Hitchcock Pediatrics Manchester/Bedford • Monthly Manchester Continuum of Care Community Care Team case conference meetings facilitated by the Mental Health Center of Greater Manchester

In addition to the above case conferences, the waiver protocols and workflow requirements aimed at improving joint workflows impacting shared patients/clients has driven increased collaboration across organizations. For example, Fusion and Dartmouth-Hitchcock Manchester/Bedford are working closely on MAT in primary care referral protocols and joint workflows that support referral to Fusion for MAT inductions with referral back to the Dartmouth-Hitchcock PCP for MAT management after stabilization.

The table below represents collaborative efforts between Network4Health B1 partners that include the development of joint workflows and/or case reviews of shared patients/clients:

KEY:
PC: Primary Care
BH: Behavioral Health
*: Participation in Northern New England (NNE) MAT Project ECHO Collaborative (incorporates case reviews)
**: Participation in the Manchester Continuum of Care Community Care Team case review meetings
🟢 : Established joint workflows/case reviews
🟠 : Ad Hoc or improving/developing joint workflows/case reviews

	CMC PC**	CMC BH**	CMC HCH PC/BH***	CLM BH	D-H PC Pedi	D-H PC Adult	EHS PC	EHS BH PHP*	FIT BH **	Farnum	Fusion PC/BH*	MCHC PC/BH**	MHCGM BH**	Non-B1 Partner
CMC PC**		🟢							🟠				🟠	
CMC BH**	🟢		🟢						🟠		🟠			
CMC HCH PC/BH***		🟢						🟠	🟢	🟠	🟠		🟢	🟢
CLM BH										🟠				🟢
D-H PC Pedi														🟢
D-H PC Adult									🟠		🟢		🟠	🟢
EHS PC							🟢		🟠	🟠			🟠	🟢

EHS BH PHP*	🟠		🟠	🟠		🟠	🟢		🟠	🟠	🟠	🟠	🟠	🟢
FIT BH**							🟠	🟢		🟠	🟠	🟠	🟠	🟠
Farnum**			🟠	🟠			🟠	🟠	🟠			🟠	🟠	🟢
Fusion PC/ BH*						🟢							🟢	🟢
MCHC PC/BH**								🟠	🟠	🟠			🟢	🟢
MHCGM BH**	🟢	🟠	🟠	🟠	🟢	🟠			🟠	🟠	🟠	🟠		🟠
Non-B1 Partner			🟢		🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢		

B1-8f

DIRECT Secure Messaging: All Network4Health B1 partners have implemented and use direct messaging technologies in daily practice. With support from the Network4Health A2 HIT project, we have identified multiple gaps in the use of this technology across entities, consistency of use and the sharing and maintenance of direct addresses. Throughout this reporting period, Network4Health staff continued to educate partners about the importance of building consistent use of direct messaging in integrated care workflows at the individual partner workflow design sessions , B1 workgroups, the B1 Advisory Committee meetings, and the Network4Health All-Partners quarterly meetings. Network4Health's B1 project team will support the rollout of the A2 HIT project to build a Community Directory of secure messaging addresses to support the accuracy and maintenance of referral systems in 2019. Network4Health recognizes that organizations are limited in their ability to collect address data and keeping this data updated is a resource intensive task. Please see A2-3 for additional detail on this effort.

B1-8g

Closed Loop Referrals: Closed loop referrals improve the level of care coordination across providers and community based organizations.

Throughout this reporting period, Network4Health staff continued to educate partners about the concept of closed loop referrals in primary and behavioral health settings, ensuring that partners had at minimum, a manual process for tracking and closing referrals within their practice team and frequently utilizing functionality available in their EMRs. Network4Health provided best practice recommendations regarding closed loop referrals within the *"Timely Referral Communication"* section of Network4Health's *"Integrating Healthcare Delivery – Recommended Protocols and Best Practices"* referenced in section B1-8h below.

As referenced in A2-3, Network4Health continues to support the planned implementation of enabling technology, Par8O, a closed loop referral system. With Par8o, decision support including network participation, plan design, provider clinical preferences, and appointment availability is visible to referring providers and staff at the point of referral.

Currently Network4Health IDN 4 is working in conjunction with Granite Pathways and other IDN's to determine a collaborative solution to closed loop referral to accommodate multiple programs in the state. IDN 4 still believes that Par8o offers the best available and sustainable solution and continues to support this product in discussions.

Until these discussions are complete, Network4Health has worked with B1 partners to develop interim workflows to insure closed loop referral functionality.

B1-8h

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

Network4Health developed a document, "*Integrating Healthcare Delivery – Recommended Protocols and Best Practices*" which was shared with the 12/19/18 B1 workgroup meeting, via email, and is also be available on Network4Health website (https://idn4-network4health-nh.org/integrated-healthcare and Attachment_B1.8h). In the spirit of collaboration these recommended protocols and best practices were shared with the other IDNs. "*Integrating Healthcare Delivery – Recommended Protocols and Best Practices*" provides Network4Health recommendations for the following protocols and best practices:

- Multi-disciplinary core teams
- Interactions between providers and community based organizations
- Timely communication and referrals (Closed Loop Referrals)
- Privacy
- Interactions between providers
- Safe transitions from institutional settings back to primary care, behavioral health and social
- support service providers
- Intake procedures
- Adherence to NH Board of Medicine guidelines on opioid prescribing
    - NH Center for Excellence: 2nd Edition of Medication Assisted Treatment (MAT) Best Practices, https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf
    - NH Charitable Foundation: SBIRT, https://sbirtnh.org/playbook/
    - Institute for Clinical Systems Improvement (ICSI) evidenced-based model for depression: https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

Partners provided workflows and protocols as required through their IEPs and where there were gaps Network4Health provided resources through education and discussion at the Integrated Care Workgroup meetings, the Integrated Care Advisory Board meeting, and individual IEP meetings. A challenge across partners is operationalizing and standardizing some best practices. The importance of using PDSA cycles, training, and strong communications is continually reinforced with partners. The NH CHI facilitator we have contracted with provides PDSA tools and 1:1 coaching to partners as needed. This is offered to all partners.

Partners generally found that current workflows and protocols needed minor to moderate modifications to accommodate integrated care delivery. A benefit was in documenting many of these workflows in Visio, and having them as resources for staff and for on boarding new hires.

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	• Mental health topics (multiple) • SUD topics (multiple)	individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	Documented work flows and/or protocols that include, at minimum: • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support 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)				

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

B1-9a

Achievement of all the requirements of a Coordinated Care Practice: IDN 4's B1 project set the expectation with all partners, and developed plans to initiate the requirements with other partners that have met Coordinated Care. The plans include the following:

- Ongoing education and reinforcement of the requirements of Coordinated Care Designation including the NH Plus requirements, and the continuum to reach integrated care designation
- The SSA provides opportunities twice a year to discuss progress with our partners:
    - IDN 4-wide SSA results for the region have been and will continue to be shared with the Integrated Care meetings; identifying successes and potential areas for improvement. This also helps us adapt our trainings and focus to better meet the needs of the IDN partners.
    - Individual partner SSA results have been and will continued to be discussed with partners at their regular face-to-face IEP meetings with the B1 team to discuss current state and gaps. In 2019 we will be working with our contracted NH CHI team to present an SSA Blueprint that identifies specific areas along the integrated care continuum that an organization can focus their efforts. We will use this to help partners prioritize and better plan their transition to improved integrated care delivery.
- Key to progression is a solid foundation in coordinated care components. Reinforcement of the foundational elements of coordinated care and enhancement of those elements are being addressed with each partner as outlined in their IEPs with an eye toward movement forward, introducing elements of integrated care designation. For example:
    - Where elements were piloted, we ask for roll-out plans for full implementation
    - While the required trainings for clinical and non-clinical staff were met, N4H believes it's important to reinforce core trainings. Below are some examples of how we plan to do this:
        - Chronic Condition Education for BH teams: N4H will again partner with Rivier University to provide a Lunch and Learn webinar series, open to all IDN 4 partners, and extended invitation to all IDNs
        - Supplemental SBIRT trainings will be offered to all partners
        - Motivational interviewing, recognized as a gap in primary care settings will be offered and partners will be strongly encouraged to participate and implement a plan to create a culture that reinforces motivational interviewing style communication with patients to improve patient centered care.

Some partners have already begun to work toward greater integration. Below highlights some of that progress:

- Fusion implemented MAT and plans to choose and implement an evidence-based treatment of mild-moderate depression in the primary care setting.
- Dartmouth-Hitchcock Primary Care is preparing for MAT by identifying waivered providers, developing joint workflows with both Fusion and MHCGM, and developing internal MAT related workflows

Both Manchester Community Health Center (MCHC) and CMC's Healthcare for the Homeless (HCH), the two Network4Health partners identified to attain Integrated Care Designation, completed all aspects of Coordinated Care and Integrated Care Designation per the DSRIP 1115 waiver program standard terms and conditions. Both partners created internal workgroups for their Integration Enhancement Plans (IEPs) with targets scheduled to meet Coordinated Care Practice designation by December 2018. Both organizations provided robust integrated primary and behavioral health care prior to the start of the waiver program, but identified activities to further develop their care coordination processes and meet the specific requirements of the waiver program for care coordination designation. Below outlines the additional activities completed by each organization to meet all care coordination designation requirements:

Manchester Community Health Center

- Multi-disciplinary core teams were expanded at three of the four locations to support full multi-disciplinary at all locations. Physical reconfigurations were made at the locations to support all teams sitting in "pods" to support continuous interactions and communication between multi-disciplinary team members. This is a model that MCHC had used at their Child Health Services location and were able to now expand to all primary care teams. All staff was moved at the end of June 2018 to allow them to start working in pods near or in their team rooms as of July 2018.
- Additions were made to their existing intake, screening and assessment processes to align with all domains of the Comprehensive Core Standardized Assessment (CCSA). Initial work was done on paper, to allow for implementation while modifications were made by their EMR vendor to allow for electronic data capture, tracking and reporting for all CCSA domains. EMR modifications are now complete and through December 20, 2018, the team had completed 630 CCSA's and 245 ASQ's (children). The MCHC team also recently started tracking warm handoffs to various roles within the multi-disciplinary teams. Finally, MCHC completed documentation of new and existing workflows for any CCSA domain positive screenings.
- Initial CCSA Training was completed in June 2018
- Additional workflow modifications were also completed to make positive CCSA results visible to all multi-disciplinary core team members.

CMC, Healthcare for the Homeless

- Additions were made to their existing intake, screening and assessment processes to align with all domains of the Comprehensive Core Standardized Assessment (CCSA). Initial work was done on paper, to allow for implementation while modifications were made by their EMR vendor to allow for electronic data capture, tracking and reporting for all CCSA domains. EMR modifications are now complete. The HCH team also completed documentation of new and existing workflows for any CCSA domain positive screenings.
- CCSA Training was completed at staff meetings in Q4 2018

B1-9b

Adoption of both Medication Assisted Treatment (MAT) and evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting: As previously reported, Manchester Community Health Center runs a fully implemented Medication Assisted Treatment (MAT) program. Healthcare for the Homeless completed a MAT planning grant in June 2018, and implemented their MAT

program during the fall of 2018. Both organizations utilize the Guidance Document on Best Practices: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Disorders in New Hampshire (see Attachment_B1.9b1 and https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf).

Manchester Community Health Center currently uses evidence based treatment of mild-moderate depression through the use of PHQ-2/9 initial screening tools, further behavioral health assessments to confirm diagnoses, medication assistance with primary care, in-house Behavioral Health Consultant visits to encourage treatment of the diagnosis and/or traditional therapy treatment options(CBT, solution focused, etc.). In keeping with their culture of continuous improvement, however, they are evaluating both a "Collaborative Care" model (based on IMPACT) , developed by the AIMS Center (http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment [aims.uw.edu]), and the Institute for Clinical Systems Improvement (ICSI) evidenced-based model for depression for their adult population (https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/ , see Attachment_B1.9b2). They are also moving forward with the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH model) for children and young adults (https://jbcc.harvard.edu/match-trac).

Healthcare for the Homeless chose the Institute for Clinical Systems Improvement (ICSI) evidenced-based model for depression (https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/). Part of their decision making was that Cherokee Health System uses the ICSI model, and they also have a healthcare for the homeless program. The model was implemented in December 2018 and they have found this model to help them improve their closed loop referrals and tracking of patients with mild to moderate depression.

The relationship that Network4Health has forged with Cherokee Health System continues to benefit our partners beyond the conference trainings. The Cherokee Health System COO made herself available to our partners to discuss integration, such as the choice and implementation of ICSI.

B1-9c
At Risk Patients

Network4Health recommends that provider sites coordinate care with NH Managed Care Organizations (MCOs) and include them as part of the multi-disciplinary team. MCOs offer the unique ability to capture claims data, which is an important data point when identifying at risk and high risk individuals. Leveraging the data analysis capabilities of the MCOs benefits not only population/value based care efforts of organizations, but also provides granular level information to provide better individualized patient-centered care.

The December 19th Integrated Care workgroup addressed concepts and tools related to High Risk Stratification and Value Based Care. A subcommittee that includes MCOs will be created in 2019 to further develop recommended best practices to bring to the Integrated Care workgroup for review.

Both Manchester Community Health Center and Healthcare for the Homeless practice sites use EMR systems that have the capacity to identify at-risk patients and use a variety of methods for identifying at-risk and high risk patients based on the CCSA and clinical findings. All partners have expressed a willingness to modify their risk identification workflows, to better identify high risk or complex patients

identified through clinical indicators, positive behavioral health or substance use screenings and the CCSA social determinants of health domains.

Plan Care/ Monitor/Manage Patients Progress Towards Goals

Both Manchester Community Health Center (MCHC) and Healthcare for the Homeless utilize workflows within their electronic medical records (EMR) to set goals and track progress towards meeting these goals. MCHC currently utilizes care plans for specific patient risk groups. MCHC regularly participates 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. Internally, MCHC has also made modifications to ensure that CCSA results are visible to all multi-disciplinary core team members via their shared EMR.

Healthcare for the Homeless (HCH) already utilizes care plans in managing patient care, but hopes to utilize waiver funds to enhance their usability for the multi-disciplinary core team in the coming year.

Closed Loop Referrals

Both MCHC and HCH use their EMR to automate their closed loop referral process.

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*	*Yes*	*Yes*
Healthcare for the Homeless	*Yes*	*Yes*	*Yes*	*Yes, piloting with implementation of the ICSI depression model*

B1-9d

Network4Health B1 project partners identified the community based social support partners with whom they are currently working or with whom they need to develop enhanced collaboration to support the implementation of the CCSA social determinant of health related domains. Many of these Community Based Organizations (CBOs) and the Network4Health director has worked closely with CBO partners to increase HIT capabilities such as internet access, direct secure messaging and closed loop referral system supported by the IDN. The HIT director and B1 team work with partners to identify CBOs who are key stakeholders for their clients/patients.

Network4Health encourages partners to have robust relationships and regular communications with CBOs and all stakeholders. A communication plan template was provided to our partners during the IEP development phase.

Attachment_B1.9d1 and Attachment_B1.9d2 demonstrate the referral workflow used by the Healthcare for the Homeless team for partner agency referrals. Healthcare for the Homeless Manchester has formal agreements in place that are proprietary, but they attest to those being in place. The Healthcare for the Homeless team is enhancing existing protocols and workflows in alignment with Network4Health

recommended best practices and protocols. Healthcare for the Homeless Manchester has indicated they have formal contracts with the following organizations: Manchester Health Department; CMC; The Mental Health Center of Greater Manchester; Pastoral Care Services(PCS); Manchester Community Health Center, Dartmouth-Hitchcock Clinic; Poisson Dental Clinic; Medication Assistance Program; Families In Transition - New Horizons Shelter; Child and Family Services; State DHHS- Primary Care for Homeless; State Bureau of Drug and Alcohol Services; State-DHHS Immunization program; Doctors Office/Physicians Services; Lens Crafters Inc.; Interagency Council on Homelessness.

Healthcare for the Homeless Manchester has indicated informal agreements with the following: State Bureau of Homeless and Housing; NH Coalition for Homeless; NH Housing and Finance Authority; Elliot Hospital; local private practices/specialty providers; Dartmouth Medical School & Family Practice Residency; UNH; St. Anselm's; Rivier College; UNH School of Social Work; SNHU; HCH-Portsmouth; HCH-Nashua; Ryan White-ID clinics; Child Health Services; VA Med Center/VASH/ VA-PAC teams; State-Voc-Rehab Dept; federal SSA/state DDS offices; State-DHHS-Medicaid/FoodStamps/TANF; City Welfare; local EMS-Ambulance; Manchester Police Dept; Manchester Fire Department "Safe Station", Granite Pathways, Farnum Center, State-DOC/Probation/Parole/Prison Re-entry; Southern NH– CAP Agency for WIC and Heat Assistance; Rite Aid Pharmacy; local MD providers; NH-Legal-Aid; Disability attorneys; Office of Public Defenders; NAMI-NH; DOC Community Corrections / DOJ Prison half-way houses; Salvation Army; YWCA; NH Domestic Violence Coalition; The Way Home, Teen Challenge and shelters/food pantries; state Behavioral Health Collaborative; Integrating Care Collaborative.

AttachmentB1.9d3 demonstrates workflow and communication protocols with social service and other provider organizations relevant to domain with in the comprehensive core standardized assessment. Attachment_B1.9d4 demonstrates the Manchester Community Health Center referral workflow for partner agency referrals. Manchester Community Health Center has Memoranda of Agreement with multiple agencies in place that are proprietary, but they attest to those being in place. In particular, Manchester Community Health Center works with Medication Assistance Program, NH Legal Assistance and NH food banks. The Manchester Community Health Center team is committed to enhancing the documentation of existing protocols and workflows in alignment with Network4Health recommended best practices and protocols.

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

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional	Adoption of both	Protocols				

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

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

Use the format below to identify the total number of practices/providers who have **achieved** designation as a Coordinated Care Practice or Integrated Care Practice. IDNs are expected to make

continual progress toward achieving their projected number of designated Coordinated Care Practices and Integrated Care Practices.

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

Included in Attachment_B1.10 is a detailed review of all coordinated care and integrated care milestones and the status for each Network4Health B1 partner.

Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	Up to 18	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	*0 Coordinated Care Practices*	*0 Coordinated Care Practices*	18
Integrated Care Practice	Up to 5	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	*0 Integrated Care Practices*	*0 Integrated Care Practices*	**5**

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

Progress Toward Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
1	**Catholic Medical Center** - Amoskeag Family Practice	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team - Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions	- IEP project team has matured, improved overall project communication, and gained greater participation and buy in from leadership at both the primary care practice level and the larger health system level. - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy by primary care, care coordination and behavioral health services representatives - Recruitment/hiring process for Behavioral Health Patient Navigators and Licensed Mental Health Clinician in process - Enhancement and development of workflows between primary care

			for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	and behavioral health, internally and with MHCGM, specifically the Intensive Transition Team (another B1 sponsored IEP) - Developed information sharing agreement between CMC and MHCGM - Regular participation in the Network4Health Integrated Care Workgroup, and other integrated care activities, such as the Value Based Care Summit, collaborative meetings with the Manchester Veteran's Medical Center Community Outreach staff - Completion of SBIRT training and implementation across multi-disciplinary team - CCSA implemented - Standardized workflows and protocols established
2	**Catholic Medical Center** – Behavioral Health Practice	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team - Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	- IEP project team has matured, improved overall project communication, and gained greater participation and buy in from leadership at both the practice level and the larger health system level. - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy by primary care, care coordination and behavioral health services representatives - Recruitment/hiring process for Behavioral Health Patient Navigators and Licensed Mental Health Clinician in process - Enhancement and development of workflows between primary care and behavioral health, internally and with MHCGM, specifically the Intensive Transition Team (another B1 sponsored IEP) - Executed information sharing agreement between CMC and MHCGM - Regular participation in the Integrated Care workgroup, and other integrated care activities, such as the Value Based Care Summit, collaborative meetings with the Manchester Veteran's Medical Center Community Outreach staff - Completion of SBIRT training and implementation across multi-disciplinary team - CCSA implemented - Standardized workflows and protocols established or refined
3	**Catholic Medical Center** – Bedford Center Internal Medicine and Pediatrics	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team	- IEP project team has matured, improved overall project communication, and gained greater participation and buy in from leadership at both the primary care practice level and the larger health system level.

	(formerly known as Family Health & Wellness Center at Bedford)	Cohort 2	- Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	- Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy by primary care, care coordination and behavioral health services representatives - Recruitment/hiring process for Behavioral Health Patient Navigators and Licensed Mental Health Clinician in process - Enhancement and development of workflows between primary care and behavioral health, internally and with MHCGM, specifically the Intensive Transition Team (another B1 sponsored IEP) - Developed information sharing agreement between CMC and MHCGM - Regular participation in the Network4Health Integrated Care Workgroup, and other integrated care activities, such as the Value Based Care Summit, collaborative meetings with the Manchester Veteran's Medical Center Community Outreach staff - Completion of SBIRT training and implementation across multi-disciplinary team - CCSA implemented - Standardized workflows and protocols established
4	**Catholic Medical Center** - Willowbend Family Practice	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team - Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	- IEP project team has matured, improved overall project communication, and gained greater participation and buy in from leadership at both the primary care practice level and the larger health system level. - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy by primary care, care coordination and behavioral health services representatives - Recruitment/hiring process for Behavioral Health Patient Navigators and Licensed Mental Health Clinician in process - Enhancement and development of workflows between primary care and behavioral health, internally and with MHCGM, specifically the Intensive Transition Team (another B1 sponsored IEP) - Developed information sharing agreement between CMC and MHCGM - Regular participation in the Network4Health Integrated Care Workgroup, and other integrated care activities, such as the Value Based Care Summit, collaborative meetings with the Manchester Veteran's Medical Center Community Outreach staff

				- Completion of SBIRT training and implementation across multi-disciplinary team - CCSA implemented - Standardized workflows and protocols established
5	**Catholic Medical Center** – Healthcare for the Homeless	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for Healthcare for the Homeless integration efforts in the short term and future looking. - Weekly meetings with Network4Health Integration Team to discuss IEP development and all components required for Integrated Care Designation. - Participation in the June 2018 Cherokee Integration Academy	- IEP project team has matured, improved overall project communication - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy - Review, enhancement and modification of workflows between primary care and behavioral health teams within the practice. - Practice workflow review with Ansell Horn, APRN through National Healthcare for the Homeless technical assistance program - Meetings completed to review joint workflows with the Farnum Center staff - Completion of required trainings - CCSA implemented - Standardized workflows and protocols in place - MAT clinic is open and workflows are in place - Implementation completed for ICSI evidence based model for mild to moderate depression with all BH clinicians
6	**Center for Life Management –** Behavioral Health	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and all components required for Coordinated Care Designation. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Implementation of IEP, including the hiring of a Patient Nurse Navigator - CLM is challenged in that the largest primary care provider in Derry is not a B1 partner; however, they have made a concerted effort to educate this practice about integrated care and are making progress in improving joint protocols and workflows between them. - Continues regular meetings with the Network4Health team - Active participants and enthusiastic collaborators in the Integrated Care Workgroup and other Network4Health activities. For example, CLM hosts presentations to share their integrated practice targeting people with developmental and intellectual disabilities between CLM and Community Crossroads - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference - Enhancement and development of workflows and protocols were completed - Completion of required trainings and implementation across multi-disciplinary team

				- CCSA implemented - Standardized workflows and protocols established or refined
7	**Dartmouth-Hitchcock -** Adult Primary Care	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in initial workflow discussions with the Mental Health Center of Greater Manchester and separately with Fusion Health Services - Development of job descriptions for Licensed Mental Health Clinicians and Family Support Specialists - Collaboration with other Dartmouth-Hitchcock B1 projects to collaborate on CCSA implementation, job descriptions and workflows to standardize implementation across the Dartmouth system. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Integrated healthcare IEP project team experienced adapted well to the loss of an RN and the lead physician, and fill those roles with an interim medical lead and additional clinical staff. - IEP efforts aligned with the larger D-H system integration initiatives and are able to leverage D-H training & HIT resources - Implementation of BHCs has been positive by provider staff, who are still adapting to fully utilizing this resource - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy - Recruitment/hiring process complete for integrated care positions identified through IEP - Enhancement and development of workflows between primary care and behavioral health, internally and externally with MHCGM and Fusion - Provided EMR access to MHCGM to improve information sharing and care coordination - Regular participation in the Integrated Care workgroup, and other integrated care activities - Completion of required training and implementation across multi-disciplinary team - CCSA implemented per D-H system wide protocol and timeline - Standardized workflows and protocols established or refined
8	**Dartmouth-Hitchcock -** Pediatric Primary Care	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in initial workflow discussions with the Mental Health Center of Greater Manchester and separately with Fusion Health Services - Development of job descriptions for Licensed Mental Health Clinicians and Family Support Specialists - Collaboration with other	- Integrated healthcare IEP project team experienced adapted well to the loss of an RN and the lead physician, and fill those roles with an interim medical lead and additional clinical staff. - IEP efforts aligned with the larger D-H system integration initiatives and are able to leverage D-H training & HIT resources - Implementation of BHCs has been positive by provider staff, who are still adapting to fully utilizing this resource - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy - Recruitment/hiring process complete for integrated care positions identified through IEP - Inclusion of Mental Health Center of Greater Manchester Adolescent

			Dartmouth-Hitchcock B1 projects to collaborate on CCSA implementation, job descriptions and workflows to standardize implementation across the Dartmouth system. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	Psychiatrist at monthly case conferences - Provided EMR access to MHCGM to improve information sharing and care coordination - Regular participation in the Integrated Care workgroup, and other integrated care activities - Completion of required training and implementation across multi-disciplinary team - CCSA implemented per D-H system wide protocol and timeline - Standardized workflows and protocols established or refined
9	**Easterseals NH –** Farnum Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Meetings with Network4Health Integration team to discuss IEP development and understanding of Coordinated Care Designation requirements.	- Development and submission of an Integration Enhancement Plan as a roadmap for improved practice integration efforts via enhanced care coordination - Formation of a centralized integration project team - Significant work done to communicate and gain Easterseals NH and Farnum Center administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan, involving both Medicaid waiver and BDAS support - Development of job descriptions for Care Coordinator positions - Significant internal discussion on the collaboration workflows between Easterseals NH Care Coordination and the Farnum Center - Current intake screening satisfies CCSA requirement - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy - Enhancement of workflows between Farnum and other IDN 4 partners, including EHS, MHCGM and HCH - Scheduled chronic conditions training for Q4 2018, but needed to be rescheduled Q1 2019 to ensure full staff attendance. Completed January 23, 2019. - Standardized workflows and protocols in place
10	**Elliot Health System -** Doctors Park Pediatrics	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan - Meetings with Network4Health Integration Team to discuss IEP development - Participation in the June 2018 Cherokee Integration Academy	- Implementation of integrated care practice as per IEP - Significant work done to communicate and gain Elliot Health System administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Elliot Case Management department plans to use a standardized CCSA system-wide, and the CCSA will be modified

				accordingly over time - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy - Completed required trainings, and proactively pursues trainings that support change management and integrated care best practices - Standardized workflows and protocols established or refined
11	**Elliot Health System –** Partial Hospitalization Program	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Focus on implementing PHP; will begin to focus on IEP in Fall 2018	- Development and submission of an Integration Enhancement Plan or improved practice integration efforts at the PHP and Drug court program - Current intake screening satisfies CCSA requirement - Development of workflows that proactively engage primary care and community-based organizations to delivery integrated healthcare - Staff completed chronic conditions training and other required trainings - Standardized workflows and protocols established
12	**Families in Transition- New Horizons -** Family Willows Treatment and Recovery Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- IEP project team is maturing and continues to meet regularly with the Network4Health B1 team as well as with the Network4Health HIT team, who is closely supporting their organization-wide EMR implementation - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care conference - Recruitment/hiring process for multi-disciplinary care team members near completion - Enhancement and development of workflows and protocols - Completion of required trainings and implementation across multi-disciplinary team - CCSA implemented - Standardized workflows and protocols established or refined
13	**Fusion Health Services**	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Definition of new multi-disciplinary team - Recruitment/hiring process for multi-disciplinary care team members is complete - Provides MAT services to patients and accepts MAT referrals from Network4Health providers - Significant effort in the establishment of joint workflows and protocols with MHCGM, Dartmouth-Hitchcock primary care, Manchester Safe Station, Granite Pathways, the new Sununu Center and Rose Meadow (Residential Programs for Individuals with Brain Injury, Spinal Cord Injury &

				Neurological Disorders) - Developed and implemented CCSA across all domains - Standardized workflows and protocols established - Staff trained on Integrated Care fundamentals - Behavioral Health staff trained on Chronic Diseases
14	**Manchester Community Health Center -** MCHC, Hollis Street	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation.	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - MAT in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.
15	**Manchester Community Health Center -** MCHC, Tarrytown	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - MAT in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.

			Workgroup	
16	**Manchester Community Health Center -** Westside Neighborhood Health Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - MAT in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.
17	**Manchester Community Health Center -** Child Health Services at MCHC	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.

			- IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
18	**Mental Health Center of Greater Manchester –** Behavioral Health	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Initiated 2 x workflow discussions with CMC, Dartmouth, Elliot Health Systems and Fusion Health Services - Hired 3 Intensive Transition Team members within reporting period (ITT Coordinator and 2 Case Managers). 2 additional Case Managers to start in July 2018. - Significant work completed on ITT team workflows and patient identification criteria. This will be tested and further refined during initial implementation. - Initial CCSA created within EMR and ready for implementation with ITT team. - Additional EMR modifications to care plan made to support workflow of Intensive Transition Team - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Integrated CCSA questions into EHR, provided training to MHCGM staff - Created specialized EHR forms, including the Intensive Transition Team (ITT) Progress Note/Care Plan which auto-populates risk scores from the CCSA into the Care Plan form. - Identified and confirmed partners for ITT support, including the Elliot Hospital and Catholic Medical Center Emergency Departments, and Catholic Medical Center primary care practices. - Recruited and hired ITT staff (coordinator, 4 case managers, peer specialist/recovery coach, program assistant) - Rolled out the CCSA to patients. - Worked collaboratively with local primary care, substance use disorder, and social services agencies to provide ITT services to 83 individuals (as of 12/21/18). Tracked and analyzed outcome measures to improve program design. - Attended regular case conference meetings with core partners at CMC Healthcare for the Homeless to discuss high-risk patients. - Designated a MHCGM psychiatrist to attend monthly pediatric primary care case conferences at Dartmouth Hitchcock. - Completed required trainings for ITT and other MHCGM staff including Integrated Care, Cultural Competency, Chronic Disease Management, Motivational Interviewing, and Stages of Change. - Completed the first three out of four Zero Suicide trainings for all MHCGM staff, linking this initiative to MHCGM integration efforts around transitions of care, safety planning, etc. - As part of the Zero Suicide initiative, began the development of a risk-score system to include social determinant measures. - Developed partnership with Fusion Healthcare to offer MAT services onsite to MHCGM clients. - Worked with Granite Pathways and Fusion Healthcare to secure medical staff for the new Sununu Center for Youth, and incorporating the MHCGM Mobile Crisis Response Team into the Sununu

				emergency protocols. - Identified a MHCGM psychiatrist to begin weekly phone consultation calls with partnering primary care practices. - Developed drafts of shared release of information forms with CMC and Dartmouth Hitchcock. - Developed procedures to manage electronic referrals from hospitals and primary care partners. - Began planning stages of developing joint workflow protocols with three CMC primary care practices.

Progress Toward Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
1	**Catholic Medical Center -** Healthcare for the Homeless	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for Healthcare for the Homeless integration efforts in the short term and future looking. - Weekly meetings with Network4Health Integration Team to discuss IEP development and all components required for Integrated Care Designation - Participation in the June 2018 Cherokee Integration Academy	- IEP project team has matured, improved overall project communication - Participation in the September 2018 Part 2 Cherokee Health System Integrated Care Conference Academy - Review, enhancement and modification of workflows between primary care and behavioral health teams within the practice. - Practice workflow review with [redacted], APRN through National Healthcare for the Homeless technical assistance program - Meetings completed to review joint workflows with the Farnum Center staff - Completion of required trainings - CCSA implemented - Standardized workflows and protocols in place - MAT clinic is open and workflows are in place - Implementation completed for ICSI evidence-based model for mild to moderate depression with all BH clinicians
2	**Manchester Community Health Center -** MCHC, Hollis Street	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized

			all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - MAT in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.
3	**Manchester Community Health Center -** MCHC, Tarrytown	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - MAT in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.
4	**Manchester Community Health Center -** Westside	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA

	Neighborhood Health Center	Cohort 2	work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - MAT in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings.
5	**Manchester Community Health Center -** Child Health Services at MCHC	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	- Enhancement of already mature integrated healthcare delivery model to create consistency across all practice sites - Enhancement of EMR to support all CCSA domains and multi-disciplinary team view of CCSA positive screenings in the care plan - Training and rollout of Comprehensive Core Standardized Assessment with required domains; - Multi-disciplinary Core Teams in place; - Information sharing: care plans, treatment plans, case conferences, closed loop referrals in place - Standardized workflows and protocols in place - Significant work to review existing methodologies for high risk patient identification - Completion of required trainings. o

B1 - Coordinated Care - 123118

	Task Name	Duration	Start	Finish	% Complete
1	**B1 Integrated Healthcare - Coordinated Care Practices**	580d	03/01/17	06/04/19	85%
2	**Development of Core Deliverables and Process**	580d	03/01/17	06/04/19	85%
3	**Comprehensive Core Standardized Assessment Tool/Process**	240d	03/01/17	01/31/18	100%
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	100%
6	Refine Comprehensive Core Standardized Assessment Process	165d	06/14/17	01/31/18	100%
7	Finalize Comprehensive Core Standardized Assessment Process	0	01/31/18	01/31/18	100%
8	**Depression Screening Tool/Process**	88d	03/01/17	06/30/17	100%
9	Develop Depression Screening Tool	50d	03/01/17	05/09/17	100%
10	Develop Depression Screening Process	25d	05/10/17	06/13/17	100%
11	Refine Depression Screening Process	5d	06/14/17	06/20/17	100%
12	Finalize Depression Screening Process	8d	06/21/17	06/30/17	100%
13	**Shared Care Plan**	580d	03/01/17	06/04/19	74%
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	100%
16	Refine Shared Care Plan Process	8w	08/06/18	10/01/18	100%
17	Finalize Shared Care Plan Process	34w	10/02/18	06/04/19	40%
18	**Participant Selection Process**	85d	03/01/17	06/27/17	100%
19	Define Selection Criteria	50d	03/01/17	05/09/17	100%
20	Develop Selection Process	30d	05/10/17	06/20/17	100%
21	Select CHI Participants	1w	06/21/17	06/27/17	100%
22	Sign CHI Agreement (SSA administration)	22d	07/03/17	08/01/17	100%
23	Sign CHI Agreement (Integration Practice Facilitation)	130d	08/02/17	01/31/18	100%
24	**Coordinated Care Practice Cohort 1**	954d	09/15/17	06/14/21	23%
25	**CHI Assessment Cohort 1 Baseline**	54d	09/15/17	11/29/17	100%
26	CHI Assessment Administered	21d	09/15/17	10/13/17	100%
27	CHI Results Collected	32d	10/16/17	11/28/17	100%
28	CHI Report Delivered	1d	11/29/17	11/29/17	100%
29	**Participant Implementation Process Cohort 1: Initial IEP**	397d	11/30/17	06/21/19	40%
30	Up to 2 Participants Selected for Coordinated Care Practice Cohort 1	3w	11/30/17	12/20/17	100%
31	Integration Enhancement Project Team Created	1w	12/21/17	12/27/17	100%
32	Integration Enhancement Plan (IEP) Created	43d	12/28/17	02/27/18	100%
33	Cohort 1 IEPs Due to Network4Health	0	02/27/18	02/27/18	100%
34	Network4Health IEP Funding Review	31d	02/28/18	04/11/18	100%
35	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	04/12/18	04/12/18	100%
36	Intiate Integration Enhancement Plan - (12 months)	253d	06/01/18	05/31/19	60%

	Task Name	Duration	Start	Finish	% Complete
37	6 month Status Report and Lessons Learned Due	142d	06/01/18	12/21/18	100%
38	9 month Status Report and Lessons Learned Due	204d	06/01/18	03/22/19	
39	12 month Status Report and Lessons Learned Due	268d	06/01/18	06/21/19	
40	**CHI Assessment Cohort 1 and 2 Follow-up 1 (Progress Assessment Checkpoint)**	71d	05/14/18	08/22/18	100%
41	CHI Assessment Administered	10w	05/14/18	07/24/18	100%
42	CHI Results Analysis	20d	07/25/18	08/21/18	100%
43	CHI Report Delivered	1d	08/22/18	08/22/18	100%
44	**Participant Implementation Process Cohort 1 & 2 (combined) IEP Renewal**	314d	03/25/19	06/16/20	
45	Status Report and CHI Assessment Results Reviewed	2w	03/25/19	04/05/19	
46	IEP Modifications and Continued Funding Requests Reviewed	2w	03/25/19	04/05/19	
47	IEP Continuation and Funding Continuation Confirmation	1d	04/08/19	04/08/19	
48	Integration Enhancement Plan Continuation- (12 months)	253d	06/03/19	05/29/20	
49	3 month Status Report and Lessons Learned Due	14w	06/03/19	09/09/19	
50	6 month Status Report and Lessons Learned Due	27w	06/03/19	12/11/19	
51	9 month Status Report and Lessons Learned Due	200d	06/03/19	03/16/20	
52	12 month Status Report and Lessons Learned Due	265d	06/03/19	06/16/20	
53	**CHI Assessment Cohort 1/2 Follow-up 3 (Progress Assessment Checkpoint)**	51d	03/15/19	05/24/19	
54	CHI Assessment Administered	22d	03/15/19	04/15/19	
55	CHI Results Collected	28d	04/16/19	05/23/19	
56	CHI Report Delivered	1d	05/24/19	05/24/19	
57	**CHI Assessment Cohort 1/2 Follow-up 4 (Progress Assessment Checkpoint)**	36d	10/29/19	12/19/19	
58	CHI Assessment Administered	3w	10/29/19	11/18/19	
59	CHI Results Collected	20d	11/19/19	12/18/19	
60	CHI Report Delivered	1d	12/19/19	12/19/19	
61	**Participant Implementation Process Cohort 1 & 2 IEP Renewal**	318d	03/17/20	06/14/21	
62	Status Report and CHI Assessment Results Reviewed	2w	03/17/20	03/30/20	
63	IEP Modifications and Continued Funding Requests Reviewed	2w	03/17/20	03/30/20	
64	IEP Continuation and Funding Continuation Confirmation	1d	03/31/20	03/31/20	
65	Integration Enhancement Plan Continuation- (12 months)	255d	06/01/20	05/31/21	
66	3 month Status Report and Lessons Learned Due	14w	06/01/20	09/04/20	
67	6 month Status Report and Lessons Learned Due	27w	06/01/20	12/09/20	
68	9 month Status Report and Lessons Learned Due	200d	06/01/20	03/15/21	
69	12 month Status Report and Lessons Learned Due	265d	06/01/20	06/14/21	
70	**Coordinated Care Practices Cohort 2**	333d	03/01/18	06/21/19	30%
71	**Participant Implementation Process Cohort 2 Initial IEP**	333d	03/01/18	06/21/19	30%
72	Up to 2 Participants Selected for Coordinated Care Practice Cohort 2	0	03/01/18	03/01/18	100%
73	Integration Enhancement Project Team Created	4d	03/01/18	03/06/18	100%

	Task Name	Duration	Start	Finish	% Complete
74	Integration Enhancement Plan (IEP) Created	67d	03/07/18	06/08/18	100%
75	Cohort 1 IEPs Due to Network4Health	0	06/08/18	06/08/18	100%
76	Network4Health IEP Funding Review	22d	06/11/18	07/11/18	100%
77	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board/Steering Committee)	1d	07/12/18	07/12/18	100%
78	Intiate Integration Enhancement Plan - (10 months)	1d	08/01/18	08/01/18	60%
79	6 month Status Report and Lessons Learned Due	1d	12/21/18	12/21/18	100%
80	9 month Status Report and Lessons Learned Due	1d	03/22/19	03/22/19	
81	12 month Status Report and Lessons Learned Due	226d	08/01/18	06/21/19	
82	Transition Cohort 2 to CHI Assessment Follow-up Timeline in alignment with Cohort 1	0	03/15/19	03/15/19	
83	**Evaluation Metrics Reporting (Data - per approved metrics)**	913d	07/01/17	01/29/21	42%
84	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/31/18	100%
85	Prepare evaluation plan measures	152d	07/01/17	01/30/18	100%
86	Submit	1d	01/31/18	01/31/18	100%
87	On-going data reporting for period ending 06/29/2018	150d	01/01/18	07/31/18	100%
88	Prepare evaluation plan measures	149d	01/01/18	07/30/18	100%
89	Submit	1d	07/31/18	07/31/18	100%
90	On-going data reporting for period ending 12/31/2018	148d	07/01/18	01/31/19	90%
91	Prepare evaluation plan measures	147d	07/01/18	01/30/19	90%
92	Submit	1d	01/31/19	01/31/19	90%
93	On-going data reporting for period ending 06/29/2019	151d	01/01/19	07/31/19	
94	Prepare evaluation plan measures	150d	01/01/19	07/30/19	
95	Submit	1d	07/31/19	07/31/19	
96	On-going data reporting for period ending 12/31/2019	149d	07/01/19	01/31/20	
97	Prepare evaluation plan measures	148d	07/01/19	01/30/20	
98	Submit	1d	01/31/20	01/31/20	
99	On-going data reporting for period ending 06/29/2020	152d	01/01/20	07/31/20	
100	Prepare evaluation plan measures	151d	01/01/20	07/30/20	
101	Submit	1d	07/31/20	07/31/20	
102	On-going data reporting for period ending 12/31/2020	147d	07/01/20	01/29/21	
103	Prepare evaluation plan measures	146d	07/01/20	01/28/21	
104	Submit	1d	01/29/21	01/29/21	
105	**Process Milestones**	1049d	01/01/17	02/08/21	50%
106	**Milestones for period ending 06/31/2017**	152d	01/01/17	07/31/17	100%
107	Develop Implementation Plan	152d	01/01/17	07/31/17	100%
108	Implementation timeline	152d	01/01/17	07/31/17	100%
109	Budget	152d	01/01/17	07/31/17	100%

	Task Name	Duration	Start	Finish	% Complete
110	Workforce Plan	152d	01/01/17	07/31/17	100%
111	Participant Selection	152d	01/01/17	07/31/17	100%
112	Organizational Leadership Sign-off	152d	01/01/17	07/31/17	100%
113	**Milestones for period ending 12/31/2017**	153d	07/01/17	01/31/18	100%
114	Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/17	01/31/18	100%
115	Up to 2 participants have demonstrated progress towards Integrated Care Practice	153d	07/01/17	01/31/18	100%
116	**Milestones for period ending 06/31/2018**	151d	01/01/18	08/01/18	100%
117	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	151d	01/01/18	08/01/18	100%
118	Up to 2 participants have demonstrated progress towards Integrated Care Practice	151d	01/01/18	08/01/18	100%
119	**Milestones for period ending 12/31/2018**	154d	07/01/18	02/08/19	100%
120	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	154d	07/01/18	02/08/19	100%
121	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	154d	07/01/18	02/08/19	100%
122	**Milestones for period ending 06/31/2019**	152d	01/01/19	08/01/19	
123	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	152d	01/01/19	08/01/19	
124	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	152d	01/01/19	08/01/19	
125	**Milestones for period ending 12/31/2019**	155d	07/01/19	02/10/20	
126	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	155d	07/01/19	02/10/20	
127	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	155d	07/01/19	02/10/20	
128	**Milestones for period ending 06/29/20**	153d	01/01/20	08/03/20	
129	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	01/01/20	08/03/20	
130	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	01/01/20	08/03/20	
131	**Milestones for period ending 12/31/2020**	153d	07/01/20	02/08/21	
132	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/20	02/08/21	
133	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	07/01/20	02/08/21	
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Attachment_B1.2b

B1 - Integrated Care - 123118

	Task Name	Duration	Start	Finish	Predecessors	% Complete
1	**B1 Integrated Healthcare - Integrated Care Practices**	580d	03/01/17	06/04/19		89%
2	**Development of Core Deliverables and Process**	580d	03/01/17	06/04/19		89%
3	**Comprehensive Core Standardized Assessment Tool/Process**	240d	03/01/17	01/31/18		100%
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	100%
7	Finalize Comprehensive Core Standardized Assessment Process	0	01/31/18	01/31/18	6	100%
8	**Depression Screening Tool/Process**	88d	03/01/17	06/30/17		100%
9	Develop Depression Screening Tool	50d	03/01/17	05/09/17		100%
10	Develop Depression Screening Process	25d	05/10/17	06/13/17	9	100%
11	Refine Depression Screening Process	5d	06/14/17	06/20/17	10	100%
12	Finalize Depression Screening Process	8d	06/21/17	06/30/17	11	100%
13	**Shared Care Plan**	580d	03/01/17	06/04/19		74%
14	Develop Shared Care Plan Tool	60d	03/01/17	05/23/17		100%
15	Develop Shared Care Plan Process	127d	05/24/17	11/16/17	14	100%
16	Refine Shared Care Plan Process	8w	08/06/18	10/01/18		100%
17	Finalize Shared Care Plan Process	34w	10/02/18	06/04/19	16	40%
18	**MAT Treatment Program**	363d	03/01/17	07/25/18		100%
19	Research MAT Model	60d	03/01/17	05/23/17		100%
20	Develop MAT Plan/Protocol	200d	05/24/17	02/28/18	19	100%
21	Refine MAT Plan/Protocol	100d	03/01/18	07/20/18	20	100%
22	Finalize MAT Plan/Protocol	3d	07/23/18	07/25/18	21	100%
23	**Participant Selection Process**	85d	03/01/17	06/27/17		100%
24	Define Selection Criteria	50d	03/01/17	05/09/17		100%
25	Develop Selection Process	30d	05/10/17	06/20/17	24	100%
26	Select CHI Participants	1w	06/21/17	06/27/17	25	100%
27	Sign CHI Agreement (SSA administration)	22d	07/03/17	08/01/17		100%
28	Sign CHI Agreement (Integration Practice Facilitation)	130d	08/02/17	01/31/18	27	100%
29	**Integrated Practice Cohort 1 (1 practice)**	954d	09/15/17	06/14/21		23%
30	**CHI Assessment Cohort 1 Baseline**	54d	09/15/17	11/29/17		100%
31	CHI Assessment Administered	21d	09/15/17	10/13/17		100%
32	CHI Results Collected	32d	10/16/17	11/28/17	31	100%
33	CHI Report Delivered	1d	11/29/17	11/29/17	32	100%
34	**Participant Implementation Process Cohort 1: Initial IEP**	397d	11/30/17	06/21/19		40%
35	Up to 2 Participants Selected for Integrated Care Practice Cohort 1	3w	11/30/17	12/20/17	33	100%
36	Integration Enhancement Project Team Created	1w	12/21/17	12/27/17	35	100%
37	Integration Enhancement Plan (IEP) Created	43d	12/28/17	02/27/18	36	100%
38	Cohort 1 IEPs Due to Network4Health	0	02/27/18	02/27/18	37	100%
39	Network4Health IEP Funding Review	31d	02/28/18	04/11/18	38	100%

Attachment_B1.2b

	Task Name	Duration	Start	Finish	Predecessors	% Complete
40	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	04/12/18	04/12/18	39	100%
41	Intiate Integration Enhancement Plan - (12 months)	253d	06/01/18	05/31/19	40FS +34d	60%
42	6 month Status Report and Lessons Learned Due	142d	06/01/18	12/21/18	41SS	100%
43	9 month Status Report and Lessons Learned Due	204d	06/01/18	03/22/19	41SS	
44	12 month Status Report and Lessons Learned Due	268d	06/01/18	06/21/19	41SS	
45	**CHI Assessment Cohort 1 Follow-up 1 (Progress Assessment Checkpoint)**	71d	05/14/18	08/22/18		100%
46	CHI Assessment Administered	10w	05/14/18	07/24/18		100%
47	CHI Results Analysis	20d	07/25/18	08/21/18	46	100%
48	CHI Report Delivered	1d	08/22/18	08/22/18	47	100%
49	**CHI Assessment Cohort 1 Follow-up 2, Cohort 2 Follow-up 1 (Progress Assessment Checkpoint)**	51d	03/15/19	05/24/19		
50	CHI Assessment Administered	22d	03/15/19	04/15/19		
51	CHI Results Collected	28d	04/16/19	05/23/19	50	
52	CHI Report Delivered	1d	05/24/19	05/24/19	51	
53	**Participant Implementation Process Cohort 1 & 2 (combined) IEP Renewal**	314d	03/25/19	06/16/20		
54	Status Report and CHI Assessment Results Reviewed	2w	03/25/19	04/05/19	43	
55	IEP Modifications and Continued Funding Requests Reviewed	2w	03/25/19	04/05/19	43	
56	IEP Continuation and Funding Continuation Confirmation	1d	04/08/19	04/08/19	55	
57	Integration Enhancement Plan Continuation- (12 months)	253d	06/03/19	05/29/20	41	
58	3 month Status Report and Lessons Learned Due	14w	06/03/19	09/09/19	57SS	
59	6 month Status Report and Lessons Learned Due	27w	06/03/19	12/11/19	57SS	
60	9 month Status Report and Lessons Learned Due	200d	06/03/19	03/16/20	57SS	
61	12 month Status Report and Lessons Learned Due	265d	06/03/19	06/16/20	57SS	
62	**CHI Assessment Cohort 1 Follow-up 3, Cohort 2 Follow-up 2 (Progress Assessment Checkpoint)**	36d	10/29/19	12/19/19		
63	CHI Assessment Administered	3w	10/29/19	11/18/19	59FS -30d	
64	CHI Results Collected	20d	11/19/19	12/18/19	63	
65	CHI Report Delivered	1d	12/19/19	12/19/19	64	
66	**Participant Implementation Process Cohort 1 & 2 IEP Renewal**	318d	03/17/20	06/14/21		
67	Status Report and CHI Assessment Results Reviewed	2w	03/17/20	03/30/20	60	
68	IEP Modifications and Continued Funding Requests Reviewed	2w	03/17/20	03/30/20	60	
69	IEP Continuation and Funding Continuation Confirmation	1d	03/31/20	03/31/20	68	
70	Integration Enhancement Plan Continuation- (12 months)	255d	06/01/20	05/31/21	57	
71	3 month Status Report and Lessons Learned Due	14w	06/01/20	09/04/20	70SS	
72	6 month Status Report and Lessons Learned Due	27w	06/01/20	12/09/20	70SS	
73	9 month Status Report and Lessons Learned Due	200d	06/01/20	03/15/21	70SS	
74	12 month Status Report and Lessons Learned Due	265d	06/01/20	06/14/21	70SS	
75	**Integrated Care Practice Cohort 2 (1 practice)**	333d	03/01/18	06/21/19		48%
76	**CHI Assessment Cohort 2 Baseline**	41d	03/01/18	04/26/18		100%
77	CHI Assessment Administered	20d	03/01/18	03/28/18		100%
78	CHI Results Collected	20d	03/29/18	04/25/18	77	100%
79	CHI Report Delivered	1d	04/26/18	04/26/18	78	100%

Attachment_B1.2b

	Task Name	Duration	Start	Finish	Predecessors	% Complete
80	**Participant Implementation Process Cohort 2 Initial IEP**	333d	03/01/18	06/21/19		42%
81	Up to 2 Participants Selected for Integrated Care Practice Cohort 2	0	03/01/18	03/01/18		100%
82	Integration Enhancement Project Team Created	4d	03/01/18	03/06/18	81	100%
83	Integration Enhancement Plan (IEP) Created	67d	03/07/18	06/08/18	82	100%
84	Cohort 1 IEPs Due to Network4Health	0	06/08/18	06/08/18	83	100%
85	Network4Health IEP Funding Review	22d	06/11/18	07/11/18	84	100%
86	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board/Steering Committee)	1d	07/12/18	07/12/18	85	100%
87	Initiate Integration Enhancement Plan - (11 months)	232d	07/02/18	05/31/19	86FS -8d	60%
88	6 month Status Report and Lessons Learned Due	1d	12/21/18	12/21/18		100%
89	9 month Status Report and Lessons Learned Due	1d	03/22/19	03/22/19		
90	12 month Status Report and Lessons Learned Due	226d	08/01/18	06/21/19		
91	Transition Cohort 2 to Cohort 1 Timeline	0	06/21/19	06/21/19	90	
92	Transition Cohort 2 to CHI Assessment Follow-up Timeline in alignment with Cohort 1	0	03/15/19	03/15/19		
93	**Evaluation Metrics Reporting (Data - per approved metrics)**	913d	07/01/17	01/29/21		42%
94	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/31/18		100%
95	Prepare evaluation plan measures	152d	07/01/17	01/30/18		100%
96	Submit	1d	01/31/18	01/31/18	95	100%
97	On-going data reporting for period ending 06/29/2018	150d	01/01/18	07/31/18		100%
98	Prepare evaluation plan measures	149d	01/01/18	07/30/18		100%
99	Submit	1d	07/31/18	07/31/18	98	100%
100	On-going data reporting for period ending 12/31/2018	148d	07/01/18	01/31/19		90%
101	Prepare evaluation plan measures	147d	07/01/18	01/30/19		90%
102	Submit	1d	01/31/19	01/31/19	101	90%
103	On-going data reporting for period ending 06/29/2019	151d	01/01/19	07/31/19		
104	Prepare evaluation plan measures	150d	01/01/19	07/30/19		
105	Submit	1d	07/31/19	07/31/19	104	
106	On-going data reporting for period ending 12/31/2019	149d	07/01/19	01/31/20		
107	Prepare evaluation plan measures	148d	07/01/19	01/30/20		
108	Submit	1d	01/31/20	01/31/20	107	
109	On-going data reporting for period ending 06/29/2020	152d	01/01/20	07/31/20		
110	Prepare evaluation plan measures	151d	01/01/20	07/30/20		
111	Submit	1d	07/31/20	07/31/20	110	
112	On-going data reporting for period ending 12/31/2020	147d	07/01/20	01/29/21		
113	Prepare evaluation plan measures	146d	07/01/20	01/28/21		
114	Submit	1d	01/29/21	01/29/21	113	
115	**Process Milestones**	1049d	01/01/17	02/08/21		50%
116	**Milestones for period ending 06/31/2017**	152d	01/01/17	07/31/17		100%
117	Develop Implementation Plan	152d	01/01/17	07/31/17		100%
118	Implementation timeline	152d	01/01/17	07/31/17		100%
119	Budget	152d	01/01/17	07/31/17		100%

Attachment_B1.2b

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

Attachment_B1.8a

	Primary Care & Behavioral Health Organizations	Demographic Information	Physical Health Review	Housing Assessment	Educational Attainment	Family and Support Services	Legal	Developmental Screenings	Functional status assessment	Employment / Entitlement	Depression Screening	Risk assessment / Suicide	Substance Use Review
1	**Catholic Medical Center** - Amoskeag Family Practice	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	**Catholic Medical Center** - CMC Behavioral Health	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
3	**Catholic Medical Center** - Willowbend Family Practice	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	**Catholic Medical Center** - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	**Catholic Medical Center** - Healthcare for the Homeless	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	**Center for Life Management**	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
7	**Dartmouth-Hitchcock Bedford/Manchester Adult**	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
8	**Dartmouth-Hitchcock Bedford/Manchester Pediatric**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	**Easterseals NH/ Farnum Center**	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
10	**Elliot Health System -** Doctors Park Pediatrics, Manchester	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11	**Elliot Health System -** Partial Hospitalization Program	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
12	**Families in Transition - New Horizons, Willows Treatment Center**	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
13	**Fusion Health Services**	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
14	**Manchester Community Health Center - MCHC, Hollis Street**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	**Manchester Community Health Center - MCHC, Tarrytown**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16	**Manchester Community Health Center - Westside Neighborhood Health Center**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17	**Manchester Community Health Center - Child Health Services at MCHC**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18	**Mental Health Center of Greater Manchester**	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes

Attachment_B1.8c

Network4Health B1 Partner Trainings
through 12/31/2018

			B1: Core Series				Behavioral Health Series				Chronic Disease Series	Additional Organization Specific Courses
	TRAININGS	**MDCT**	**Cherokee Integration Academy**	**Cherokee Team Based Integrated Care Bootcamp**	**Core Standardized Assessment**	**Integration in Practice / Behavioral Health 101**	**Mental Health First Aid**	**SBIRT**	**Cultural Competence**	**Motivational Interviewing**	**Diabetes/ Hyperglycemia Dyslipidemia Hypertension**	
							B1: Integration Participants					
	Catholic Medical Center											
BH	CMC Behavioral Health	MDCT Staff: 6 (Behavioral Health staff only. Primary care and care Coordinators reflected in CMC Primary Care Practice team counts)	Completed 6/14/18-6/15/18 Non-clinical staff: 2	Completed 9/27/18-9/28/18: Leadership: 1	Completed, 12/18 All staff	Met through attendance at Cherokee. Staff was provided overview at staff meetings. Network4Health staff also presented at staff meeting.	Completed: 11/29/2018, non-clinical staff: 2	N/A	Completed: Cultural Sensitivity Module, part of internal training. Staff: 6	Optional	**Completed** **8/7/18: Chronic Disease Training for BH Professionals** **Clinical: 6, Non-clinical: 3**	Completed Trainings: -2/2018 - 4/2018: 1 non-clinical staff Completed the IHI Webinar Series Session 1: Safe and Competent Opioid Prescribing and the Model for Improvement Session 2: Opioid Overdose Harm Reduction and Linkage with Community-Based Efforts Session 3: Limiting Opioid Demand Through Use of Nonpharmacologic Pain Management Strategies Session 4: Developing a Systematic Organizational Approach for Safe Opioid Prescribing Session 5: Identification and Management of Patients with Opioid use Disorders 5/10/18: Initial Training on Addiction & Recovery; Staff: 1 8/21/18 and 10/24/2018: Co-occuring Disorders Training; Clinical: 1, Non-clinical: 1
Primary Care	Bedford Center Internal Medicine and Pediatrics	MDCT Staff: 4 (BH staff within CMC Behavioral Health Services Practice)	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 3	Completed 9/27/18-9/28/18: Provider: 1; Clinical staff: 1	Completed, 12/18 All staff	Met through attendance at Cherokee. Staff was provided overview at staff meetings. Network4Health staff also presented at staff meeting.	-Completed 4/11-4/12/18 course supported by E4 ITCOD project Clinical Staff: 3 Non-clinical staff: 2 - Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Completed 11/20/18 Clinical staff: 7; Non-clinical staff: 7	Completed. Yearly internal course provided to all staff.	Optional - Offered twice in September through the E4 ITCOD Project	**Complete for MDCT**	2019: Southern NH AHEC Community Health Worker Training x 3, in 2019 when Behavioral Health Navigators are hired.
Primary Care	Amoskeag Family Practice	MDCT Staff: 4 (BH staff within CMC Behavioral Health Services Practice)		Completed 9/27/18-9/28/18: Clinical staff: 1	Completed, 12/18 All staff	Met through attendance at Cherokee. Staff was provided overview at staff meetings. Network4Health staff also presented at staff meeting.	Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Completed 9/14/18 Clinical staff: 7; Non-clinical staff: 4	Completed. Yearly internal course provided to all staff.	Optional - Offered twice in September through the E4 ITCOD Project	**Complete for MDCT**	2019: Southern NH AHEC Community Health Worker Training x 3, in 2019 when Behavioral Health Navigators are hired.
Primary Care	Willowbend Family Practice	MDCT Staff: 5 (BH staff within CMC Behavioral Health Services Practice)		Completed 9/27/18-9/28/18: Clinical staff: 1	Completed, 12/18 All staff	Met through attendance at Cherokee. Staff was provided overview at staff meetings. Network4Health staff also presented at staff meeting.	-Completed 4/12/18 course supported by E4 ITCOD project Clinical Staff: 2 -Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Completed 11/29/18 Clinical staff: 7; Non-clinical staff: 10	Completed. Yearly internal course provided to all staff.	Optional - Offered twice in September through the E4 ITCOD Project	**Complete for MDCT**	Southern NH AHEC Community Health Worker Training x 3, in 2018 or 2019 when Behavioral Health Navigators are hired.
Primary Care	Healthcare for the Homeless	MDCT Staff: 4	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 2	Completed 9/27/18-9/28/18: Clinical staff: 1	Completed, 12/18 All staff	Attestation of internal training by integrated behavioral health staff during orientation.		Attestation of internal training by integrated behavioral health staff during orientation.	Completed. Yearly internal course provided to all staff.		Complete. Attestation of internal training by diabetes nurse educator during staff orientation.	10/4/2018: Co-Occurring Disorders Training - Clinical Staff: 2
BH	**Center for Life Management**	MDCT staff: 4 (Primary Care staff external to organization)	Completed 6/14/18-6/15/18 Clinical staff: 4 Non-clinical staff: 2	Completed 9/27/18-9/28/18: Clinical staff: 2	Completed for staff working on pilot	Met through attendance at Cherokee. Staff was provided overview at staff meetings	CLM support staff attended Mental Health First Aid Training in June 2018	N/A	Completed: 06/2018 - CLM support staff attended Mental Health First Aid Training 12/2018 - 4 CLM admin staff recently viewed a webinar on cultural competency. https://www.thinkculturalhealth.hhs.gov/resources/presentations/4/why-culturally-and-linguistically-appropriate-services	Completed: -September 13, 2018: Motivational Interviewing: 21 Clinicians; 7 Supervisors; 3 Non-clinical staff - September 14, 2018: 17 CLM supervisory staff Completed training on Motivational Interviewing for Supervisors	Completed: 8/15/2018 - 45 CLM staff attended the Chronic Disease Training for BH Professionals	Completed Trainings -5/10/18: Initial Training on Addiction & Recovery; Staff: 5 -8/21/18: Co-occurring Disorders Training; Clinical: 3, Non-clinical: 2 -9/28/18: 34 Clinical, 11 Supervisors, 22 Non-clinical staff participated in Stages of Change and Motivational Interviewing Training.
	Dartmouth Hitchcock											
Primary Care	Dartmouth-Hitchcock Manchester/Bedford (Adult)	MDCT Staff: 17	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 2	Completed 9/27/18-9/28/18: Clinical staff: 1; Non-clinical staff: 1	Completed (combined Manchester/Bedford Adult and Pediatric reporting) 10/16/18 11/5/18 12/7/18 12/13/18 12/27/18 12/28/18 12/31/18 Clinical: 59 Non-clinical: 58	Completed (combined Manchester/Bedford Adult and Pediatric reporting) 10/16/18 11/5/18 12/7/18 12/13/18 12/27/18 12/28/18 12/31/18 Clinical: 59 Non-clinical: 58	Optional	Previously Implemented. Optional refresher course offered prior to 5/31/19	Completed 11/26/18 and 12/13/18 Clinical: 1; Non-clinical: 16	Optional	**Complete for MDCT**	Additional Completed Trainings - Summer/Fall 2018: 3 providers Completed a MAT overview - 2/2018-4/2018: 4 providers Completed the IHI Webinar Series Session 1: Safe and Competent Opioid Prescribing and the Model for Improvement Session 2: Opioid Overdose Harm Reduction and Linkage with Community-Based Efforts Session 3: Limiting Opioid Demand Through Use of Nonpharmacologic Pain Management Strategies Session 4: Developing a Systematic Organizational Approach for Safe Opioid Prescribing Session 5: Identification and Management of Patients with Opioid use Disorders

Attachment_B1.8c

Network4Health B1 Partner Trainings
through 12/31/2018

			B1: Core Series				Behavioral Health Series				Chronic Disease Series	Additional Organization Specific Courses
	TRAININGS	**MDCT**	**Cherokee Integration Academy**	**Cherokee Team Based Integrated Care Bootcamp**	**Core Standardized Assessment**	**Integration in Practice / Behavioral Health 101**	**Mental Health First Aid**	**SBIRT**	**Cultural Competence**	**Motivational Interviewing**	**Diabetes/ Hyperglycemia Dyslipidemia Hypertension**	
B1: Integration Participants												
Primary Care	Dartmouth-Hitchcock Manchester/Bedford (Pediatric)	MDCT staff: 21	Completed 6/14/18-6/15/18 Clinical staff: 1	Completed 9/27/18-9/28/18: Clinical staff: 1	Completed (combined Manchester/Bedford Adult and Pediatric reporting) 10/16/18 11/5/18 12/7/18 12/13/18 12/27/18 12/28/18 12/31/18 Clinical: 59 Non-clinical: 58	Completed (combined Manchester/Bedford Adult and Pediatric reporting) 10/16/18 11/5/18 12/7/18 12/13/18 12/27/18 12/28/18 12/31/18 Clinical: 59 Non-clinical: 58		Previously implemented/Complete.	Completed 11/16/8 and 11/29/18 Clinical: 1; Non-clinical: 14		**Complete for MDCT**	
SUD	**Easterseals NH Farnum Center**	MDCT staff: 6	Completed 6/14/18-6/15/18 Non-clinical staff: 2	Completed 9/27/18-9/28/18: Clinical/Leadership staff: 2	Completed. CCSA in place prior to IEP. No training required.	Met through attendance at Cherokee.	Not required	N/A	Completed. Internal course provided to staff.	Not required	-Completed: Chronic Disease Training for Behavioral Health Professionals: Completed: 1/23/19 - Staff: 62	
	Elliot Health System											
Primary Care	Elliot Health System Primary Care - Doctors Park Pediatrics	MDCT staff: 5	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 3	Optional	Completed.	- June 2018 – Team members were trained by internal Elliot staff. - Provider, Psychiatry, Therapist and Social Worker meet weekly for combined training and case conference.	Optional	SBIRT was adopted by the EHS system with the initial JSI SBIRT state-wide initiative a few years ago; incremental training to address gaps and staff turvover is scheduled for Q1 2019.	Completed. Part of onboarding.	Optional	Completed. Current therapist has 20 years of experience in pediatrics and is counseled by Pediatric Providers during weekly case meetings as required.	
SUD	Elliot Health System Partial Hospitalization Program	MDCT staff: 6	Staff was not yet in place, new program.	Completed 9/27/18-9/28/18: Non-clinical staff: 2	Completed. Onboarding for new PHP staff included intake and assessment that meets CCSA.	Met through attendance at Cherokee. PHP Director has previously run integrated programs and does in-person training with her team.	Optional	n/a	Completed. Part of onboarding.	Optional	-Completed. Chronic Disease Training for Behavioral Health Professionals: Completed: 9/26/18 Clinical staff: 3 Non-clinical staff: 4	-Completed: 10/24/18 - ASAM Criteria Training; Clinical Staff: 3, Non-clinical staff: 5 (combined PHP/Drug Court Staff)
SUD	**Families In Transition - New Horizons, Willows Treatment Center**	MDCT staff: 5	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 1	Completed 9/27/18-9/28/18: Clinical/Leadership staff: 1	Completed for pilot staff 12/2018.	Met through attendance at Cherokee.	11/29/18 - Non-Clinical Staff: 4	N/A	Completed 10/11/18: Stigma Training Staff: 22	10/15-10/16/18: Intro to Motivational Interviewing Staff: 29	-Completed: Chronic Disease Training for Behavioral Health Professionals: Completed: 12/5/18 - Clinical Staff: 4 Non-clinical Staff: 13	Additional Completed Trainings -10/24/18 - ASAM Criteria Training; Clinical Staff: 1 -1/10-11/2019: Motivational Interviewing and Stages of Change Supervisory Training; Staff: 7
Primary Care	**Fusion Health Services**	Clinical Staff: 8	Completed 6/14/18-6/15/18 Clinical staff: 1	Completed 9/27/18-9/28/18: Non-clinical staff: 1	Completed 12/14/18, Clinical: 13 Non-Clinical: 8	Completed 11/4/18: Integration in Practice Training Clinical: 2, Non-Clinical: 3	Not required	Previously Implemented.	Completed: 11/15/2018, various times (on demand). Cultural Competency Webinar. Clinical Staff: 1 Non-clinical staff: 9	Not required	Completed: Chronic Disease Training for Behavioral Health Professionals: Completed: 12/5/18 - BH clinical staff: 1	Additional Completed Trainings -8/28/18: Co-occurring Disorders Training: Clinical Staff: 2 -9/5/18: Opiod Withdrawal Management Course: Clinical Staff: 1 -11/16/18: Summit on Management of the Opioid-dependent Patient and Optimal Pain Treatment: Clinical Staff: 8, Non-clinical: 2
Primary Care/BH	**Manchester Community Health Center - All Practice Sites**	MDCT Staff: 23	Completed 6/14/18-6/15/18 Clinical staff: 2 Non-clinical staff: 1	Completed 9/27/18-9/28/18: Clinical: 4; Non-clinical staff: 1	Completed, 06/2018, all staff	Not required - organization already integrated	Not required	N/A - Previously implemented	Completed - Focus on Cultural Competency with LGBTQ population, 8/2018, 203 staff	Optional	Completed 11/29/18, Clinical staff: 20	-Additional Trainings Completed: -5/10/18: Initial Training on Addiction & Recovery; Staff: 5 -10/24/18 - ASAM Criteria Training; BH Clinical Staff: 2 -8/2018 203 staff attended: 1 x Substance Use or Behavioral Health Training for all practices sites prior to 5/31/19
BH	**Mental Health Center of Greater Manchester**	MDCT Staff: 9	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 4	Completed 9/27/18-9/28/18: Non-clinical staff: 10	Completed, All Staff	-Completed 10/16/18 - Overcoming Stigma: Strategies for Health Professionals Intensive Transition Team Staff: 4	Optional	N/A	Completed. Yearly internal course provided to all staff.	Completed 9/13/18 Intensive Transition Team Staff: 5	Chronic Disease Training for Behavioral Health Professionals: Completed 8/21/18, Staff: 15 Completed 11/21/18, Staff: 68 Chronic Disease Webinars Diabetes II Completed 11/1/18, Staff: 6 Hyperlipidemia Completed 11/8/18, Staff: 5 Hypertension Completed 11/15/18, Staff: 6	-Additional Trainings Completed: -5/10/18: Initial Training on Addiction & Recovery; Staff: 3 -8/29/18: Outreach Strategies: 4 Intensive Transition Team staff -9/5/18: CALM Training: 1 Intensive Transition Team staff -9/11/18: LEAP(Listening, Empathizing, Agreeing, Partnering) Training: 1 Intensive Transition Team staff -10/3/18: CALM Training: 1 Intensive Transition Team staff -10/24/18: Foundations of Suicide: Clinical Competency 3 Intensive Transition Team staff -10/24/18 - ASAM Criteria Training; Leadership Staff: 1

Attachment_B1.8h

Integrating Healthcare Delivery - Recommended Protocols and Best Practices

Networ4Health Integrated Healthcare Project (B1)

Ann Turner, Network4Health Integrated Healthcare Clinical Director

12/17/2018

Contents

Multi-Disciplinary Core Teams 2
Privacy Protocol Recommendations 5
Intake and Patient/Client Visit Protocol 6
Referral and Transition Management 8
Protocol for Effective Care Coordination and Referral/Transition Management 13
Referral Tools 17
Sample Referral /Transition Workflows 24
Timely Referral Communication 29
Adherence to NH Board of Medicine Opioid Protocols 31
REFERENCES 34

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

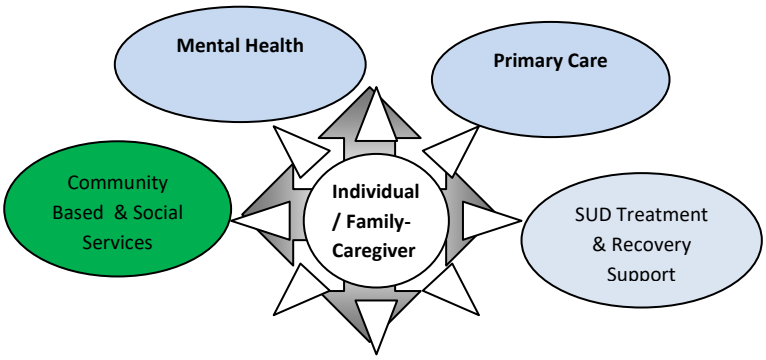
- Agency for Health Research and Quality (AHRQ)

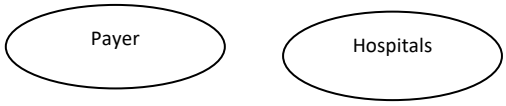
This document provides Network4Health recommendations for the following protocols and best practices:

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

Multi-Disciplinary Core Teams

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





Network4Health's (N4H) Integrating Healthcare Delivery - Recommended Protocols and Best Practices are adapted from evidence-based practices from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) and AHRQ Integration Academy, including the SAMHSA/Cambridge Health Alliance (CHA) Model of Team-Based Care Implementation Guide and Toolkit, and National Transitions of Care Coordination. The CHA, model states, "It is critical to have a team model of care to sustainably meet the acute care, preventative care, and chronic care needs of our safety net patient population. This involves both creating an expanded primary care team and clearly defining roles, responsibilities, and workflows so that the care needs of the population can be met. In addition, there needs to be sufficient attention to training team members to function at the top of their license or scope of practice and to developing tools to help them provide care effectively. Above all, the team model of care needs to facilitate the development of a trusted relationship between the consumer and key care team members."

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

Examples:

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

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

Examples:

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

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

- Determine which people on the team are best qualified to perform the tasks within the clinical and administrative systems of the practice (efficiency)
- Introduce team members so they know who each other are
- Introduce each members role (skills) so members on the team know what each other does and can do in their role
- Maximize the role of each team member within the scope of their licensure and skills, "working to the top of the license."

- Ensure that the right person is doing the right task for the right patient at the right time (is the team efficient in their workflow?)
- Ensure that each team member is competent to perform their defined and delegated functions and tasks
- Provide education and training for the functions and tasks that each team member performs
- Provide adequate IT training. Include electronic health record (EHR), secure messaging / email, closed loop referral system, intranet.
- Provide education and cross-training to substitute for other roles (in cases of absences, vacations, or periodic heavy demands on one part of the team)
- Provide all team members with communication training for effective teamwork, for example, motivational interviewing
- Assess competency of team members at least once each year (performance review) and have team members set goals which contribute to team performance
- Communicate each member's competencies to the other team members!

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

Examples:

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

  Examples:

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

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

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

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

Considerations in Forming Teams

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

HINT: Let the number of patients/clients per team be your guide…

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

HINT: If the team is too large:

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

HINT: if the team is too small:

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

Source: https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf

Privacy Protocol Recommendations

Network4Health recommends that the privacy protocol aligns with the following from the AHRQ Integration Academy Playbook:

- **Ensure conversation with Patient/Client on Information Sharing and Confidentiality**

  - Be prepared for the possibility that a patient may not want a shared record. Integrated care involves sharing of information but the clinician has a responsibility to initiate dialogue with the patient that explains why it is important to have a shared record and then to listen to patient concerns and negotiate a resolution. This could be applicable to privacy issues for HIV, STDs, and other conditions as well as behavioral health aspects of care.
  - The general principle is that the patient came to the primary care/MH/SUD site to get health care. When the practice is integrated and therefore charted for the team to view (and potentially others if the patient releases information), the patient has a right to refuse providers outside the practice access to their medical information.
- Source: https://integrationacademy.ahrq.gov/sites/default/files/playbook/Lexicon.pdf#Approach

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

- Ability to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).
- Ability for additional disclosures of patient identifying information, with patient consent, to facilitate payment and healthcare operations such as claims management, quality assessment, and patient safety activities.
- Ability for additional disclosures of patient identifying information to certain contractors, subcontractors, and legal representatives for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation.
- Ability for permitting use of an abbreviated notice of prohibition on re-disclosure more easily accommodated in EHR text fields for users of electronic health records (EHRs).

Intake and Patient/Client Visit Protocol

The work of care teams is to deliver proactive, population-based, patient-centered care. The following SAMHSA model divides the delivery into 3 domains of work: pre-visit, visit, and between visit work.

Consideration for an effective intake and patient/client visit begins during the Pre-Visit phase to better prepare the patient/client and promote self-management abilities, and is reinforced during the visit and between visits.

Work Domain (Pre-Visit, Visit, Between Visit)	**Activity/Task**	**Multi-disciplinary Team Member**
Pre-Visit	**Assist patient to prepare for visit:** • **bring medications to visit** • **prepare questions to ask provider** • **come in for pre-visit lab tests** • **invite family member/caregiver to visit if patient prefers** • **confirm need for interpreter**	**E.g., MA, receptionist**
Visit-Before Pt/client arrives	**Prepare intake packet in advance for each patient and place at the reception desk.** • **Pre-visit forms to identify patient goals for the visit** • **Medication lists** • **Patient-specific screens, E.g., CCSA** **Huddle**	**E.g., MA, receptionist** **E.g., Provider, MA, Nurse, BHC, Receptionist**
Visit	**Give intake form(s) to the patient: meds, allergies, family history, past medical history** **Assess patient's educational needs** **Give med reconciliation list to patient and verify pharmacy** **Help patients/clients identify their goals for the visit and for their health** **Share care plan with Pt/client** **Provide appropriate educational/self-management tools for patient** **Give after visit summary to patient and review with the patient** **Schedule patient for primary care follow-up, specialty appointments**	**E.g., MA, receptionist** **E.g., MA, nurse or provider** **E.g., Nurse or provider** **E.g., MA, nurse or provider** **E.g., receptionist**
Between Visits	**Follow-up on test results** **Monitor Health Maintenance and use Planned Care outreach process to help patients/clients address gaps.** **Track all important appointments to completion** **Follow-up on missed appointments and/or referrals** **Schedule additional primary care and specialty appointments**	**E.g., nurse or provider** **E.g., MA, receptionist, patient navigator/community health worker** **E.g., referral coordinator** **E.g., referral coordinator** **E.g., care coordinator, nurse, social worker**

	Routine care management/care coordination	

Source: https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf

Referral and Transition Management

Successful referrals and transitions need to address the needs and goals of both the patient/client and identified by the provider. A patient may have a very satisfying encounter with a MH/SUD provider or specialist, but if the PCP fails to send relevant information or the MH/SUD provider or specialist fails to communicate with the referring provider, care for that patient or others with similar problems may well suffer.

N4H recommends aligning referral and transitions management protocols with the following NTOCC Elements of Excellence in Transitions of Care (TOC) TOC Checklist. NH's 1115 waiver requirements, particularly the comprehensive core assessment (CCSA) address many of the NTOCC Elements of Excellence.

Source: (**http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf**)

1. **All members of the multi-disciplinary care team–including patients and their family caregivers–need access to key pieces of information in order to make transitions of care smooth, safe, and effective. NTOCC has described several steps that are critical to achieving this kind of information sharing:**
   • Improve communication during transitions between providers, patients, family caregivers and community supports;
   • Develop standardized processes for medication reconciliation and care coordination;
   • Establish accountability for sending, receiving and acting upon information necessary for safe, effective transitions of care;
   • Increase the use of case management and professional care coordination;
   • Expand the role of the pharmacist in medication reconciliation in transitions of care;
   • Develop performance measures to encourage better transitions of care; and
   • Implement payment systems that align incentives.
   Note: NTOCC believes that for HIT to make a difference in transitions of care, the technology must address each of these critical steps. Without addressing each step, the promise of HIT's affect on overall transition of care improvement will not be realized.
2. **Standardized Processes and Performance Goals Related to Transitions of Care** While some elements of facilitating care transitions might best be left to individual providers to design, the safety and effectiveness of care transitions requires some degree of standardization among providers to ensure the completion of critical activities common to all transitions of care. At a very basic level, there should be a list of key pieces of information to be conveyed to the next care site for every care transition. These standardized processes can be used to develop measures that will indicate provider performance in facilitating safe, effective transitions of care. Ultimately, there should be cross- cutting measures to indicate better outcomes resulting from better coordination among providers during a care transition.
3. **To ensure safe care transitions, standard transition processes must be in place.** Unfortunately, standard processes are generally lacking in rigor, do not include policies and procedures to make processes enforceable, and simply are not rewarded. Medication reconciliation is one such task that is critical to safe

transitions. Medication reconciliation is the process of creating the most current, complete, and accurate list possible of a patient's medications, comparing that list against other medication lists at transitions in care, and resolving any discrepancies. Medication reconciliation can be assessed as a static event (i.e., performance documentation by signature and completion of a medication reconciliation form) and by detecting errors that occurred during the process (i.e., medication discrepancies resolved). These processes address the Joint Commission's National Patient Safety Goal on medication reconciliation.

4. **Expand the Role of the Pharmacist in Transitions of Care** - Many transition of care problems relate to the safe and effective use of medications. HIT has the potential to reduce the rate of medication related problems and improve the rate and accuracy of reconciled medication lists between providers. Pharmacists have an integral part in establishing a smooth transition of care and can provide expertise in a patient's drug therapy regimen. Case managers can help patients navigate to community pharmacists for optimal medication management that can assist prescribers and patients managing complex medication schedules. Appropriate medication management promotes medication compliance and helps avoid unnecessary health care utilization.

Elements of Excellence in Transitions of Care (TOC) Checklist

*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. **Every element on this checklist may not be relevant to each provider or setting.**

*For purposes of brevity, the term patient/client is used throughout this checklist to describe the client and client system (or patient and family). The patient/client system (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client's informal support network. Depending on the setting in which this checklist is used, providers may wish to substitute resident, consumer, beneficiary, individual, or other terms for patient/client.

Overarching Concepts

Engagement

- Maximize patient/client involvement in all phases of intervention by promoting self-determination and informed decision-making.
- Provide educational information to support the patient/client's participation in the plan of care.
- Protect patient/client's right to privacy and safeguard confidentiality when releasing patient/client information.
- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess and promote the patient/client's efforts to participate in the plan of care.

Collaboration

- Define multidisciplinary team participants.
- Build relationships with all team members, with the patient/client at the center of the collaborative model.
- Communicate with other professionals and organizations, delineating respective responsibilities.
- Create awareness of patient/client and provider accountability for receiving and sending patient/client care information to and from care settings. • Provide services within the bounds of professional competency and refer patient/client as needed.

Strengths-based assessment

- Use respect and empathy in patient/client interactions.
- Recognize patient/client's strengths and use those abilities to effect change.
- Help patient/client use effective coping skills and insights to manage current crises.
- Recognize and help resolve patient/client's difficulties.
- Distinguish cultural norms and behaviors from challenging behaviors

Assessment as an ongoing process

- Keep assessments flexible, varying with presenting problem or opportunity.
- Regularly reassess patient/client's needs and progress in meeting objectives.
- Facilitate goal-setting discussion based upon the patient/client's needs during all phases of care.
- Assess effectiveness of interventions in achieving patient/client's goals.
- Communicate changes in assessment and care plan to the health care team.

Common Elements for Assessment and Intervention

- Assess patient/client's understanding of diagnosis, treatment options, and prognosis.
- Evaluate patient/client's life care planning and advance directive status.
- Evaluate impact of illness, injury, or treatments on physical, psychosocial, and sexual functioning.
- Evaluate patient/client's ability to return to or exceed pre-illness or pre-injury function level. Psychosocial functioning
- Assess past and current mental health, emotional, cognitive, social, behavioral, or substance use/abuse concerns that may affect adjustment to illness and care management needs.
- Assess effect of medical illness or injury on psychological, emotional, cognitive, behavioral, and social functioning.
- Determine with patient/client which psychosocial services are needed to maximize coping.

Cultural factors

- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.

- Assess cultural values and beliefs, including perceptions of illness, disability, and death.
- Use the patient/client's values and beliefs to strengthen the support system.
- Understand traditions and values of patient/client groups as they relate to health care and decisionmaking. Health literacy and linguistic factors
- Provide information and services in patient/client's preferred language, using translation services and interpreters.
- Use effective tools to measure patient/client's health literacy.
- Provide easy-to-understand, clinically appropriate material in layperson's language.
- Use graphic representations for patients/clients with limited language proficiency or literacy.
- Check to ensure accurate communication using teach-back methods.
- Develop educational plan based upon patient/client's identified needs.
- Evaluate caregiver's capacity to understand and apply health care information in assisting patient/client.

Financial factors

- Identify patient/client's access to, type of, and ability to navigate health insurance.
- Identify patient/client's access to and ability to navigate prescription benefits.
- Evaluate impact of illness on financial resources and ability to earn a living wage.
- Provide feedback on financial impact of treatment options.
- Educate patient/client about benefit options and how to access available resources.
- Assess barriers to accessing care and identify solutions to ensure access.

Spiritual and religious functioning

- Assess how patient/client finds meaning in life.
- Assess how spirituality and religion affect adaptation to illness.

Physical and environmental safety

- Evaluate patient/client's ability to perform activities of daily living and meet basic needs
- Assess environmental barriers that may compromise the patient/client's ability to meet established treatment goals.
- Determine with patient/client the appropriate level of care.
- Assess ability of family or other informal caregivers to assist patient/client.
- Assess for risk of harm to self or others.

Family and community support

- Identify patient/client's formal and informal support systems.
- Assess how patient/client's illness affects family structure and roles.
- Provide support to family members and other informal caregivers.
- Assess for, and if appropriate help resolve, conflicts within the family.
- Evaluate risk of physical, emotional, or financial abuse or neglect, referring to community social services as needed.

Assessment of medical issues

- Patient/client diagnosis
- Symptoms
- Medication list and reconciliation of new medications throughout treatment
- Adherence assessment and intention
- Substance use and abuse disorders
- Lab tests, consultations, x-rays, and other relevant test results

Continuity/Coordination or Care Communication

- Specific clinical providers
- Date information sent to referring physician, PCP, or other clinical providers
- Necessary follow-up care

Source: (**http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf**)

Institute of Medicine (IOM)

Network4Health also recommends aligning all patient referrals and transitions management protocols with the six Institute of Medicine (IOM) aims of high-quality health care :

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

Protocol for Effective Care Coordination and Referral/Transition Management

N4H strives to align the many initiatives practices may be involved with to minimize duplication and create synergies. With that in mind, the following that aligns with Patient Centered Medical Homes (PCMH) was used for N4H's recommendations for care coordination and referral/transition management protocols. The Safety Net Medical Home Initiative, supported by The Commonwealth Fund, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute, developed the following to help 65 primary care safety net sites in five states to support high-performing patient-centered medical homes. These elements align well with AHRQ's integrated care best practices

Design Element	Major Changes	Activities	Tools and Resources
Accountability	1. Decide as a primary care clinic to improve care coordination.	Develop a quality improvement (QI) plan to implement changes and measure progress.	National Committee for Quality Assurance (NCQA). Care Coordination Measures.
			Care Coordination Questions from Validated Instruments.
	2. Develop a tracking system.	Design the clinic's information infrastructure to internally track and manage referrals/ transitions including specialist consults, hospitalizations, ED visits, and community agency referrals.	Referral Tracking Guide.
Patient Support	3. Organize a practice team to support patients and families.	Delegate/hire and train staff to coordinate referrals and transitions of care, and train them in patient-centered communication, such as motivational interviewing or problem solving.	Referral Coordinator job description.
			Case Study of Wright Center.
		Assess patient's clinical, insurance, and logistical needs.	Referral Coordinator Curriculum.
		Identify patients with barriers to referrals/transitions and help patients address them.	The Care Transitions Program Patient Activation Assessment Form.
		Provide follow-up post referral or transition.	

Design Element	Major Changes	Activities	Tools and Resources
Relationships & Agreements	4. Identify, develop, and maintain relationships with key specialist groups, hospitals, and community agencies.	Complete internal needs assessment to identify key specialist groups and community agencies with which to partner.	Referral Coordinator job descriptions.
	5. Develop agreements with these key groups, hospitals, and agencies.	Initiate conversations with key consultants and community resources.	Case Study of Family Care Network.
			Patient-Centered Primary Care Collaborative: Colorado Primary Care–Specialty Care Compact.
		Develop verbal or written agreements that include guidelines and expectations for referral and transition processes.	Federal Expert Work Group on Pediatric Subspecialty Capacity Promising Approaches for Strengthening the Interface between Primary and Specialty Pediatric Care. (Maternal and Child Health Policy Research Center American Academy of Pediatrics and the Maternal and Child Health Bureau Department of Health and Human Services, March 2006.) Carrier E, Dowling MK, Pham HH. Care coordination agreements, facilitators and lessons learned. *Am J Manag Care*. 2012;18:e398-404.
		Standardize the information in referral requests and consultation reports to ensure it meets agreed upon expectations.	Berta W, Barnsley J, Bloom J, et al. Enhancing continuity of information: essential components of a referral document. *Can Fam Physician*. 2008;54(10):1432-1433, 1433 e1431-1436.
			Berta W, Barnsley J, Bloom J, et al. Enhancing continuity of information: essential components of consultation reports. *Can Fam Physician*. 2009;55(6):624-625 e621-625.
			Reichman M. Optimizing referrals & consults with a standardized process. *Fam Pract Manag*. 2007;14(10):38-42.

Design Element	Major Changes	Activities	Tools and Resources
Connectivity	6. Develop and implement an information transfer system.	Investigate the potential of shared EHR or web-based e-referral systems; if not available, set up another standardized information flow process.	Case Studies of Humboldt County, San Francisco, and Oklahoma e-Referral systems.
			Horner K, Wagner E, Tufano J. Electronic Consultations Between Primary and Specialty Care Clinicians: Early Insights. The Commonwealth Fund. October 2011.
			Metzger J, Zywiak W. Bridging the Care Gap: Using Web Technology for Patient Referrals: California HealthCare Foundation; September 2008.
			O'Malley AS, Grossman JM, Cohen GR, Kemper NM, Pham HH. Are electronic medical records helpful for care coordination? *J Gen Internal Med.* 2009 [Epub], Journal print copy March 2010.

Considerations when developing referral and transitions workflows:

- **Types of patients/clients referred**. Many specialists have developed criteria for the patients/clients they prefer to see. For instance, it is important to understand the levels of care when referring to mental/behavioral health providers
- **Information provided** at time of referral
- **Event notification**
- **Testing to be completed prior to referral**. If PCPs complete a specialist's preferred laboratory testing prior to the referral, it increases the value of the consultation and reduces possible duplicate testing
- **Availability for "curbside consults"**
- **Consultation report content and timeliness**
- **Post-consultation care expectations** need discussion to prevent unhappiness among providers because expectations weren't met (e.g., specialist assumes care when PCP only wanted advice, or specialist returns patient and advice when PCP wanted to transfer care)
- **Post-ED / hospitalization *[N4H recommends considering all care transitions, including prison]* care expectations**
- **Specialist-to-specialist referrals.** Many PCPs do not want specialists to refer their patients/clients to other specialists without first consulting with the PCP
- Source: **http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf**

The Joint Commission enterprise transitions of care initiative include the following important elements:

Multidisciplinary communication, collaboration and coordination	Including patient/caregiver education – from admission through transition. A care team – including a physician, nurse, pharmacist, social worker, and others as

	appropriate – communicates, collaborates and coordinates effectively; these steps include actively teaching patient and family/friend caregivers to learn and practice self-care and to follow the care plan, including how to self-manage medications.
Clinician involvement and shared accountability during all points of transition	Both sending and receiving clinicians are involved in and accountable for a successful transition. They are identified by name and exchange information electronically or by fax or telephone during the time of transition. At every point during the transition, the responsible coordinating clinician (such as a primary care physician or nurse practitioner) is identified for the patient
Comprehensive planning and risk assessment	Patients/clients are assessed for risk factors that may limit their ability to perform necessary aspects of self-care. Such risk factors include low literacy, recent hospital admissions, multiple chronic conditions or medications, and poor self-health ratings. Also, clinicians begin to assess risks that may be present at the receiving setting. For example, the clinician should confirm that the patient will have access to medications he or she needs at the next setting, as the pharmacy formulary there may not have the medications, or the ability to compound medications as ordered.
Standardized transition plans, procedures and forms	The following components are included in a written transition plan or discharge summary: active issues, diagnosis, medications, required services, warning signs of a worsening condition, and whom to contact 24/7 in case of emergency. Plans are provided in the patient's preferred language and use pictures for patients/clients having low literacy.
Standardized training	The organization begins by defining what constitutes a successful transition. Staff are taught the necessary steps to complete a successful transition and are engaged in real-time performance feedback. Successful transitions are made an organizational priority and performance expectation.
Timely follow-up, support and coordination	Organizations develop a process that provides for timely post-referral/discharge follow-up with patients/clients .
If a patient is readmitted within 30 days, gain an understanding of why	Readmissions within 30 days of discharge can often be prevented by providing a safe and effective transition of care from the hospital to home or another setting. Convene a meeting of the multi-disciplinary care team, including the attending physician and other key staff, and the patient and family members. Ask the patient questions about what happened after discharge. Find out if there were financial or transportation barriers, and whether or not home caregivers were unavailable.12 This important information can be used by organizations to improve care transitions for

	patients/clients and family/friend caregivers.
Evaluation of transitions of care measures	Monitor compliance with standardized forms, tools, and methods for transitions of care. Use surveys and data collection to find root causes of ineffective transitions and to identify patient and caregiver satisfaction with transitions and their understanding of the care plan. For example, this three-item survey queries patients/clients about key aspects of a care transition: The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital. 2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. 3. When I left the hospital, I clearly understood the purpose for taking each of my medications

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

Referral Tools

Develop a referral/transition tracking system

An effective referral/transition tracking system can be pencil and paper, a function of an e-referral system or EHRs, or developed on readily available software such as Microsoft® Excel or Access. The American College of Physicians Center for Practice Improvement & Innovation has a practical guide to tracking referrals on its website: **http://www.improvingchroniccare.org/downloads/3_referral_tracking_guide.pdf**

Sample Referral Forms Templates from Community Care North Carolina (CCNC)

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

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

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

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

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

SAMHSA-HRSA Center for Integrated Health Solutions Sample Scripts for Warm Handoffs

Warm Handoff from Primary Care to Behavioral Health
Source: Warm Handoff Scripts and Procedures (.doc)

Warm hand-off scripts and procedures from primary care to behavioral health

Primary Care Providers (PCPs) have their own style of communicating, and will have different relationships with different patients/clients. These and other factors (especially cultural considerations) will tailor each 'warm hand off' so it best helps the patient overcome any barriers to seeing a Behavioral Health (BH) provider. However, some general principles can be articulated:

- The referral to a BH provider should be as directive as a PCP would normally make a referral to any other service. There should not be a discernible difference in content or tone between a referral to a BH provider and a referral to a cardiologist. Patients/clients will pick up the importance a provider implies regarding a referral, and respond accordingly.
- Unless a patient has used a diagnostic term themselves ("I feel depressed"; "I had a panic attack"; "I'm addicted"), it is more effective to use general terms like 'stress' to refer to behavioral health problems. BH providers have the time and the skill to assess patients/clients readiness to identify themselves as having particular problems, and can work with patients/clients on de-stigmatizing these terms when necessary.
- Similarly, it is more effective to use general terms such as 'colleague' or 'someone who specializes' instead of 'counselor' or 'therapist' or 'social worker'. For many patients/clients these terms evoke stigma, fear, and misunderstanding, and may keep a patient from seeing the BH provider. Skilled BH providers can identify themselves and intervene to address any of these apparent issues. Along the same lines, a PCP asking or offering a patient 'counseling' is less effective than offering them 'education' or 'ideas' or even 'support'.

> Example 1, medical provider: It sounds like you might be having a lot of stress right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you. Is it all right with you if I introduce you to her/him?
>
> Example 2, medical assistant: From some of your answers on this questionnaire, it looks as if you may be feeling down lately. We have someone here who can give you some ideas of ways to help with this. Her/his office is just down the hall. Is it okay with you if I see if he/she is available to meet you?

Referral to a psychiatrist: The following are two sample scripts for referring to a psychiatrist. Both address the major barriers in psychiatric consultation, which are stigma and fear regarding the implications of seeing a psychiatrist, and misunderstanding about the role of a psychiatrist. Because of their history, and an almost archetypical stereotype, patients/clients commonly assume a psychiatrist is a super competent, specialized analyst, who will engage them in intensive therapy. Some patients/clients feel disgruntled, ignored, and even angry by very competent and kind psychiatrists, because they 'only' received an assessment and a prescription.

Example 1, medical provider: We have already tried three medications that have not worked for you, and I know that has been frustrating for you. We have a specialist here who is a doctor for anxiety/depression/voices, who may be able to change your medicine and find something that works for you. He/she is right here, and could see you next week. Is that okay?

Example 2 (previous history with mental health services), medical provider: You have a long history of struggles with this problem, and since you are a new patient to me, I am wondering if you would be willing to see our specialist to make some recommendations about medicine. She/he is a medical doctor, so he/she doesn't do counseling. However, we do have a counselor that I think could be helpful to you. Is it okay with you for me to make you two appointments, one for medications, and one for counseling? I will follow up with you in two weeks.

Warm Handoff from Behavioral Health to Primary Care

Source: Warm Handoff Scripts (.doc)

Scripts for behavioral health clinicians to refer to primary care clinicians within a primary care clinic

In many integrated health care settings, behavioral health (BH) services are only available to patients/clients who also receive primary care from the organization. There are rarely enough behavioral health resources for existing clinic patients/clients, let alone those who are not currently receiving medical care there. In addition, many clinicians feel that when clients receive behavioral and medical services under the same roof, the quality of care is higher due to the ease of communication (electronic and otherwise) and convenience for the patient. Sometimes in these systems the patient's first and sometimes primary contact is with a behavioral health provider. In this case, it becomes the BH clinician's responsibility to successfully refer the patient to a primary care provider (PCP), either to establish care or for a consult. The following sample scripts were developed for BH providers and front office staff.

- **Script 1**, BH clinician, to establish care with PCP: (towards the end of session): Can we change course for a minute so I can give you some important information? (wait for agreement). I know the call center/receptionist let you know that all clients who obtain BH services here also receive medical care here. I wanted to ask you if you have thoughts about your preferences for doctors. I can make some recommendations. (wait for information about gender or age preferences, location or specialties). Thank you for telling me that. I will walk you up to reception and they can help you make an appointment with a PCP who works at (this clinic). They will have access to my notes, and I will make sure to write what you and I talked about - that you (need refills for your medications/need an EKG to make sure no heart problems/follow up to recent ER visit, etc.).
- **Script 2**, BH clinician, client already established, referral back to PCP indicated: (towards the end of session, unless an appropriate opening is shown earlier in the visit). Can we change course just for a minute so we can talk about our plan for next steps? (wait for agreement). You shared with me that [reiterate the medical problems the client expressed, such as the medication not being effective or producing unwanted side effects, etc.]. It sounds like you would like to discuss this with your physician, and in that case we can make an appointment today when you leave here to see your him/her. How does that sound?
- **Alternate reason for referring to PCP:** When I look at your health record it looks like it has been over six months since you have seen your PCP. As we continue to work together on your [whatever their issues are], I would recommend that you see your PCP for a regular physical, just to make sure your problem [specify] is not being caused by another medical condition. What are your thoughts about this?

- **Script 3**, Front office/reception/call center, to establish care with PCP: I would be happy to make you an appointment with one of our BH clinicians. What have you heard about also receiving medical care at our clinic? (wait for what client already knows). Can I give you some information about this? (wait for agreement). At our organization, in order to see our BH clinicians, clients also need to receive their medical care here. What are your thoughts about this? (wait for agreement). Great! I would be happy to make an appointment with one of our medical providers as well so you can establish care with them too.

Warm Handoff from Others Staff/Departments- Sample Scripts
Source: Five Scripts For Great Handoffs (.doc)

NURSE – Handing off patient and companion to physician

GREAT Behaviors	GREAT Words
If the physician is not there: Use words that prepare the patient for your departure and for what will happen next. Walk with patient and gesture with your arm to show the way. Once in the room, invite them to make themselves comfortable. Overestimate the amount of time they can expect to wait and tell them what to expect if the wait time is longer. Build the patient's confidence in the doctor. Tell them that you are leaving, but offer to help or answer questions first. Give a gracious goodbye in which you address patient and companion by name.	*"Great, Mr. Hampton! I've got all I need. Thank you!"* *"Now, if you'll come with me, I'll show you to the room where Dr. Clark will see you."* *"Please make yourself comfortable.* *"Dr. Clark should be here within 10 minutes. If for some reason, she can't get here by then, I'll be back to give you an update."* *If patient is new: "Mr. Hampton, you'll be in great hands with Dr. Clark. She's a wonderful doctor."* *If patient already knows the doctor: "I know Dr. Clark will be very glad to see you again…"* *"Before I go, is there anything you need or any questions you have?* *"I hope all goes well, Mr. Hampton, and I hope to see you on your way out.*
If physician is there: Use words that prepare the patient for the transition. Explain what will happen next.	*"Great, Mr. Hampton! I've got all I need. Thank you!"* *"Now, if you'll come with me, I'll show you to the exam room where Dr. Clark will see you."*
Along the way, walk close to the patient and stay connected. Make small talk.	*"Isn't it a nice day? I'm so glad the rain finally let up."*
If first visit with the doctor: Introduce the patient to the doctor. Say the patient's full name first. If patient has seen this doctor before, remind the doctor of this.	*"Oh hi, Dr. Clark, I'm glad you're here. Mr. Hampton, this is Dr. Clark. You'll be in good hands with her."* *"Dr. Clark, Benjamin Hamilton is here to see you again."*
Introduce the doctor to the patient.	*"Dr. Clark, this is Mr. Hampton."* *Dr. Clark: "Nice meeting you Mr. Hampton. I was expecting you. Come right in." (Turning to nurse: "Thanks Peg. I'll take good care of him."*
Smile and make eye contact. Share a good intention.	*"Okay, Mr. Hampton, you're all set. I hope all goes well for you!"*

RECEPTIONIST — passing a patient with a billing question on to a billing person

GREAT Behaviors	GREAT Words
• Make eye contact and address the person by name. • Explain what and who. • Share the good intentions behind the request. • Build customer's confidence in your co-worker. • Solicit the person's agreement. • Gesture enthusiastically and walk with the patient to your coworker's desk.	• *"Ms. Hamilton, before we schedule your follow-up appointment, Katy, the person who handles all our insurance and billing, would like to ask you a question regarding your insurance."* • *"Katy's here to make sure everything goes smoothly so you can continue to get the care you need."* • *"Can you speak with Katy for a few moments?"*
• Introduce your coworker by full name and position. • Then introduce the patient to your coworker. • Say something to remind coworker of why the patient is here.	• *"Ms. Hamilton, this is Katy Hammond our Financial Accounts Representative. Katy helps all of our patients/clients with their insurance and payment."* • *"Katy, this is Ms. Hamilton, here to discuss your insurance question."*
• Before you go, clarify when and if they will see you the person again.	• *"Ms. Hamilton, when you and Katy have finished talking, you can come back out to the front desk and I'll help you schedule your next appointment."*

Transferring a Phone Call

GREAT Behaviors	GREAT Words
• Keep in mind that the caller may have been transferred to several other offices before reaching yours. • If the caller reached you by mistake when trying to reach someone else, tell the caller which office he or she has reached and offer to transfer the call to the proper office. • Take the time to understand what the caller needs and to figure out who he or she should actually be calling. • If you do not have the correct extension at your fingertips, take the time to look it up. • Be sure to give the caller the correct number for future use and for use if transfer is disconnected. When you transfer the call, stay on the line to make sure you've connected the person to the place they want to reach.	• *"Can I have your name please?* • *"I'm sorry, Mr. Mancini. This is Martin Internal Medicine, and it sounds like you want the pharmacy. I'll be glad to transfer your call."* • *"In case we get disconnected or you get a busy signal, would you want to write down the number? Is a pencil handy?"* • *"Their number is XXX-XXXX. Can I repeat that for you?"* • *"Please hold while I transfer your call."* • *"And thank you for calling."*

Receptionist – Passing a patient with a complaint to the office manager

GREAT Behaviors	GREAT Words
Call the person by name and thank the person for speaking up. Express empathy without judging, agreeing, or disagreeing. Tell patient that you want to help. Handle the issue or draw in the right person who can. Build up your colleague in the patient's mind. Express confidence that this colleague cares and will help. Give the person options. Follow through on the option they choose. Make sure you close the loop. Make sure the person connects with the office manager before you let go.	Receptionist: *"I'm glad you spoke up about this, Mrs. Jones. It sounds very frustrating. I want to connect you to the right person. I think Marla Roberts, our office manager, is the person who can best help you. I know she'll be very concerned. Would you like me to see if Marla's available now or would you prefer that I have her call you later today?"* To Marla: *"Marla, I'm glad you're here. You know Mrs. Jones? She has a concern that I know you'll want to know about. Do you have a few minutes to talk with Mrs. Jones? I know you can help."* To Mrs. Jones: *"You'll be in good hands with Marla. Thanks for waiting."*

Taking and delivering a phone message

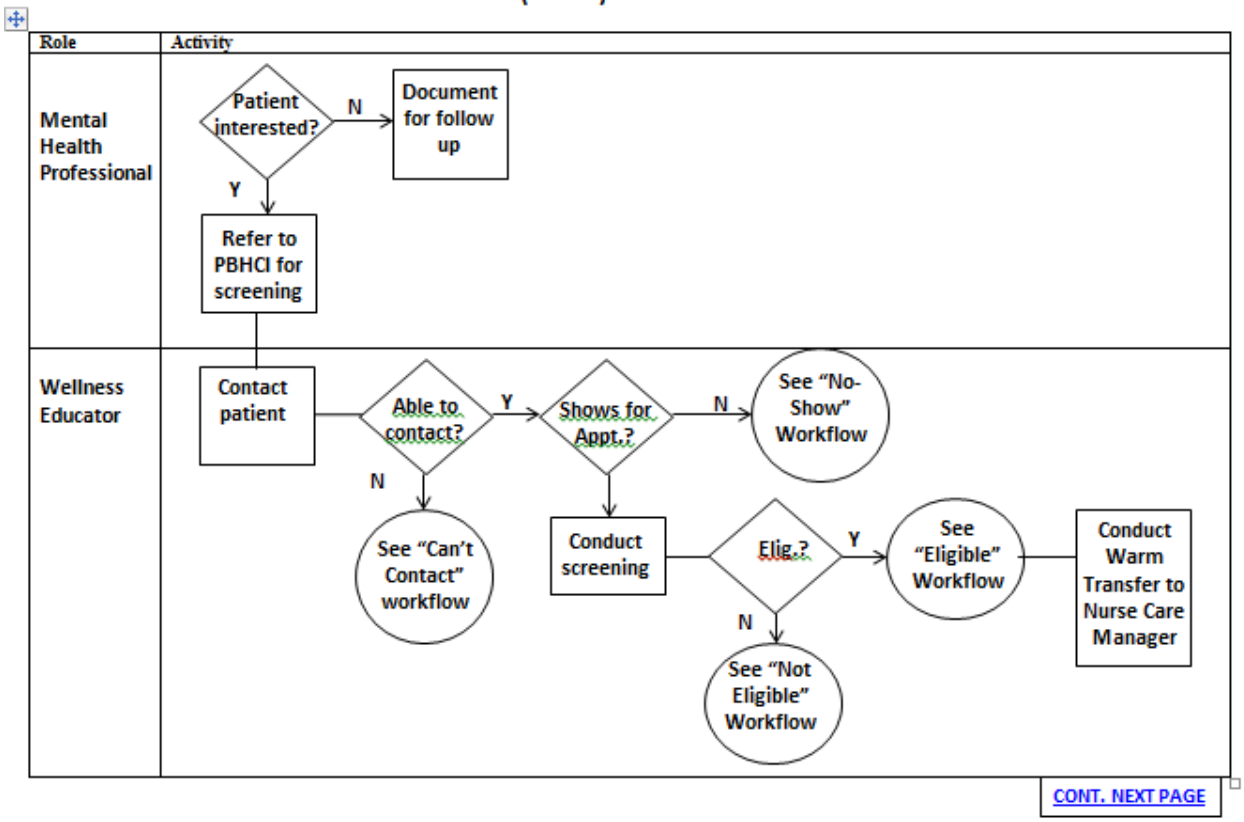
DO's	DON'T's
"I'm sorry, he's not available right now" "She's out of the office at the moment. I expect her back at 4:00. May I take a message?" "He's in a conference right now but I'll be happy to take a message."	*"She's impossible to find or reach, but as soon as I can, I'll give her your message."* *"She's working at home."* *"She's always off somewhere. It's a real challenge to get her."*

	"He's taken the afternoon off for personal business."
ACTIONS	
Write down the caller's name and phone number. Include other identifying information (e.g., name of patient the caller is associated with). Don't be shy about asking the caller to spell out a difficult name when necessary. Make note of the date and time of the call and the subject if you can tactfully find that out. This will help your coworker prioritize. If you can, locate any information your coworker will need when returning the call and provide it to him or her with the message. Be sure to put your initials at an appropriate place on the message so that your coworker will know who took the call in the event of questions. Sometimes you may have to take a message for someone who is in and nearby but who is on the phone or involved in some other work requiring immediate attention. You have a caller on the line and you need to get your coworker's attention in order to complete the call. To attempt this, place a written note in front of your coworker explaining the situation. Wait for a response. Your co-workers will appreciate your courtesy and thoughtfulness as much as patients/clients do.	

https://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

Sample Referral /Transition Workflows

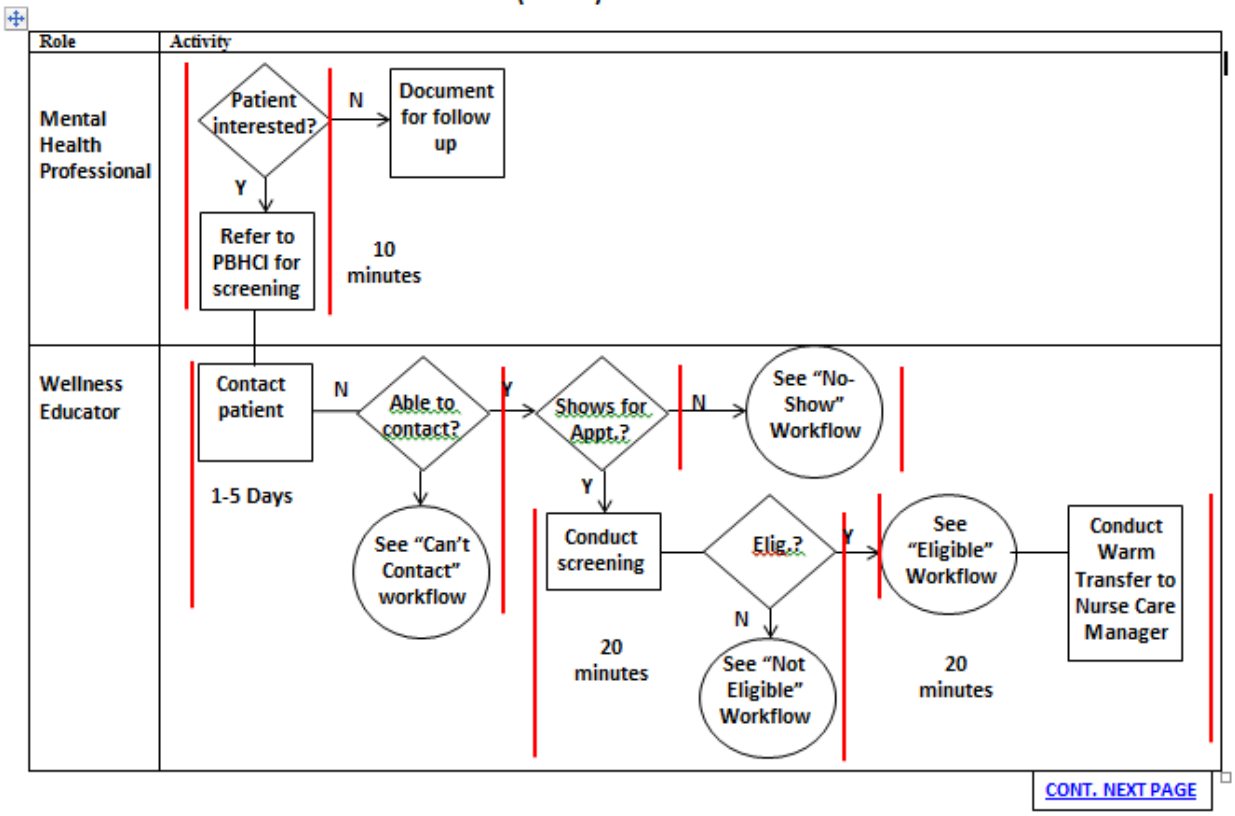
ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER

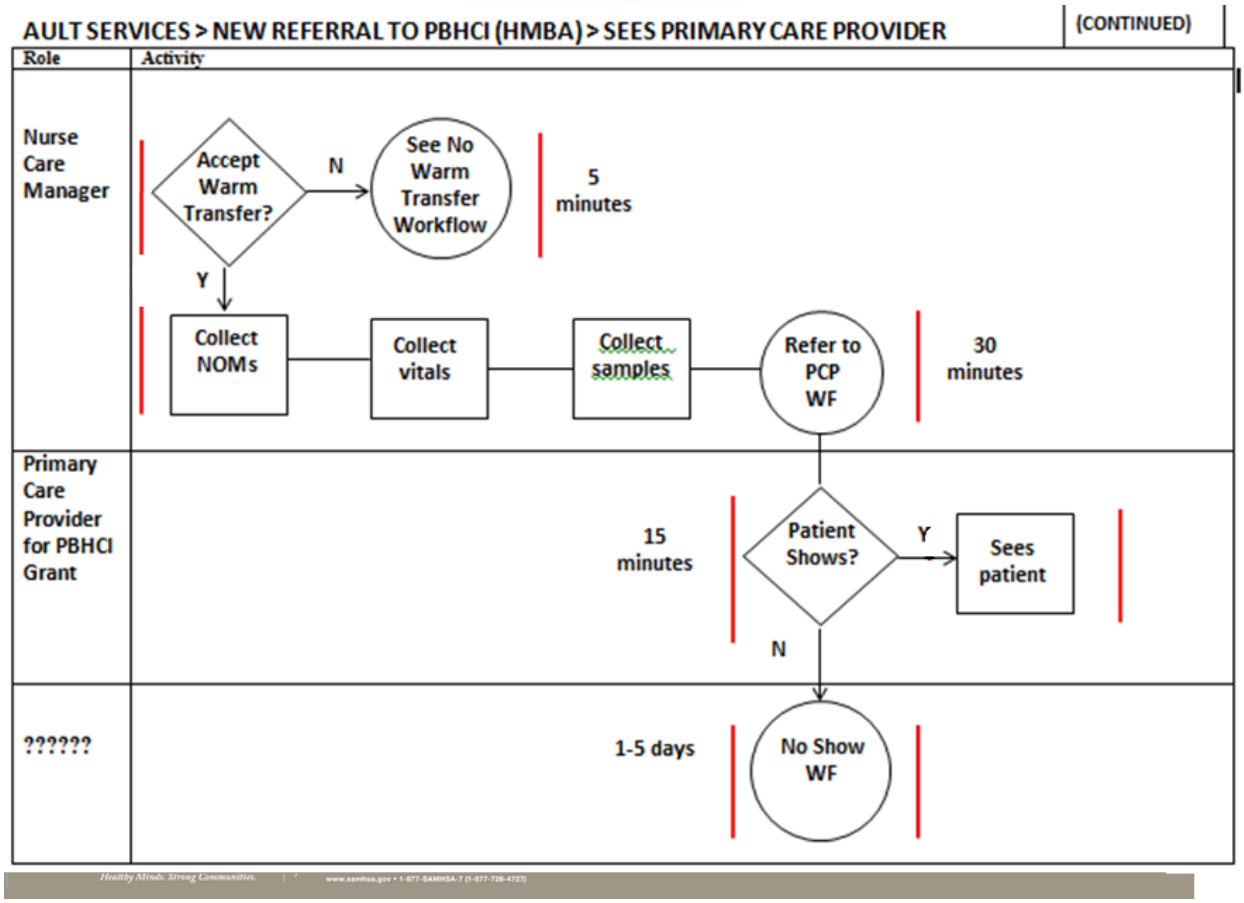


ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER (CONTINUED)

Role	Activity
Nurse Care Manager	Accept Warm Transfer? → N → See No Warm Transfer Workflow; Y → Collect NOMs → Collect vitals → Collect samples → Refer to PCP WF
Primary Care Provider for PBHCI Grant	Patient Shows? → Y → Sees patient; N →
?????	No Show WF

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





Templates to create workflow diagram and business process analysis

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

Sample Care Compact / Memorandum of Understanding (MOU)

Co-created by PCP and Mental Health provider - to be completed in writing prior to the start of the collaborative to gain agreement regarding referral types and definitions, role expectations, and communication expectations.

Sample Collaborative Care Compact Co-created PCP - MH Provider Shared Care Compact

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

Collaborative Guidelines

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

- Patients/clients are seen in an appropriate time frame;
- Clinical questions and responses are clearly stated and effectively communicated from one office to another;
- Patients/clients understand the reason for their referral and are satisfied with the referral process.

Principles

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

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

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

• A high functioning integrated health system of care provides patients/clients with access to the 'right care at the right time in the right place.'

Timely Referral Communication

Network4Health recommends the following protocols regarding timely communication and closed loop referrals.

Time Stratified Referrals

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

Referral Type

Based on urgency of care required, the referral can be marked as:

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

Appointment Scheduling

The patient/client is scheduled for an appointment with the office schedules per type of referral and patient/client preference

Closing the Loop

Once the patient/client is seen by the provider referred to, the provider sends the visit note to the referring provider with the clinical issue answered within one week of the appointment.

No Shows

If the patient/client doesn't show up as per the scheduled appointment, the provider referred to marks it as one of the following and sends it back to the referring provider:

No Show – Priority Referral (within 14 days)
No Show – Routine Referral (within 28 days)

Delayed referral timing due to:

- Delayed Priority Referral – Patient/client preference
- Delayed Routine Referral – Patient/client preference

Person Centered Care - Informed, Involved Patient/Client in Closing the Loop

Key to "closing the loop" on referrals is not only ensuring patients/clients have a good understanding of their health conditions, understand the importance of following through with referrals, but also feel empowered to do so. Address any health literacy barriers identified. The following are excellent health literacy resources:

Learn about Health Literacy, CDC: http://www.cdc.gov/healthliteracy/learn/
Quick Guide to Health Literacy: Fact Sheet https://health.gov/communication/literacy/quickguide/factsbasic.htm
Health Resources and Services Administration: http://www.hrsa.gov/publichealth/healthliteracy/

Referral Specialist

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

Reporting

Structured reports, to be simple but meaningful for both sides**: Referral Summary of Care Record**

- **Referral** - A new patient is referred between primary, mental health care, and SUD providers. Provider sends Summary of Care Record with Referral that includes:
  - Plan of Care field (Patient/client centered goals and instructions)
  - Care team (other providers)
  - Reason for Referral – Clinical Issue/Information
  - Current problem list
  - Current medication list
  - Current allergy list

Mutual Agreement for Referral Management

- Review the level of care tables and determine which services you can provide.
- The Mutual Agreement section of the tables reflects the core element of integrated care (aligning with PCMH) and outline expectations from both primary care and mental health care providers.
- The Expectations section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement.
- The Additional Agreements/Edits section provides an area to add, delete, or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients/clients self-refer to primary care or mental health provider, processes should be in place to determine the patient's overall needs and reintegrate further care with the primary care or mental health provider, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements necessary to provide timely and necessary medical care to the patient/client.
- Each provider should agree to open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- **Optimally, this agreement should be reviewed every year.**
- Source: https://c.ymcdn.com/sites/www.thepcpi.org/resource/resmgr/Final-CRL-Toolkit-6-19-17.pdf

Adherence to NH Board of Medicine Opioid Protocols

N4H integrated healthcare partners are expected to be in adherence with the New Hampshire Board of Medicine's Opioid protocols. "According to the NH Board of Medicine, the rules, codified in the Med 502 series of the NH Administrative Regulations, are divided into rules governing treatment of acute pain and rules governing treatment of chronic pain. Notably, the rules do not apply to physicians treating cancer or palliative care patients/clients."

Source: https://www.oplc.nh.gov/medicine/opioid-prescribing.htm

The NH Board of Medicine Rules

(a) Use of written treatment agreements;

(b) Provision of information to patients/clients on topics such as risk of addiction and overdose, and safe storage and disposal;

(c) Use and documentation of opioid risk assessments;

(d) Prescription of the lowest effective dose;

(e) Use of informed consent forms;

(f) Periodic review of treatment plans;

(g) Required clinical coverage; and

(h) Use of random and periodic urine drug testing for patients/clients using opioids long term.

Treating Acute Pain	• Conduct and document a physical examination and history.
	• Consider the patient's risk for opioid misuse, abuse, or diversion.
	• Prescribe for the lowest effective dose for a limited duration.
	• Document the prescription and rationale for prescribing.
	• Provide the patient with information on all of the following topics:
	  • Risk of side effects including addiction and overdose resulting in death.
	  • Risks of keeping unused medication.
	  • Options for safely securing and disposing of unused medication.
	  • Danger in operating a motor vehicle or heavy machinery while under the influence of opioids.
	• Comply with all federal and state controlled substances laws, rules, and regulations.
	• Adhere to the principles outlined in the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015).	

	With regard to the patient information requirement, the NH Board of Medicine has published a notice that, while not required, can be used to satisfy this requirement. The information sheet can be found at **https://www.nh.gov/medicine/documents/acutepainpatientinfo.pdf**	

Treating Chronic Pain	• Conduct and document a history and physical examination.
	• Conduct and document a risk assessment, including, but not limited to the use of an evidence-based screening tool such as the Screener and Opioid Assessment for patients/clients with Pain (SOAPP).
	• Document the prescription and rationale for all opioids.
	• Prescribe the lowest effective dose for a limited duration.
	• Comply with all federal and state controlled substances laws, rules, and regulations.
	• Utilize a written informed consent that explains the following risks associated with opiates:
	  • Addiction
	  • Overdose and death
	  • Physical dependence
	  • Physical side effects
	  • Hyperalgesia
	  • Tolerance
	  • Crime victimization
	• Create and discuss a treatment plan with the patient, which addresses issues such as goals of treatment in terms of pain management, restoration of function, safety, and time course for treatment.
	• Utilize a written treatment agreement that is contained in the patient's medical record and addresses, at a minimum, the following:
	  • Safe medication use and storage.
	  • Requirement to obtain opioids from only one prescriber or practice.
	  • Consent to periodic and random drug testing.
	  • Prescriber's responsibility to have clinical coverage available.
	  • Conduct that will trigger the discontinuation or tapering of opioids.
	• Document the consideration of a consultation with an appropriate specialist in the following circumstances:
	  • When the patient receives a 100 mg morphine equivalent	

	dose daily for longer than 90 days. • When a patient is at high risk for abuse or addiction. • When a patient has a co-morbid psychiatric disorder. • Require periodic review of the treatment plan and patient follow-up every four months. • Require random and periodic urine drug testing *at least annually* for all patients/clients using opioids for longer than 90 days. • Have clinical coverage available 24 hours per day, 7 days per week. • Adhere to the principles outlined in the American Society of Addiction Medicine's *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (2015). Please note that physicians treating chronic pain may forego written treatment agreements and periodic testing for those patients/clients: (a) who are residents in a long-term, non-rehabilitative nursing home where medications are administered by licensed staff, or (b) who are being treated for episodic pain and will receive no more than 50 dose units of opioids in a three-month period. The NH Medical Society has made various opioid prescribing tools and sample forms such as a pain evaluation, risk assessment, written consent form, and opioid treatment agreement available on its website at **http://nhms.org/resources/opioid**.	

The NH Medical Society has made a checklist for the Prescribing of Opioids for the Management or Treatment of Pain, **https://www.oplc.nh.gov/medicine/documents/opioid-patient-checklist.pdf** and various opioid prescribing tools and sample forms such as a pain evaluation, risk assessment, written consent form, and opioid treatment agreement available on its website at **http://nhms.org/resources/opioid**. Physicians should also consult with legal counsel or the NH Board of Medicine if they do not understand any aspect of these rules.

Board-Approved Risk Assessment Tools

- Screener and Opioid Assessment for patients/clients with Pain-Revised (SOAPP®-R)
- Screener and Opioid Assessment for patients/clients with Pain (SOAPP)® Version 1.0 - 14Q
- Opioid Risk Tool (ORT)
- Drug Abuse Screening Test, DAST-10
- Venebio Opioid Advisor At the present time, any provider wishing to use the tool will need to contact Venebio via a form at http://voa.venebio.com/contact/

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

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

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

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

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

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

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

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

Attachment_B1.9b1

Guidance Document on Best Practices:

Key Components for Delivering Community-Based **Medication Assisted Treatment Services** for Opioid Use Disorders in New Hampshire

Second Edition

A publication of the Bureau of Drug and Alcohol Services at the New Hampshire Department of Health and Human Services, with technical assistance provided by the NH Center for Excellence, a project of JSI Research & Training Institute, Inc.

Compendium Panel:

Kristy Letendre*
Peter Mason, MD*
Molly Rossignol, DO*ˣ
Seddon Savage, MD*

NH Department of Health and Human Services, Bureau of Drug and Alcohol Services Team:

Joe Harding, MSW*
Lindy Keller, MS, MLADC*ˣ
Jaime Powers, MS*ˣ

JSI Research & Training Institute, Inc. NH Center for Excellence Technical Team:

Faith Bouchard, BFA*ˣ
Anna Ghosh, MPHˣ
Lisa Mure, MEd, CPS*
Adelaide Murray, BSˣ
Rekha Sreedhara, MPH*ˣ

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NH DEPT. OF HEALTH AND HUMAN SERVICES
NHBDAS
BUREAU OF DRUG AND ALCOHOL SERVICES
Promoting Prevention and Recovery

NEW HAMPSHIRE CHARITABLE FOUNDATION

CENTER FOR EXCELLENCE | Addressing Alcohol & Drug Misuse in NH

ACRONYMS AND ABBREVIATIONS

42 CFR, Part 2 – Title 42, Part 2 of the Code of Federal Regulations
ASAM – American Society of Addiction Medicine
ASI – Addiction Severity Index
ATTC – Addiction Technology Transfer Center
BDAS – Bureau of Drug and Alcohol Services
CARA – Comprehensive Addiction and Recovery Act
CBT – Cognitive Behavioral Therapy
CHC – Community Health Center
CMS – Centers for Medicare & Medicaid Services
COWS – Clinical Opiate Withdrawal Scale
DATA 2000 – Drug Addiction Treatment Act of 2000
DEA – Drug Enforcement Administration
DHHS – Department of Health and Human Services
DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DUR – Data Utilization Review
FDA – Food and Drug Administration
HIPAA – Health Insurance Portability and Accountability Act of 1996
IM – Intramuscular
IOP – Intensive Outpatient Program
IV – Intravenous
LADC – Licensed Alcohol and Drug Counselor
MAT – Medication Assisted Treatment
MCO – Managed Care Organization
MET – Motivational Enhancement Therapy
MLADC – Master Licensed Alcohol and Drug Counselor
NCM – Nurse Care Manager
NHHPP – NH Health Protection Program
OBOT – Office-Based Opioid Treatment
OOWS – Objective Opiate Withdrawal Scale
OTP – Opioid Treatment Program
OUD – Opioid Use Disorder
PAP – Premium Assistance Program
PCP – Primary Care Provider
PDL – Preferred Drug List
PDMP – Prescription Drug Monitoring Program
PHP – Partial Hospitalization
PO – By Mouth
PRSS – Peer Recovery Support Services
QHP – Qualified Health Plan
QSO – Qualified Service Organization
SAMHSA – Substance Abuse and Mental Health Services Administration
SES – Socioeconomic Status
SOWS – Subjective Opiate Withdrawal Scale
SUD – Substance Use Disorder
TAP – Technical Assistance Publication
TIP – Treatment Improvement Protocol

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY 5
II. INTRODUCTION 7
III. OVERVIEW OF OPIOID USE DISORDER MEDICATIONS 8
IV. SERVICE DELIVERY AND CLINICAL CONSIDERATIONS 12
A. Staffing 17
B. Training & Resources 23
C. Billing 27
D. Evaluation 30
E. Treatment Planning 36
F. Induction 40
G. Psychosocial Treatment & Recovery Support Services 43
H. Drug Testing 48
V. OTHER CONSIDERATIONS 50
A. Confidentiality - 42 CFR Part 2 52
B. Communications 55
C. Stigma 57
VI. APPENDICES 58
Appendix I: MAT Quality Planning Tool 59
Appendix II: Objective Opiate Withdrawal Scale 65
Appendix III: Subjective Opiate Withdrawal Scale 66
Appendix IV: Clinical Opiate Withdrawal Scale 67
Appendix V: Sample Treatment Agreement 69
Appendix VI: Consent Form 70

I.

EXECUTIVE SUMMARY

In 2016, New Hampshire (NH) recorded 485 drug overdose deaths, a 10% increase from 2015. In the past year, an estimated 87% (424) of those deaths involved fentanyl, heroin, or other/unknown opioids (other opioids may include prescriptions such as oxycodone based medications; unknown opioids are currently unable to be investigated or classified), as compared to 90% (397) of deaths involving those substances in 2015. In 2016, there were 6,084 opioid-related emergency room visits and 2,896 naloxone (Narcan) administrations through the NH Bureau of Emergency Medical Services. As of December 7, 2017, 350 individuals have died as a result of a drug overdose, with 311 (89%) of those attributable to opiates/opioids.[1]

In response to the opioid crisis, NH has passed legislation and executed several initiatives including: allowing physicians to prescribe naloxone to anyone who may be in a position to help someone experiencing an opioid-related overdose (House Bill 271); providing protection from civil, criminal and professional liability to the prescriber, dispenser and administrator of naloxone, also known as the Good Samaritan Law (House Bill 270); not requiring a renewal of a prior authorization more frequently than once every 12 months if substance use disorder (SUD) services are a covered benefit under a health plan (Senate Bill 158); implementing screening, brief intervention and referral to treatment (SBIRT) in all community health centers to identify problem alcohol and drug use; making naloxone kits available to patients of ten community health centers at no cost; supporting community education and naloxone access events through the state's regional public health network system; and launching an opioid awareness and public education campaign. As a companion to these addiction prevention, early identification and overdose prevention initiatives, the state is making a concerted effort to expand the availability of addiction treatment through investment in and promotion of medication assisted treatment (MAT) for opioid use disorders (OUDs). Specifically, the state offers buprenorphine waiver trainings at no cost for physicians, nurse practitioners, and physician assistants and contracts with community health centers and practices part of hospital networks to initiate and expand MAT.

Similar to many other states across the country, MAT services are limited and desperately needed in NH. The need for expanded MAT is evident in the high rates of opioid misuse reflected in the sharp increases in emergency room visits, ambulance calls and in the administration of naloxone.[2]

To address the lack of capacity to treat OUDs, the NH Department of Health and Human Services (DHHS), Bureau of Drug and Alcohol Services (BDAS) convened a panel of practitioners from health care, behavioral health and specialty SUD treatment services, and the NH Medical Society to review existing MAT models in New Hampshire and other states and to identify key components and best practices to develop this compendium of recommendations and resources for implementing and delivering MAT.

1 NH Attorney General Department of Justice, Office of Chief Medical Examiner. 2016 & 2017 Drug Death Data.
2 NH Attorney General Department of Justice, Office of Chief Medical Examiner. 2016 & 2017 Drug Death Data.

GOAL: To initiate and expand MAT capacity to serve more patients with OUDs across a variety of treatment settings.

OBJECTIVES:

1. Increase the number of waivered buprenorphine prescribers;
2. Increase office-based access to MAT programs through multiple settings, including primary care offices and clinics, specialty office-based ("stand alone") MAT programs, and traditional addiction treatment programs offering medication; and
3. Increase awareness of and access to extended-release injectable (depot) naltrexone and other medications by prescription.

II.

INTRODUCTION

This compendium of best practice recommendations and resources has been developed to provide guidance and support to initiate and expand MAT services for OUDs for patient populations in a variety of service settings as requested by health care and behavioral health professionals. This document is not intended to replace best practice resources such as the *American Society for Addiction Medicine (ASAM) National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use* or the *Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocols (TIPs)* and *Technical Assistance Publications (TAPs),* but is rather a compilation of resources and recommendations identified from these and other sources.

The development of this compendium is based on several key principles:

- The disease of addiction is a complex biopsychosocial disease that is chronic in nature and is often characterized by periods of relapse and remission;
- Methadone and buprenorphine have been determined by research to be highly effective in short-term withdrawal management; and these two medications and naltrexone are show to be effective in longer term/ chronic management of OUD[3];
- Access to medication for those experiencing addiction is limited in NH;
- Only 30% of SUD treatment programs offer medications for OUD[4]; and
- Medical professionals from a range of primary care and specialty practices have expressed interest in delivering MAT to existing patient populations and/or to MAT-targeted patients provided they are able to access adequate training, technical assistance, and professional mentoring.

MAT can be delivered in a variety of service settings with the proper integration of specific components.
These settings include:

- Primary care
- Behavioral health/specialty addiction treatment
- MAT-specific treatment programs

Each of these settings exist in New Hampshire, and representatives from each were contacted to help the panel understand and consider the models used and the strengths, challenges, and opportunities. Examples will be shared throughout the document to better describe the different models and are not intended for promotional purposes.

3 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
4 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

III.

OVERVIEW OF OPIOID USE DISORDER MEDICATIONS

According to SAMHSA's Addiction Technology Transfer Center (ATTC) Network, *MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.* MAT is linked to many positive outcomes including:[5,6,7]

- Decreasing mortality;
- Increasing retention in treatment;
- Reducing medical and SUD treatment costs;
- Reducing opioid overdose among patients in treatment;
- Increasing abstinence from opioids; and
- Lowering a person's risk of contracting HIV or hepatitis C.

Three medications are approved by the U.S. Food and Drug Administration (FDA) for treating OUDs -- methadone, buprenorphine, and naltrexone -- with several products/formulations available for each of these medications. While all three pharmacotherapies are approved options with different indications and contraindications, this compendium will focus primarily on the following medications:

- Buprenorphine (e.g., Suboxone®, Subutex®, Zubsolv®, Bunavail®, Probuphine®, Sublocade®)
- Naltrexone (extended-release injectable/depot/XR-NTX: Vivitrol®)

These medications were selected because they may be prescribed in an office-based setting, unlike methadone which, per federal regulation, must be dispensed at certified opioid treatment programs (OTPs). Additionally, this guidance document focuses on depot naltrexone, specifically Vivitrol, the only commercial product currently available, rather than oral naltrexone (ReVia®, Depade®) because poor medication adherence has resulted in lower retention rates when compared to depot naltrexone.[8] Prescribers are strongly advised, however, to have a thorough understanding of each therapeutic medication and the different products and formulations available in an effort to, in agreement with the patient, identify which pharmacotherapy will be the best treatment option.

Sampling of Research Findings Associated with Buprenorphine, Naltrexone and Methadone

Research outcomes relative to these medications are important to review as medications are considered.

For example, in an examination of buprenorphine maintenance versus placebo or methadone maintenance, which included 31 trials and 5,430 participants, findings indicated that buprenorphine retained fewer participants than methadone when dose intervals are flexible and at low fixed doses.

5. Connery, H. Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. 2015. Harv Rev Psychiatry. 23(2):63-75.
6. The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
7. Kakko, J. et. al. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: A randomised, placebo-controlled trial. The Lancet. February 22, 2003; (361)662-66
8 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

However, at medium to high doses no differences were seen. Additionally, based on the literature reviewed, no difference was observed between methadone and buprenorphine for reducing criminal activity or mortality rates. Specifically, this research found the following:

- Low fixed-dose studies indicated that methadone (≤ 40 mg) was more likely to retain participants than low-dose buprenorphine (2 - 6 mg), (3 studies, 253 participants, RR 0.67; 95% CI: 0.52 to 0.87);
- No difference in retention was observed between medium-dose buprenorphine (7 - 15 mg) and medium-dose methadone (40 - 85 mg), (7 studies, 780 participants, RR 0.87; 95% CI 0.69 to 1.10); and
- No difference in retention was observed between high-dose buprenorphine (≥ 16 mg) and high-dose methadone (≥ 85 mg), (RR 0.79; 95% CI 0.20 to 3.16).[9]

Another study looked at the long-term (18-month) outcomes of office-based treatment with buprenorphine/naloxone and the impact of socioeconomic status (SES) and other characteristics. Of the 176 patients with an OUD who were on buprenorphine/naloxone and receiving intensive outpatient counseling, 110 completed the follow-up interview with 77% of those reporting that they remained on the medication. Individuals who were still on buprenorphine/naloxone were more likely to report abstinence, involvement with recovery programs, and to be employed. No differences were observed between high and low SES groups.[10]

In a randomized, comparative effectiveness trial of 24 weeks of treatment – following an acute inpatient detoxification admission, done at typical community-based treatment programs across the U.S., 570 participants were randomized to receive treatment with either extended-release injectable naltrexone (XR-NTX) (283) or buprenorphine-naloxone (BUP-NX) (287) and were intended to be treated. 474 participants were successfully inducted, with XR-NTX significantly more difficult to initiate than BUP-NX patients. Among patients that were successfully inducted, 24-week relapse events were similar across XR-NTX patients (52%) and BUP-NX patients (56%). Overall, if induction to either medication is successful, XR-NTX and BUP-NX were comparably effective and safe options.[11]

In a recent study, 308 patients were randomly assigned to treatment; outpatient (N=201); short-term inpatient (N=59); and long-term inpatient (N=48) as usual (TAU) (N=155) or TAU + injection naltrexone (depot naltrexone; XR-NTX) (N=153). Five weeks after randomization, patients being treated with XR-NTX+TAU that initiated the study on short-term inpatient experienced little relapse (7%); however, those assigned to TAU experience a high rate of relapse (63%). By the end of the study (26 weeks) there was continued relapse across treatment conditions and settings; however, relapse rates were lower among the XR-NTX+TAU condition patients across treatment settings. The XR-NTX exerted a protective effect among outpatient, reducing the relapse rate to 38% as compared to short-term inpatient (59%) and long-term inpatient (46%).[12]

According to the results of a retrospective, longitudinal study comparing patients who received MAT versus those who did not receive medication to support recovery, of 10,513 patients who received one of the four approved

9 Mattick RP, Breen C, Kimber J, Davoli M. *Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review).* Copyright © 2014. The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
10 Parran et. al. Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy. *Drug and Alcohol Dependence.* 106 (2010) 56–60.
11 Lee, J. et. al. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioids relapse prevention (X:BOT): A multicentre, open-label, randomized controlled trial. The Lancet. November 2017. Retrieved from: *http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32812-X/fulltext*
12 Nunes, E.V., et. al. Relapse to opioid use disorder after inpatient treatment: Protective effect of injection naltrexone, *Journal of Substance Abuse Treatment* (2017). Retrieved from: *https://www.ncbi.nlm.nih.gov/pubmed/28473233*

medications for the treatment of OUDs (depot naltrexone, n=156, 1.5%; oral naltrexone, n=845, 8.3%; buprenorphine, n=7,596, 72% or methadone, n=1,916, 18.2%), the per-patient mean cost associated with treatment including inpatient, outpatient and pharmacy costs was $10,710 vs. $6,791 for patients receiving no drug treatment. However, six-month risk-adjusted outcomes indicated lower total healthcare costs by 29% for patients who received a medication for their opioid use disorder. Specifically, treatment with depot naltrexone was associated with significantly fewer opioid and non-opioid related hospitalizations and fewer emergency department visits than patients who received methadone. It is important to note that the cost of depot naltrexone is much higher in comparison to other medications for OUDs. In looking at total costs, this medication is not significantly different compared to oral naltrexone or buprenorphine, but is significantly lower than methadone.[13]

Additional References

1. Connery, H. Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. Harvard Review of Psychiatry. Volume 23, Number 2: March/April 2015.
2. Bart G. Medication Maintenance for Opiate Addiction: The Foundation of Recovery. J Addict Dis. 2012 July; 31 (3): 207-225.
3. Watkins K, Ober A, Lamp K. Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care. JAMA Intern Med. 2017;177(10):1480-1488. Retrieved from: http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2652574.
4. Korthuis, P.T. et. al. Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review. Ann Intern Med. 2017 February 21; 166(4): 268–278. doi:10.7326/M16-2149.
5. Jones et. al. Neonatal Abstinence Syndrome After Methdone or Buprenorphine Exposure. New England Journal of Medicine. December 2010. 363;24.
6. Lee et. al. Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. N Engl J Med. 374 (13), March 31, 2016.

13 Baser O, Chalk M, Fiellin DA, Gastfriend DR. Cost and utilization outcomes of opioid dependence treatments *Am J Manage Care.* 2011;17:S235-248.

The following chart provides a brief overview of the differences between the three medications. For more detailed prescribing information, please refer to the ASAM National Practice Guidelines.

OPIOID USE DISORDER MEDICATION DIFFERENCES [14,15,16,17]			
PRESCRIBING CONSIDERATIONS	**METHADONE**	**BUPRENORPHINE**	**NALTREXONE**
Product/Formulation		E.g., Suboxone,* Subutex, Zubsolv,* Bunavail,* Probuphine, Sublocade	Extended-release injectable/depot/XR-NTX; Vivitrol
Mechanism of Action	Full Agonist: Binds to and activates receptors. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Partial Agonist: Binds to and partially activates opioid receptors. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Antagonist: Binds and competitively blocks opioid reward effects.
Uses of Medication	Withdrawal and Treatment	Withdrawal and Treatment	Treatment
Route of Administration	Oral tablet or liquid	Sublingual tablet, sublingual or buccal film, implant, injection	Intramuscular (IM) injection
Frequency of Administration	Daily	Based on formulation and clinical needs of the patient.	Monthly
Dosage	Based on formulation and clinical needs of the patient.		
Regulatory Context	May only be dispensed at a certified opioid treatment program (see He-A 300 rules, part 304).[18]	Any licensed prescriber with a DEA registration and a buprenorphine waiver.	Any healthcare provider who has a license to prescribe (e.g., physician, nurse practitioner, physician assistant).
Typical Visit Requirement	Initial: Daily	Initial: Weekly *Interval may change based on course of treatment*	Monthly
Cost of Medication	Low	Depends on product	High
Controlled Substance Schedule	Schedule II	Schedule III	Not a Scheduled Medication
Diversion Value	High	High	Low
Discontinuation of Medication	Tapering Required	Tapering Required	No Tapering Required

** Suboxone, Zubsolv, and Bunavail contain both buprenorphine and naloxone. Naloxone is an antagonist and is used to decrease potential for diversion and misuse. If used intravenously a person will experience immediate withdrawal as a result of the naloxone.*

14 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
15 National Council for Behavioral Health. Webinar: Making the Case: How MAT Improves Mental Health Care for those with OUDs held by Dr. Hilary Connery on October 6, 2015.
16 Retrieved from Substance Abuse and Mental Health Services Administration (SAMHSA). An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence. Winter 2012. Volume 11. Issue 1, http://www.integration.samhsa.gov/Intro_To_Injectable_Naltrexone.pdf.
17 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
18 He-A 300 Certification and Operation of Alcohol and Other Drug Disorder Treatment Programs, Part He-A 304 Operational Requirements for Opioid Detoxification and Methadone Maintenance, Treatment, and Rehabilitation Programs, http://www.gencourt.state.nh.us/rules/state_agencies/he-a300.html

IV.

SERVICE DELIVERY AND CLINICAL CONSIDERATIONS

There are many components related to the development, implementation, and integration of a MAT program for the treatment of OUD. An overview of each element will be described in the following sections. Federal and state requirements and best practice recommendations and resources will be identified throughout this guidance document to assist with the initiation or expansion of office-based opioid treatment (OBOT) programs. Formal structuring of office systems to support best practices in MAT is strongly encouraged to facilitate efficient patient care and reduce system stress.

Many different service models can be used to deliver MAT within each setting. The following chart provides an overview of the models that can be used in a primary care clinic or office, behavioral health/specialty addiction treatment program, and a MAT-specific setting.

Overview of Buprenorphine and Naltrexone Service Delivery Models				
	Primary Care Clinic or Office-Based	Behavioral Health/ Specialty Addiction Treatment Program	MAT-Specific Treatment Programs	
			Free-Standing MAT Clinic	Opioid Treatment Program (OTP)/ Methadone Clinic
General Description	Engages existing PCP to become waivered Prescribes buprenorphine and/or naltrexone Arranges psychosocial treatment and recovery support services	Provides psychosocial treatment and recovery support services Employs or contracts with buprenorphine and/or naltrexone prescribers	Establishes clinic specifically to provide buprenorphine and/or naltrexone Engages prescriber, psychosocial treatment provider and care coordinator Provides or refers to recovery support services	Expands services to include prescribing of buprenorphine and/or naltrexone Engages waivered prescribers and utilizes existing psychosocial treatment provider and care coordinator Provides or refers to recovery support services
Prescriber *Roles* • Diagnoses opioid use disorder • Inducts onto MAT • Prescribes • Provides routine follow-up visits	Employs waivered prescriber May link to other waivered prescriber for cross coverage	Employs Medical/ Psychiatric Director or other waivered prescribers Partners with waivered prescriber in community	Employs waivered prescriber	Employs waivered prescriber

Overview of Buprenorphine and Naltrexone Service Delivery Models				
	Primary Care Clinic or Office-Based	Behavioral Health/ Specialty Addiction Treatment Program	MAT-Specific Treatment Programs	
			Free-Standing MAT Clinic	Opioid Treatment Program (OTP)/ Methadone Clinic

Counselor
Roles
• Provides SUD counseling
  • Group
  • Individual
• Provides counseling for co-occurring disorders as needed
• Encourages and refers to recovery support
	Embed addiction counselor or contracts with outside provider	Designates counseling staff	Designates counseling staff	Designates counseling staff

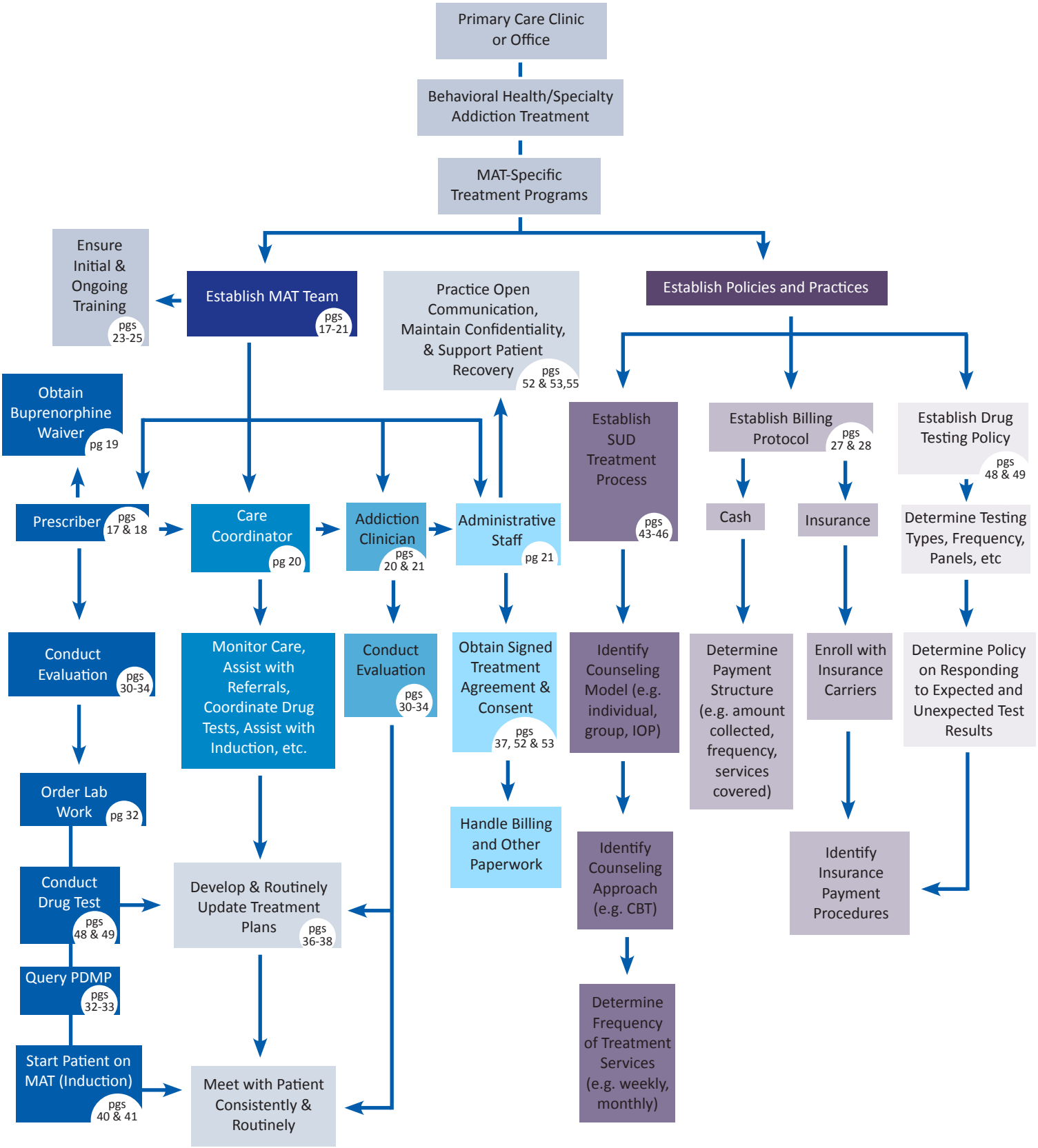
Care Coordinator *Roles* • Facilitates communication between prescriber, counselor, and patient • Provides routine support to patients outside of office visits • Conducts drug testing and pill/ film counts • Links with recovery support services	Role may be assumed by various positions (e.g., nurse, medical assistant, counselor).			

The following chart references the federal and state requirements and the best practices that are strongly encouraged by the state of New Hampshire. The simplest form of MAT with buprenorphine which meets federal and state regulations involves a waivered prescriber writing a prescription for a patient who meets criteria for an OUD, providing regular office visits, documenting care properly and ensuring capacity to refer patients for appropriate counseling and other appropriate ancillary services.

In addition to these requirements, the state is promoting additional best practices to support the successful delivery of MAT. Some of these recommendations include querying the Prescription Drug Monitoring Program (PDMP) each time a prescription is written, conducting routine and random drug testing and pill/film counts and practicing timely communication among the prescriber, the patient and other providers.

Federal & State Requirements	New Hampshire Recommendations
• Obtain buprenorphine waiver to prescribe - Physician (MD/DO) (eight hour waiver training) OR - Nurse Practitioner/Physician Assistant (24 hours of training including the 8 hour waiver training) • Conduct full evaluation and medical exam - Verify that patient meets criteria for an opioid use disorder - Verify that patient is deemed appropriate for MAT and medication • Provide regular office visits • Document care properly (e.g., treatment plans, confidentiality) • Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services	• Establish a core team of qualified staff to deliver MAT • Provide initial and on-going training and resources to all staff • Query the PDMP each time a prescription is written • Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers • Perform routine and random drug tests • Perform routine and random pill/film counts • Practice timely communication among the prescriber, the patient and other providers

To further outline the MAT requirements and recommended best practices, a visual representation is provided below and a Quality Planning Tool is available in Appendix I to help MAT programs review and assess their progress related to the development and implementation of the recommended best practices. Periodic use of this tool is encouraged to inform continual quality improvement. Programs can anticipate that the first one to two years after implementation will involve assessing and adjusting programming and service delivery as necessary.



IV. A. STAFFING: Establish a Core Team

A. STAFFING: Establish a Core Team

Establishing a core team dedicated to patient care and service coordination specific to MAT is fundamental for an organized MAT setting.[19] This team may involve clinic staff exclusively or may include partnering providers to provide comprehensive treatment services to meet patient needs.

To establish a team, it is important to identify or recruit interested and qualified staff who encompass the attitudes, values, and competence associated with treating patients with OUDs. It is recommended that the team consist of, at a minimum, a prescriber, a care coordinator, a licensed alcohol and drug counselor (LADC) or behavioral health provider with training in the treatment of SUDs, and non-clinical, administrative staff. Each of the recommended positions are described in more detail in this section.

Prescriber

Buprenorphine: Physicians (MD or DO), Nurse Practitioners (NPs), and Physician Assistants (PAs) who have received a waiver through the DEA (Drug Enforcement Administration) can prescribe buprenorphine.

Physicians have been able to prescribe buprenorphine since October 2002 when the FDA approved buprenorphine for clinical use in treating OUDs. The eight-hour DATA-waiver course is required in order to apply to prescribe to up to 30 patients in the first year and to increase the limit to 100 patients thereafter. Physicians who have prescribed buprenorphine to 100 patients for at least one year can apply to increase their patient limits to 275 patients under new federal regulations. As of February 27, 2017, prescribing of buprenorphine was extended to NPs and PAs per the Comprehensive Addiction and Recovery Act (CARA). 24 hours of training including the 8 hour waiver training is required in order to apply to prescribe to up to 30 patients.

Naltrexone (NR-NTX): This medication may be prescribed by any healthcare provider (e.g., NPs, PAs) who is licensed to prescribe medications. There is no limit on the number of patients for whom this medication may be prescribed.

Approved in October of 2010, extended-release injectable naltrexone is the most recent drug authorized for the treatment of OUDs.

Methadone: For the treatment of pain, methadone can be prescribed by any prescriber with a DEA registration, but for OUDs this medication can only be dispensed at a licensed opioid treatment program (OTP)/methadone clinic. If methadone is determined to be the most appropriate medication for a patient, primary care offices and clinics, behavioral health/specialty addiction treatment programs, and free-standing MAT clinics, can refer patients to one of the eight licensed OTPs in New Hampshire.

The following table recommends prescriber models by setting and medication.

19 Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

OVERVIEW OF PRESCRIBER MODELS BY SETTING			
	PRIMARY CARE CLINIC OR OFFICE	**BEHAVIORAL HEALTH / SPECIALTY ADDICTION TREATMENT PROGRAM**	**MAT-SPECIFIC TREATMENT PROGRAM**
Buprenorphine	Recruit interested prescriber(s) in practice to obtain buprenorphine waiver, prescribe medication, and oversee patient care.	Have prescriber obtain buprenorphine waiver. Establish a working relationship with a prescriber(s) in the community waivered to prescribe buprenorphine.	Hire prescribers to obtain buprenorphine waiver.
Naltrexone (XR-NTX)	Identify existing healthcare providers to prescribe naltrexone and oversee patient care.	Have existing healthcare provider prescribe naltrexone. Establish a working relationship with a healthcare provider(s) in the community to prescribe naltrexone.	Have existing provider prescribe naltrexone. Hire or subcontract with a licensed healthcare provider to prescribe naltrexone and to participate in oversight of patient care.
If methadone is determined to be the most appropriate medication for patients, providers can establish care coordination plans with one of the state's eight methadone clinics. For a list of OTPs, visit the NH Alcohol and Drug Treatment Locator, www.nhtreatment.org.			

Buprenorphine Waiver Process

TO QUALIFY FOR A BUPRENORPHINE WAIVER, A PRESCRIBER MUST:

1. Be a licensed physician (MD or DO), nurse practitioner, or physician assistant
2. Meet and verify any one or more of the following criteria:
   a. Complete DATA-waiver course on the management and treatment of patients with opioid use disorders as provided by an approved vendor. NPs and PAs are required to complete 24 hours of training including the 8 hour waiver training.
   b. Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.
   c. Hold an addiction certification from the American Society of Addiction Medicine.
   d. Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association.
   e. Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment.
   f. Have other training or experience that the state medical licensing board or Health and Human Services considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.
3. Submit notification of intent to SAMHSA. *http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php*

SAMHSA will send a letter within 45 days with approval status. If approved, a DEA identification number will be provided to treat up to 30 patients for the first year.

Physicians who have prescribed buprenorphine for a year can submit a second letter of intent to treat 100 patients. After treating at this patient limit for a year, physicians can apply to increase to 275 patients.

For more information: *https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management*

BUPRENORPHINE WAIVER TRAININGS

Training must be obtained from one of the following approved training providers. Different learning formats are offered at varying costs.

Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) - FREE training
(https://pcssmat.org/education-training/mat-waiver-training/)

American Academy of Addiction Psychiatry (AAAP)
(https://www.aaap.org/education-training/buprenorphine/)

American Society of Addiction Medicine (ASAM)
(https://www.asam.org/education/live-online-cme/buprenorphine-course)

American Osteopathic Academy of Addiction Medicine (AOAAM)
(http://www.aoaam.org/?page=PCSSMAT&hhSearchTerms=%22PCSS-MAT%22)

Care Coordinator

Care coordination is a critical component for effective delivery of MAT and patient care. How care coordination is provided often varies from program to program, but there are components of care coordination that are consistent across different styles, approaches and practice settings.

Care coordination often involves a range of tasks and responsibilities specific to medication assistance, including but not limited to, coordinating induction, administering drug tests, and lab screens and monitoring results, collaborating with other providers in compliance with Title 42, Part 2 of the Code of Federal Regulations (42 CFR, Part 2), and assisting patients with accessing treatment, recovery support services, and other ancillary services. Depending on the structure and capacities of the MAT setting, a case manager, medical assistant, physician's assistant, nurse, or another staff member may assume the role of care coordinator.

The most central component of successful MAT models is care coordination for patients.

Example: Using Nurses to Coordinate Patient Care

In 2003, Boston Medical Center (BMC) created the Collaborative Care Model of Office-Based Opioid Treatment also known as the Massachusetts Model in an effort to expand access to buprenorphine treatment. The model utilizes Nurse Care Managers (NCMs) to provide clinical support to waivered physicians. Specifically, the NCM is the initial contact for patients and serves as the main liaison between the patient and physician throughout treatment. The NCM is responsible for conducting the initial patient assessment to better understand the patient's medical, social, and psychiatric history; works with the patient through the induction process; provides stabilization and maintenance support through weekly appointments and telephone check-ins; and conducts urine toxicology screens and verifies behavioral health counseling. Additionally, NCMs are responsible for relapse prevention, overdose education and support for patient self-management.[1] Since the program's inception, BMC has grown to serve over 500 patients with twenty-four waivered primary care physicians.

In 2007, this model was implemented in community health centers through support provided by the Massachusetts Bureau of Substance Abuse Services (BSAS). By 2017, thirty-three health centers, in addition to BMC, were enrolled in the State Office-Based Addiction Treatment-Buprenorphine Program and the number of waivered physicians in Massachusetts increased from 24 to over 600.[2] Since the grant was disseminated across the Commonwealth over 10,000 patients have been served. Each NCM has a caseload of 125 patients (8-12 patients per day) and receives assistance from a medical assistant. Additionally, as of 2013, 67% of the patients stayed in treatment for more than twelve months and 50% for more than five years.[3]

Information obtained from Colleen LaBelle, M.S.N., RN – B.C., C.A.R.N., Director of Boston Medical Center's OBAT on February 9, 2018.

1. LaBelle, C. T.; Bergeron, L. P.; Wason, K.W.; and Ventura, A. S. Policy and Procedure Manual of the Office Based Addiction Treatment Program for the use of Buprenorphine and Naltrexone Formulations in the Treatment of Substance Use Disorders. Unpublished treatment manual, Boston Medical Center, 2018.
2. Substance Abuse and Mental Health Services Administration. Number of DATA-Certified Physicians. (2018). Retrieved from https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=MA
3. Labelle, C. et. al. Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. Journal of Substance Abuse Treatment. (2015).

The credentials held by care coordinators is secondary to their understanding of the nature of addiction and behaviors associated with this disease, in combination with a caring and problem solving approach to challenges.

Many existing MAT programs distribute responsibilities across available staff. However, treatment retention and compliance can be vastly improved through identifying one or more positions to coordinate care for all MAT patients. For MAT settings in which all services are not co-located, care coordination becomes even more critical.

Behavioral Health/Addiction Clinician

MAT combines medication assistance with behavioral health and/or SUD treatment and recovery support services such as recovery coaching and community-based support groups. Studies have found that programs providing regular, structured, SUD focused counseling had better outcomes than programs providing little or no counseling.[20] Having an on-site LADC/MLADC or a behavioral health clinician with training in the treatment of SUDs will help to encourage behavior change and will also hold patients accountable in, thereby receiving the support they will need in recovery. If the MAT program does not have SUD treatment services on-site, it will be crucial that formal agreements be established with several treatment providers offering different levels of care in an effort to support a patient's recovery. Additionally, it will be important for the care coordinator to consistently monitor treatment attendance based on program expectations and routinely provide and obtain updates from the external providers. Please refer to Section G: Psychosocial Treatment and Recovery Support Services which describes the levels of care and suggested programming.

Administrative Staff

Non-clinical and administrative staff are often responsible for obtaining patient intake information and consents, handling the billing and other accounting procedures, and most importantly, they are the first person the patient comes in contact with. Thus, it is important that these personnel receive the same education and training as clinical staff to include addiction as a disease, pharmacotherapy and stigma-related issues. Staff should also receive on-going record keeping and confidentiality training. Ensuring that the patient is welcomed into the program beginning at intake can positively influence the treatment experience.

INCENTIVES & SUPPORTS FOR RECRUITING AND RETAINING STAFF:

- Establish shared collegial patient care
- Provide on-going supervision
- Provide initial and on-going training
- Pay training and registration fees
- Ensure for practical caseloads
- Offer competitive wages

20 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

IV. B. TRAINING & RESOURCES: Provide Initial and On-Going Training & Resources

B. TRAINING & RESOURCES: Provide Initial and On-Going Training & Resources

> *...the attitude of staff members, is probably the next most important determinant of treatment effectiveness...*
>
> *(Bell 1998, p. 168)*

Patient outcomes are influenced by a variety of factors. Staff can play a significant role. It is important to ensure that the attitudes, values, and competence around MAT and interactions with patients among all staff are conducive for delivering MAT services. All staff should have on-going access to training and supervision, current literature and other resources. The following is a list of resources related to MAT best practices and service delivery models as well as resources by medication and topic area and information for accessing SUD treatment and recovery support services and other resources for patients, families and friends.

MAT BEST PRACTICE RESOURCES
The ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use • Guidelines - https://asam.org/resources/guidelines-and-consensus-documents/npg • Pocket Guide - https://asam.org/resources/guidelines-and-consensus-documents/npg/pocket-guide-and-app
SAMHSA TIP 63: Medications for Opioid Use Disorders • TIP - https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorders-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC
SAMHSA Medication Assisted Treatment of Opioid Use Disorder • Pocket Guide - https://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf
American Hospital Association, Stem the Tide: Addressing the Opioid Epidemic • Guideline - http://www.aha.org/content/17/opioid-toolkit.pdf?utm_source=eblast&utm_medium=email&utm_content=AHA_opioidtoolkit&utm_campaign=eblast-newtoolkit-11-06-17
Providers' Clinical Support System For Medication Assisted Treatment • www.pcssmat.org
MATx Mobile App by SAMHSA • https://store.samhsa.gov/product/MATx-Mobile-App-by-SAMHSA/PEP16-MATAPP
RESOURCES ON MAT MODELS
Agency for Healthcare Research and Quality, Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings • Technical Brief - https://www.ncbi.nlm.nih.gov/books/NBK402352/
Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review • Article - Korthuis, P.T. et. al. Ann Intern Med. 2017 February 21; 166(4): 268–278. doi:10.7326/M16-2149.

RESOURCES BY MEDICATION	
BUPRENORPHINE	**SAMHSA TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction** • TIP - https://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/Bookshelf_NBK64245.pdf • Quick Guide – https://store.samhsa.gov/shin/content/KAPT40/KAPT40.pdf
	Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals • Training - http://attcnetwork.org/projects/buptx.aspx
NALTREXONE	**Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide** • Guide – https://store.samhsa.gov/shin/content//SMA14-4892R/SMA14-4892R.pdf
METHADONE	**SAMHSA TIP 43: Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs** • TIP - https://store.samhsa.gov/shin/content//QGCT43/QGCT43.pdf • Knowledge Application Program Key - https://store.samhsa.gov/shin/content/SMA12-4108/SMA12-4108.pdf **Recovery-oriented Methadone Maintenance** • Monograph - http://www.williamwhitepapers.com/books_monographs/
RESOURCES BY TOPIC AREA	
Screening	**Screen and Intervene: NH S · BI · RT Playbook Version 2.1** • http://sbirtnh.org/playbook/
	Institute for Research, Education, & Training in Addictions • www.ireta.org
Assessment	**SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders** • TIP - https://store.samhsa.gov/shin/content//SMA13-3992/SMA13-3992.pdf • Quick Guide - https://store.samhsa.gov/shin/content//SMA10-4531/SMA10-4531.pdf
Induction	**The ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use** • Guidelines -https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24
	Withdrawal Scales • Clinical Opiate Withdrawal Scale (COWS) - http://www.naabt.org/documents/cows_induction_flow_sheet.pdf • Objective Opiate Withdrawal Scale (OOWS) - https://www.ncbi.nlm.nih.gov/books/NBK143183/ • Subjective Opiate Withdrawal Scale (SOWS) - http://www.buppractice.com/node/5775
Confidentiality	**Substance Use Disorder Privacy Workbook: 42 CFR Part 2** • Workbook - https://chhs.unh.edu/sites/chhs.unh.edu/files/departments/institute_for_health_policy_and_practice/pdfs/sud_privacy_part_2_idn_workbook_unh_1017.pdf
Diversion Control	**Diversion Control Protocol Template for Opioid Use Disorder Treatment Providers** • http://media.campaigner.com/media/33/333080/MAT-PDOA%206-28-17/MAT_PDOA_DiversionControlTemplate.pdf

RESOURCES BY TOPIC AREA (CONTINUED)	
Drug Testing	**Appropriate Use of Drug Testing in Clinical Addiction Medicine** • http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/11/appropriate_use_of_drug_testing_in_clinical-1-7.pdf
	Urine Drug Testing in Clinical Practice • http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/07/2012-GourlayHeit-UDT-monograph.pdf
	The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine • Webinar Series - https://elearning.asam.org/drugtestingwebinars

NH SUBSTANCE USE DISORDER TREATMENT RESOURCES
NH Statewide Addiction Crisis Line • 1-844-711-HELP (4357)
NH Alcohol and Drug Treatment Locator • www.nhtreatment.org
NH Department of Health and Human Services, Bureau of Drug and Alcohol Services Resource Guide • State-funded SUD Treatment Services - https://www.dhhs.nh.gov/dcbcs/bdas/documents/resource-guide-treatment.pdf • State-funded Recovery Support Services - https://www.dhhs.nh.gov/dcbcs/bdas/documents/recovery-resource-guide.pdf

RESOURCES FOR PATIENTS, FAMILY AND FRIENDS
SAMHSA Decisions in Recovery: Treatment for Opioid Use Disorder • https://archive.samhsa.gov/MAT-Decisions-in-Recovery/Default.aspx
ASAM Opioid Addiction Treatment: A Guide for Patients, Families and Friends • http://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece/0?
Family Resource Center • http://www.familyresourcectr.org/

IV. C. BILLING: Establish Billing Protocol

C. Establish Billing Protocol

Services can be covered through different payer/payment mechanisms to include cash and third-party payers. While cash can be collected to cover the services that are delivered, it is recommended that office-based opioid treatment programs credential with third-party payers in an effort to better support patients and their ability to access available services.

Non-Insurance Payment Model: Establish a payment structure to identify the cost of services and when and how payment will be collected. Policies on how to address late payments and patients who may not be able to pay for services in full are strongly recommended.

Third-Party Payer Reimbursement Model: Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers. The MCOs and other third-party carriers use specific strategies to help manage the prescribing of addiction medicines. It is strongly recommended that MAT programs familiarize themselves with the requirements of each carrier, and the time it takes to meet requirements prior to prescribing medication to ensure that the patient does not become responsible for unpaid claims.

For more information about third-party reimbursement, please visit:

NH Health Insurance Marketplace - http://www.nh.gov/insurance/consumers/mp_plans.htm

Premium Assistance Program (PAP) - http://www.dhhs.state.nh.us/ombp/pap/

NH Health Protection Program (NHHPP) - http://www.dhhs.nh.gov/ombp/nhhpp/

INSURANCE STRATEGIES FOR MANAGING MEDICATION ASSISTED TREATMENT [21]		
Preferred Drug List (PDL)	**Prior Authorization**	**Medical Necessity: Quantity and Duration Limits**
Identify if a medication is on the PDL.	*If a prescribed medication is not on the PDL, the provider will need to obtain a prior authorization before the medication will be paid for.*	*A provider should be aware of utilization guidelines for each medication prescribed in that restrictions may be placed on the amount prescribed and the frequency of the prescription.*

Drug utilization reviews (DURs) may be initiated by a MCO or third-party carrier in which claims documentation is reviewed against a clinical database to identify patient prescribing discrepancies (e.g., duplication of prescriptions, incompatibility with other prescriptions).

Legislation (Senate Bill 158) was passed on July 3, 2017, and went into effect on August 28, 2017, to "declare that if substance use disorder services are a covered benefit under a health benefit plan, a health carrier that has authorized or approved medication assisted treatment for such services shall not require a renewal of a prior authorization more frequently than once every 12 months."[22] A sunset clause is not in place and is, therefore, indefinite unless repealed. This legislation applies to all medication products and formulations for the treatment of opioid and alcohol use disorders.[23]

To file a complaint and to initiate an emergency appeal process, contact the Consumer Services Unit at 603-271-2261 or submit a complaint online at: https://www.nh.gov/insurance/complaints/index.htm.

21 Retrieved from CMS, SAMHSA, CDC, NIH Informational Bulletin - http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf.
22 NH State Legislature, Senate Bill 158. Retrieved from: https://legiscan.com/NH/bill/SB158/2017.
23 Technical assistance regarding SB 158 provided by Michele Merritt, Esq., President & CEO of New Futures, Inc.

IV. D. EVALUATION: Establish a Process for Assessing Patients

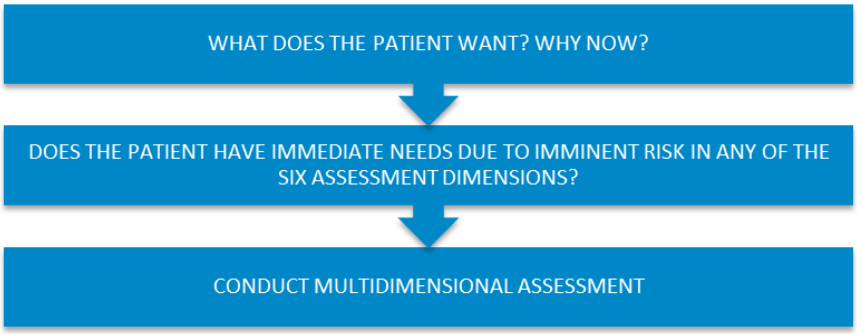
D. EVALUATION: Establish a Process for Assessing Patients

Prior to prescribing medication a thorough evaluation should be conducted with the patient to identify if he/she is an appropriate candidate for MAT and, if so, the type of medication that would be most suitable.

A clinical and medical assessment is needed to determine the level of care the patient meets. Understanding the patient's medical history, past and current use of alcohol and/or drugs, family background, environment and other factors, will help identify which medication and psychosocial treatment will be most appropriate.

It is recommended that the behavioral health clinician and prescriber be involved with the evaluation process. The following indicates the steps for conducting a thorough evaluation.[24]

1. **Conduct Patient Assessment:** Utilize evidence-based tools such as the Addiction Severity Index (ASI)[25], a semi-structured assessment tool available on the public domain, to evaluate an individual.
   a. Evaluate the patient's physical, mental, and emotional health, past and current substance use, and medical history.
   b. Identify current and past medications, allergies, pregnancy status, personal history of infectious diseases such as hepatitis, HIV, and TB, and social and environmental factors.
   c. Engage the patient in treatment by asking open-ended questions to identify his/her treatment goals.
   d. Utilize information gathered, including how patient's overall assessment aligns with ASAM criteria to assess level of care.



Sample Open-Ended Questions:

- What was your first exposure to opioids?
- Tell me about your use?
- How do you use opioids?
- What other substances do you use?
- What prescribed medicines do you take regularly?
- What medical conditions do you have or have you been treated for?
- Is there a chance you could be pregnant?
- What are your goals for treatment?
- What services and supports have been helpful to you in the past?
- What services and supports would be helpful to you?
- Who is a support to you?

24 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
25 Retrieved from the Treatment Research Institute - https://www.tresearch.org/products/assessment-and-evaluation.

The table below lists appropriate observations for each ASAM dimension that would qualify an individual for needing opioid pharmacotherapy as a component of overall treatment.

ASAM Dimensions	Observation
DIMENSION 1: Intoxication and/or Withdrawal Potential	Physiologically dependent on opiates and requires some form of treatment to assist in alleviating withdrawal symptoms. It is possible that patients will qualify for MAT without being physically dependent on opioids (i.e., diagnosis of OUD without recent use but risk of use based on cravings or environment, or periodic use in setting of addiction).
DIMENSION 2: Biomedical Conditions and Complications	None or manageable with outpatient medical monitoring
DIMENSION 3: Emotional/Behavioral/Cognitive Conditions and Complications	None or manageable in an outpatient structured environment
DIMENSION 4: Readiness to Change	Ready to embark on changes associated with abstinence
DIMENSION 5: Relapse/Continued Use/Continued Problem Potential	At risk of relapse/continued use and willing to engage in structured treatment to promote treatment progress
DIMENSION 6: Recovery Environment	Has supportive recovery environment and/or options for a stable living environment

2. **Conduct Physical Exam:** An exam should be performed by either the prescribing physician or another healthcare provider prior to prescribing medication. The exam should include identifying physical signs of opioid use, intoxication, withdrawal, and other complicating signs of SUD (e.g., abscesses, cellulitis) as well as overall physical health including nutritional status. Several opioid withdrawal scales are available to help a clinician identify and quantify OUDs. These scales include:

   a. Objective Opiate Withdrawal Scale (OOWS)[26] – Tool for determining level of withdrawal (see Appendix II: *Objective Opiate Withdrawal Scale (OOWS)).*

   b. Subjective Opiate Withdrawal Scale (SOWS)[27] – Self-reporting tool for identifying opiate withdrawal (see Appendix III: *Subjective Opiate Withdrawal Scale (SOWS)).*

   c. Clinical Opiate Withdrawal Scale (COWS)[28] – Tool for identifying signs and symptoms which integrates subjective and objective items (see Appendix IV: *Clinical Opiate Withdrawal Scale (COWS)).*

26 Retrieved from the National Institutes of Health - http://www.ncbi.nlm.nih.gov/books/NBK143183/.
27 Retrieved from buppractice - http://www.buppractice.com/node/5775.
28 Retrieved from The National Alliance of Advocates for Buprenorphine Treatment - http://www.naabt.org/documents/cows_induction_flow_sheet.pdf.

3. **Conduct Laboratory Tests/Drug Tests:** The following should be considered at the time of initial evaluation:
   a. infectious disease (tuberculosis, hepatitis A, B, C, sexually transmitted diseases and HIV);
   b. pregnancy test;
   c. blood count;
   d. drug testing; and
   e. liver function testing.

Depending on the results of these tests further follow up may be required.

Opioid Use Disorder Severity Classifications:

Mild: 2 – 3 symptoms

Moderate: 4 – 5 symptoms

Severe: 6 – 11 symptoms

4. **Determine Diagnosis:** A diagnosis of OUD must be identified before prescribing a medication. The assessment, physical exam, drug testing, and other information gathered during the evaluation process will be essential to determine the diagnosis. A patient must be diagnosed with at least a "mild" OUD, two of eleven criteria indicated in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) met by the patient within the last twelve months. A non-medical clinician can determine this diagnosis; however, the prescriber should confirm the diagnosis. The diagnosis of an SUD/OUD is followed similar to any chronic illness. It is important to review continued drug and alcohol use with patients, symptoms of craving, physical symptoms that may occur with cessation of drug use and side effects of prescribed medications. For more details, see Section E. Treatment Planning.

5. **Query PDMP:** The NH PDMP grants access to system accounts to practitioners and approved delegates so that they may enter and review controlled substance dispensing information on their patients. Per NH law, it is a requirement that prescribers review data prior to prescribing an opioid when treating or managing a patient for pain. It is essential that all prescribers review data prior to prescribing scheduled medications in an effort to ensure appropriate prescribing.
   Per NH law, each dispenser is required to submit information into the PDMP regarding each prescription dispensed for a Schedule II, III, or IV controlled substance. In accordance with transmission methods, information is to be submitted daily by the close of business on the next business day from the date the prescription was dispensed. Veterinarians shall submit the information no more than 7 days from the date the prescription was dispensed. Dispensers who have a federal DEA license, but who do not dispense controlled substances may request a waiver from the requirements of having to report to the PDMP from the board.

To register in the NH Prescription Drug Monitoring Program:

1. Open an Internet browser window and navigate to the following URL: *https://newhampshire.pmpaware.net/login*
   a. Click "Create an Account"
   b. Enter a current, valid email address
   c. Select and enter a password twice for validation (a password must contain at least 8 characters, including 1 capital letter and 1 special character (such as !, @, #, $))
   d. Click "Save and Continue"

2. At the role selection screen, expand the role categories to select the role that best fits your profession.
   a. Click "Save and Continue"

3. A message is temporarily displayed stating that an email has been sent to your email address for verification.
   a. The email will arrive in your inbox within a few minutes
   b. Within this email, click the link to verify that your email address is valid and current.

4. After validation, you will be redirected to the demographics screen.
   a. Enter your name, date of birth, employer information, and other information as configured by the PDMP Administrator (required fields are marked with a red asterisk).
   b. Please enter all active DEA numbers associated with your NH license, if applicable.
   c. Click "Submit Your Registration"

5. You will be taken to a landing page notifying you that your account is pending approval.
   a. Additional validation documents are not required, as is indicated by the "None Required" message in the "Validation Documents Required" column.

PDMP administrators will process the registration within 24 hours. If approved, notification will be sent via email to set up a password. If the request is not approved, an email with an explanation as to why registration was not approved will be sent. Please contact 603-271-6978 if you have not received some type of communication after you have submitted an application for registration.

The following table provides recommendations for when and by whom each evaluation component may be initiated.

Evaluation Components	Staff Responsible for Component	Initiation of Evaluation Component
Assessment	Behavioral Health/Addiction Clinician Strongly recommended that prescriber conduct an abbreviated assessment	Assessment may be completed over a period of a few sessions; however, a shortened version is essential at intake to identify patient history and needs necessary to prescribe the appropriate pharmacotherapy.
Physical Exam	Prescriber or other health care provider	Prior to prescribing pharmacotherapy
Lab/Drug Tests	Prescriber or other healthcare provider may order May be conducted in-house or an outside lab may be used	Prior to prescribing pharmacotherapy and ongoing
Diagnosis	Behavioral Health/Addiction Clinician Prescriber must confirm diagnosis	Prior to prescribing pharmacotherapy
PDMP Check	Prescriber or other approved designee	Prior to prescribing pharmacotherapy

Example: Promoting Individualized Care through Comprehensive Evaluation

A wide array of services to include primary care, addiction medicine and psychiatry are offered at one practice. The addiction program offers individual and group counseling and office-based opioid treatment. Prior to prescribing medication, an evaluation of the patient is conducted which takes approximately three hours. The patient meets with the intake and project coordinator who conducts a 1.5 – two-hour assessment, a half hour is spent with the addiction medicine physician who also performs a physical exam, and a one-hour psychiatric consult is provided. This comprehensive evaluation allows the care team to identify the appropriate treatment needed. The model this practice utilizes, in which all services are available, assists with the evaluation process, and also allows for patients to receive specialized and coordinated care.

Information obtained from Dr. Mark Logan, Green Mountain Family Practice Medicine, Rutland, VT in September 2015.

IV. E. TREATMENT PLANNING: Monitor Patient Progress

E. TREATMENT PLANNING: Monitor Patient Progress

After the patient has been evaluated, the prescriber will determine the appropriate medication based on information collected from the patient related to his or her history, and based on medical and social factors. A behavioral health clinician can assist with developing a plan for psychosocial treatment. The plan should be the result of shared decision-making with the patient, and may include supportive family or friends if the patient chooses.
To determine the best plan, the prescriber and clinician collaboratively review the following:

- Co-morbid medical conditions
- Socioeconomic factors (e.g., transportation, child care, employment/education)
- Medication adherence
- Setting/Level of care (e.g., more structure, frequency of visits)

If the prescriber and the clinician are not considerate of these factors, medication and psychosocial treatment adherence may be adversely affected and the patient's recovery compromised. Two respective treatment plans, one for monitoring MAT and one for behavioral health treatment, can be developed. One inclusive plan is acceptable for settings that provide both services.

The following highlights recommended components to include in the medication treatment plan and provides examples that may be included under each component. Plans should be individualized to meet the needs and goals of the patient.

MAT Treatment Plan Components	
Components	**Considerations/Examples**
Diagnosis	This diagnosis will be made with the assistance of behavioral health professionals familiar with the DSM-5 criteria for use disorders; other co-morbid diagnoses may exist and also need to be documented and addressed within the context of integrated care. (e.g., Opioid Use Disorder, severe, dependence)
Goals of Treatment	• Abstinence from illicit opioids or substances • Cessation of tobacco products • Abstinence from use of needles • Treatment completion of hepatitis C infection (if appropriate)
Treatment Objectives (over a defined period of time)	• By X week on MAT drug tests will be negative for illicit opioids
Medication Plan	• Medication prescription (type of medication, dose, and other instructions) • Participate in weekly in-person visits for first four weeks followed by… • Every other week visits with prescriber alternating with nurse care coordinator • Check-in calls once a week
Counseling Plan	• Varies by patient and site • Level of care will be determined by prescriber and behavioral health clinician

MAT Treatment Plan Components	
Recovery Support Expectations	• Participate weekly in mutual help/12 step programs • Participate in other community-based supports
Plan for Patient Participation (including for non-adherent patients, voluntary discharge, treatment completion)	• More frequent visits • Referral to higher level of care • Reduction in dose of buprenorphine • Meeting with provider and team to determine next steps

Additionally, an agreement and informed consent for medication, release of information for any agencies and other physicians and providers, induction to include labs, drug testing at each visit, and querying of the PDMP prior to visit to evaluate adherence are necessary. Completion of these components may be documented in the treatment plan at the discretion of the program.

In the event that a patient does not follow the plan and/or relapses, it is recommended that the prescriber and clinician review and revise treatment plans accordingly, rather than summarily discharging a patient. In addition to the treatment plan, a treatment agreement can be a helpful tool to clarify treatment goals, identify and reinforce expectations and promote medication adherence. A sample treatment agreement[29] for the prescribing of opioid medications is provided in Appendix V: Sample Treatment Agreement.

The length of time that a medication is prescribed for a use disorder is not defined by best practices other than to note that the longer one is treated with medication, the longer the person typically remains abstinent. There are times that the patient and the prescriber will discuss changes to the original regimen. This might be the case when the patient has made changes in his or her life compatible with recovery (avoiding triggers, involvement with healthy activities, etc.). At other times it may be necessary to make changes because the medication is not effective or causing side effects. The prescriber and the clinician can work collaboratively to determine the best way to support the patient and the regimen that will suit the individual.

There are times that family members, friends or others in the person's sphere exert pressure on the individual based on preconceived notions, opinions and inaccurate understanding of MAT. Best practice does not support weaning medication once it is started unless reviewed with the prescriber and patients' team of caregivers and all understand the risk and benefit involved.

29 Center for Substance Abuse Treatment. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. Appendix H Sample Treatment Agreement/Contract.

Sample Treatment Timeline	
Week 0	Intake, Diagnosis, Treatment Plan Development and Patient Expectation Discussion
Week 1	Induction
Week 2	Stabilize Patient
Week 3	Conduct Labs
Week 4	Review Treatment Plan
Week 6	Review Patient Progress • Drug testing should show absence of illicit substances. • If unexpected opioid noted and confirmed, then consider 1) a change in dose of buprenorphine, 2) a change in medication or 3) a higher level of care. • If other illicit substance found, recommend a higher level of care (e.g., IOP, PHP, residential). It is not recommended to discharge the patient from care nor stop medication altogether. • Review patient record (includes infectious disease review) and refer for any treatment needed (hep C, further medical work up for co-morbid diseases)
12 Weeks	Review Patient Progress • If abstinent, change diagnosis to OUD, severe (mild, moderate) in early remission.
Every 2 Weeks	Check-In Visits • Schedule 15-minute visits with counselor, recovery coach or care coordinator. • Schedule 5 -15 minutes with prescriber (longer if office does not have counselor, coach or coordinator). • Document progress on components consistent with treatment plan: ▪ Patient report of wellness/recovery ▪ Current living/housing/transportation or other potential barriers to care ▪ Psychosocial treatment progress ▪ Mutual help participation ▪ Medication adherence, side effects ▪ Substance Use (Opioids, Benzodiazepines, Alcohol, Stimulants, Other) ▪ Other substance use and plan (include nicotine use and readiness to change) ▪ Primary care follow-up needs (e.g., physical, immunizations) ▪ Co-morbid psychiatric disease ▪ Co-morbid medical issues ▪ Infectious disease
Monthly	Conduct Drug Testing
Twice Per Year	Conduct Random Drug Testing and Film/Pill Count
At 6 Months	Test for Liver Enzymes
At 12 Months	Recheck for Infectious Disease

IV. F. INDUCTION: Start Patients on Buprenorphine

F. INDUCTION: START PATIENTS ON BUPRENORPHINE

- There should be a sufficient interval (range: 6-12 hours) between the last opioid use and the first buprenorphine/naloxone dose.
- If a long-acting opioid has been used, i.e. methadone, MS Contin, or other long-acting opioid, a longer interval of at least 48 hours should be used to avoid precipitating withdrawal with buprenorphine.
- **NOTE: Starting buprenorphine while one is taking an opioid (prescribed or illicit) or if the timing is too soon after last dose of an opioid agonist, can precipitate withdrawal.**

The goal of the induction phase is to find the dose of buprenorphine that relieves the patient of craving and withdrawal symptoms. A waivered prescriber is responsible for evaluating and monitoring the patient during the induction phase. The induction phase has been described as an observed event in an office setting though many experts site home induction as effective and safe in appropriate cases.[30]

Before induction the patient should not have any signs of intoxication or sedation; drug testing needs to correlate with patient self-report. Symptoms of opioid withdrawal need to be documented. This can be evaluated using the Clinical Opiate Withdrawal Scale (COWS) (Appendix IV).

There may be situations in which induction with buprenorphine is conducted even though a patient has been free of opioids for some time and is not in acute opioid withdrawal (for example: post-detox, post-hospitalization, post-incarceration). In these cases, the COWS need not be utilized to determine timing of dosing.

Some patients may already be taking daily buprenorphine illicitly with no other opioids, as documented by drug test results. Induction may not be necessary in these cases as per the discretion of the prescriber.

Dosing of Buprenorphine:

1. The typical first dose of buprenorphine is 2/0.5 to 4/1mg and the sublingual tab/film should be observed to have dissolved completely under the tongue (this can take as long as 15 minutes).
2. Have patient demonstrate proper medication administration:
   a. Tab/film placed under tongue
   b. No food/drink during administration
   c. Allow saliva to pool in front of mouth
   d. Spit out saliva once tab/film dissolved
3. After the first dose, patients will need to wait in the office or waiting room and be checked after 30-60 minutes for adverse effects (i.e., change in mental status, difficulty breathing, hives, sedation) and to repeat the COWS to evaluate symptoms.
4. A repeat dose of 2/0.5-4/1 mg can be used 1-2 hours after the first dose if withdrawal symptoms are still present. A total first day dose of buprenorphine/naloxone should not exceed 16/4mg.
5. After the first day's induction dose the patient should be contacted and/or observed in office by designated staff.

30 Lee, J., Vocci, F., Fiellin, D. Unobserved "home" induction onto buprenorphine. Journal of Addiction Medicine. 8(5):299-308, September/October 2014.

6. Dosing should be based on the experience from induction.
    a. If symptoms were relieved, then the dose should be kept at the total dose used for induction.
    b. If symptoms were not relieved, then buprenorphine can be titrated in increments of 2/0.5-4/1 mg daily.
7. Stabilization/maintenance dosing is variable but rarely exceeds a total daily dose of 16/4 mg.

IV.

G. PSYCHOSOCIAL TREATMENT & RECOVERY SERVICES:

Identify How Substance Use Disorder Services Will Be Delivered

G. PSYCHOSOCIAL TREATMENT & RECOVERY SUPPORT SERVICES: Identify How Substance Use Disorder Services Will Be Delivered

There are three important parts to MAT: medication, SUD treatment and recovery support services and care coordination. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.[31] Additionally, to maintain a buprenorphine waiver, the prescriber must be capable of referring patients for counseling and other ancillary services.

The following chart highlights key considerations for ensuring patients receive psychosocial services.

DELIVERY OF PSYCHOSOCIAL SERVICES	
ON-SITE	**OFF-SITE**
• Hire a LADC/MLADC or behavioral health clinician who has training in the treatment of SUDs • Identify the type of treatment that will be provided (e.g., individual, group, intensive outpatient counseling) • Identify the psychosocial approaches that will be used (e.g., CBT, MET) • Determine the frequency of services • Review psychosocial treatment expectations and responsibilities with patient • Develop and routinely update treatment plan collaboratively with patient • Refer to recovery support and other ancillary services	• Establish strong working relationships or formal agreements with providers offering different levels of treatment and recovery support services • Review psychosocial treatment expectations and responsibilities with patient • Obtain signed consent form from patient to approve open communication • Routinely provide and obtain updates from the external provider to consistently monitor treatment attendance and progress

Below are the most common treatment options used in conjunction with MAT. MAT can be provided during any level of care. Advantages of group counseling over individual counseling include the opportunity for patients to interact and problem solve with their peers[32].

- **Individual Outpatient Counseling –** *Service provided by a clinician to assist an individual in achieving treatment objectives through the exploration of SUDs and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug-related problems.*
- **Group Outpatient Counseling –** *Service provided by a clinician to assist two or more individuals and/or their families/ significant others in achieving treatment objectives through the exploration of SUDs and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug-related problems.*
- **Family Counseling –** *Provides education, allows family members to express their feelings and concerns, and helps secure the family's support for the person in recovery.*
- **Intensive Outpatient Services –** *Structured individual and group alcohol and/or other treatment services and activities that are provided according to an individualized treatment plan. Services for adults are provided at least nine hours per week and services for adolescents are provided at least six hours per week.*

31 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
32 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

The following are additional treatment options available in NH.

- **Partial Hospitalization (PHP)** – *Combination of 20 or more hours per week of group and individual sessions in conjunction with, either directly or through referral, medical and psychiatric services, psychopharmacological services, addiction medication management, recovery support services and 24-hour crisis services.*
- **Residential Services** – *Program providing 24-hour support and services where an individual lives full time at the program and receives individual and/or group counseling, educational sessions and introduction to self-help groups.*

Group medical visits have been used in some MAT practices in an effort to provide treatment services more efficiently. These involve the prescriber and behavioral health/addiction clinician co-facilitating a group with a ten-minute individual medical appointment preceding or following the group.

Example: Utilizing Group Medical Visits to Provide Substance Use Disorder Treatment

An independent OBOT program uses a group medical visit approach for delivering psychosocial and medical treatment. This program is designed to be between 18-24 months. Each week patients are required to participate in a group visit which is facilitated by an addiction clinician, be involved with treatment planning, and complete a urine drug test which tests for 12 substances, including buprenorphine. The group structure is based on evidenced-based curriculum as well as some elements taken from 12 step programs. A prescriber is present during the group once a month (every 30 days) to answer and discuss any medical-related questions. Each group consists of no more than twelve people to ensure adequate opportunity for everyone to share. Before or after the group, the prescriber meets with each patient for a ten-minute check-in to review treatment plan goals, discuss medication adherence, side effects, treatment progress and concerns. This treatment model provides patients with the opportunity to problem solve and gain support from their peers while also being able to discuss medical concerns directly with the prescriber.

Information obtained from Groups, Heather Prebish, Clinical Director, on December 7, 2017.

Different treatment interventions can be used to initiative behavior change. Some approaches utilize positive reinforcement while others capitalize on readiness to change. The box to the right lists some of the more commonly used treatment interventions.

Regardless of the type of treatment or approach used, several topics are essential including:[33]

- Education about addiction and the effects of substances;
- Education about relapse prevention strategies to learn skills to attain and maintain recovery;
- Education on opioid-related health issues (e.g., HIV, Hepatitis);
- Providing linkages to existing family support systems; and
- Providing referrals to community supports.

Examples of Treatment Interventions:

- Cognitive behavioral therapy
- Motivational enhancement therapy
- Contingency management/ motivational incentives
- Community reinforcement approach
- Behavioral couples counseling

In addition to treatment services, recovery support services can be made available during any stage of a patient's recovery. Specifically, Peer Recovery Support Services (PRSS) are non-clinical services designed to help people achieve and maintain their recovery provided by people with lived experience of addiction and recovery. Many of these services can be accessed at community-based Recovery Centers.

Peer Recovery Support Services include:

Telephone Peer Recovery Support Services: Scheduled and as needed telephone contact that provides peer support and encouragement as well as information about community resources, mutual support groups and other supports that may be available to individuals in or seeking recovery.

Peer Recovery Coaching: Services provided by trained peers who serve as guides and mentors to individuals seeking or in recovery in order to assist those individuals with developing a recovery plan and removing barriers to recovery.

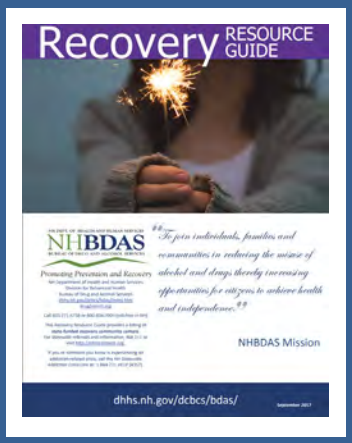
Wellness Activities: Activities vary by Recovery Center and may include gardening, yoga and meditation, financial literacy, goal setting, work readiness training and more.

Mutual Support Group Meetings: Every Recovery Center makes space available for a variety of recovery groups including Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, and family support groups.

33 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

NH Alcohol and Drug
TREATMENT LOCATOR
nhtreatment.org

The NH Alcohol and Drug Treatment Locator is an online directory for locating alcohol and drug treatment and recovery support service providers in New Hampshire who offer evaluation services, withdrawal management, outpatient counseling, residential treatment, recovery support services and other services by location, service type, population/specialties served, and/or payer.



The Treatment and Recovery Resource Guides list treatment and recovery support services funded by the NH Department of Health and Human Services, Bureau of Drug and Alcohol Services. These resource guides can be accessed at: https://www.dhhs.nh.gov/dcbcs/bdas/guide.htm.

Example: Supporting Patient Needs by Offering Multiple Pharmacotherapy and Psychosocial Treatment Options

One OTP offers a full array of SUD services to include most products and formulations of methadone, buprenorphine, and naltrexone and a variety of psychosocial treatments including residential treatment. These services are made available to patients depending on multiple factors including physiological aspects, socioeconomic factors, setting (e.g., more structure, frequency of visits), and medication adherence. Patients are required to participate in one group session per month, brief psychosocial counseling with a physician monthly, and are encouraged to participate in recovery support groups.

Information obtained from Stephen Straubing MD, DABAM, Meridian Behavioral Healthcare, Gainesville, FL. on October 8, 2015.

IV. H. DRUG TESTING: Establish Policies and Procedures

H. DRUG TESTING: Establish Policies and Procedures

Drug testing is a tool that uses a biologic sample to detect presence or absence of a specific drug as well as specific metabolites of drugs within a specified window of time. The use of drug testing provides a source of information to complement self-report, collateral reports, and provider assessments. Drug testing should be considered therapeutic and NOT punitive and used for treatment planning assistance. In addition, it can be helpful in exploring denial, motivation, and actual substance use behavior. It is important for a physician or other provider to understand the various testing techniques, their sensitivity and specificity, and cost to the medical system, insurance, and patient. It is strongly recommended that providers utilize the expertise of toxicologists or local certified Medical Review Officers (MROs) for any questions arising for their patients' individual situations.

Testing Types: Urine is the biological sample that is most widely used though tests utilizing other samples (e.g. saliva, hair, blood) are becoming more available and popular.

Testing Categories: There are two categories of drug testing: definitive and presumptive. Presumptive tests have lower sensitivity and/or specificity compared to definitive testing.

	Definitive Drug Testing (Quantitative)	Presumptive Drug Testing (Qualitative)
Test setting	• Lab	• Point of Care
Analytical method	• Gas or Liquid Chromatography	• Immunoassay
Purpose	• Confirmation	• Screening - *Any dispute of results should be definitively evaluated, especially in cases where the result may effect clinical care, legal status, or change in medication*
Advantages	• Gold standard method but can take more time to obtain results and can cost more	• Immediate results at the cost of being less accurate
For both presumptive and definitive testing it is important to understand the cut off concentrations for the substances to provide the best clinical utility.		

Documenting/Reporting Testing: The proper reporting of a drug that is prescribed and present in the test is documented as "expected". A substance that is not prescribed and present is documented as "unexpected". It would also be unexpected if a prescribed medication is not definitively detected.

Recommendations for Appropriate Use of Drug Testing in Clinical Addiction Medicine[34] *(these recommendations are not intended to substitute for independent clinical judgment)*
1. The frequency of testing should be determined based on patient situation (usually more frequent at beginning of treatment).
2. Testing should be based upon clinical indication for a broad panel of drugs; knowledge of local drug use trends can guide the choice of panels.
3. Use random drug testing over routine visit testing.
4. Use different matrices (samples) depending on the patient situation (i.e., dry mouth, shy bladder, etc.).
5. Improved sample collection and detection technologies can reduce sample adulteration and substitution.
6. Consider cost to value ratio.
7. Consider the medical necessity of test results.

Recommended Resources
Appropriate Use of Drug Testing in Clinical Addiction Medicine • http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/11/appropriate_use_of_drug_testing_in_clinical-1-7.pdf
Urine Drug Testing in Clinical Practice • http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/07/2012-GourlayHeit-UDT-monograph.pdf
The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine • Webinar Series - https://elearning.asam.org/drugtestingwebinars

34 "Smarter Drug Testing" strategies as published in a Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine by an expert panel selected by ASAM, 2017.

V.

OTHER CONSIDERATIONS

In addition to the service delivery and clinical considerations described in the previous sections, there are several overarching components to consider when providing office-based MAT. Practices are strongly encouraged to integrate these components in all aspects of service delivery in an effort to offer a successful model of care.

V. A. Confidentiality/42 CFR, Part 2

A. Confidentiality/42 CFR Part 2[35]

42 CFR Part 2 ("Part 2") are the federal SUD confidentiality regulations issued by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to protect the confidentiality of SUD treatment records. The purpose of Part 2 is to protect patients from unintended bias associated with SUDs. SAMHSA amended the Part 2 regulations effective March 21, 2017 in an effort to support integrated behavioral health models of care. SUD treatment providers must handle treatment information about SUD patients with heightened confidentiality. The Part 2 non-disclosure requirements are more strict than the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and some of these same confidentiality requirements have been adopted into New Hampshire law. In most cases, to share treatment information with a third-party (e.g. pharmacist, family, social service agencies), a SUD provider must obtain written consent from the SUD patient.

The following provides a brief summary of the Part 2 confidentiality requirements and the key issues MAT providers must think about if they need to disclose patient SUD treatment information.

Please refer to the Substance Use Disorder Privacy Workbook: 42 CFR Part 2 developed by the Health Law and Policy Programs at UNH School of Law, Institute for Health Policy and Practice, and the NH Citizens Health Initiative: (https://chhs.unh.edu/sites/chhs.unh.edu/files/departments/institute_for_health_policy_and_practice/pdfs/sud_privacy_part_2_idn_workbook_unh_1017.pdf).

Instances Not Requiring Written Consent:

- a patient is in imminent danger of harming himself/herself or others
- crimes on agency/program property
- child abuse or neglect abuse, neglect, exploitation, or self neglect of incapacitated adults
- medical emergency
- research
- audit by CMS
- court order
- internal communication
- de-identified information
- qualified service organization agreement

The heightened confidentiality obligations in Part 2 apply to the records created by a Part 2 program, or records received from a Part 2 program.

A Part 2 program* can be any of the following:

- A medical personnel or staff member who:
  - Holds themselves out as providing and does provide SUD treatment, diagnosis, or referral for treatment; or
  - Whose primary function is SUD treatment, diagnosis, or referral for treatment and is identified as such, and practices in a general medical facility; or
  - Is a NH Licensed Alcohol and Drug Counselor (LADC) providing SUD services; or
- An entity (other than a general medical facility) that holds itself out as providing and does provide SUD treatment, diagnosis, or referral for treatment; or
- A unit within a general medical facility that holds itself out as providing and does provide SUD treatment, diagnosis, or referral for treatment.

MAT providers are not automatically defined as a Part 2 program unless the providers "holds themselves out as providing" or identifies SUD treatment, diagnosis, or referral to treatment as their primary function.

*A Part 2 program is one that meets the definition and is federally assisted, which means it receives federal financial assistance of any kind, is authorized by the federal government or is tax exempt through the IRS.

35 Technical Assistance regarding 42 CFR Part 2 provided by Lucy Hodder, Director of Health Law and Policy Programs, UNH School of Law/Institute for Health Policy and Practice.

Part 2 requires the following five components, as applicable.

1. **Patient Records Security Policies** – Specific policies and procedures are required to protect patient information. Refer to page 25 of the SUD privacy workbook for more details.
2. **Notice of Privacy Rights** – Patients must receive a notice of the federal confidentiality requirements in writing immediately. Refer to page 26 and form A of the SUD privacy workbook for more details.
3. **Patient Consent Forms** – Refer to pages 27-29 and form B (pages 43-48) of the SUD privacy workbook for detailed consent instructions. Please refer to Appendix VI for a sample consent without instructions.

The consent form must include the following elements:

1. Name of Patient
2. Name of Provider
3. Type and Amount of Information to be Disclosed
4. "To Whom" the Disclosure is to be Made: Including the name of the entity if a treating provider, or the name of the individual if a non-treating provider.
5. Purpose of Disclosure
6. Date When Consent is Signed
7. Signature of Patient
8. Signature of Parent or Guardian (if applicable)
9. Signature of Individual Authorized to Sign in Lieu of the Patient (if applicable)
10. Language Regarding the Right to Revoke the Consent ("This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.")
11. Date Consent Expires

4. **Non Re-Disclosure Notices** – Any information disclosed by a Part 2 program pursuant to a written consent must be accompanied by the following disclosure language. Refer to page 30 and form C of the SUD privacy workbook.

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at Sections 2.12(c)(5) and 2.65."

5. **Qualified Service Organization (QSO) Agreements** – Part 2 providers can share SUD information with certain third parties who provide specific services to the organization pursuant to a QSO Agreement. Refer to pages 22-24 and form D of the SUD privacy workbook for more details on what type of organization can be a QSO.

V. B. Communications

B. Communications

Effective and timely communication among the prescriber and other providers and the patient is critical. The communication must be well documented, and confidential, consistent with SAMHSA confidentiality regulation *Title 42, Part 2 of the Code of Federal Regulations* (42 CFR Part 2). It is recommended that policies and practices be established for each level of communication to ensure that care is well coordinated and aligned with patient needs.

The chart below highlights several communication factors to consider.

Patient Communication	Intra-office Communication	External Communication
• Establish and review program guidelines, and expectations and medication plan • Discuss frequency of visits with prescriber and other treatment expectations • Review how to communicate with prescriber and the office outside of scheduled visits	• Identify care coordinator and the responsibilities of the position (e.g. nurse, addiction clinician, other office staff) • Document care plan in electronic record • Document office visits and drug test results • Establish routine meeting times for MAT team to discuss patient progress, challenges and administrative issues	• Establish protocol for written and oral communication between prescriber and primary care provider and clinician (if not located in practice) and incorporate into electronic medical record • Determine responsibility for monitoring adherence to program, need for change in treatment plan, etc. • Collaborate with other health care providers who are managing concurrent health problems that are complicated by the patient's MAT (e.g., pregnancy, surgical procedures requiring pain control)

V. C. Stigma

C. Stigma

Addiction is highly stigmatized on many fronts. Similarly, MAT can be a controversial issue. Some professionals in the field, as well as individuals in recovery, do not support the use of medication and consider methadone, buprenorphine and naltrexone as "replacing one drug for another". It is important for all staff to recognize that:

1. addiction is a chronic, relapsing disease;
2. on-going support will be needed to help a person reach their recovery goals;
3. treatment may require the use of medications, low- or high-intensity SUD treatment and/or recovery support services;
4. the use of medication in conjunction with treatment and recovery supports is reinforced by literature in reducing the risk of relapse, overdose and death and is superior in efficacy to not being on a prescription; and
5. people are at a higher risk of addiction because of their genes, temperament, or personal situation.[36]

People who have an addiction are often extremely sensitive to the stigma attached to this disease and may also self-stigmatize due to feelings of guilt and shame. This stigma may be reinforced by past treatment they have received from medical providers, thus making them cautious about trust and open communication. Providers need to recognize this reluctance and train all staff to avoid stigmatizing language and behavior. Using person first language, e.g. person with a substance use disorder or opioid use disorder, and appropriate medical terminology, e.g. "unexpected" results related to drug testing rather than "dirty" results, is important. Stronger than the language that you use is the attitude that you convey through your interactions. It is necessary to:

- Be recovery-oriented rather than disease-oriented.
- Treat each patient with respect.
- Recognize and celebrate all levels of progress.

If patients express concerns about stigma, reassure them that they have a disease in the same way that others may have diabetes, hypertension or other chronic conditions. In each of these cases, a treatment plan is developed which may include the use of medications. Commend efforts to seek help and participate in the necessary treatment to reach recovery goals.

Remember: You are not just providing medical treatment for an OUD. You are also dispensing hope and a belief that recovery is possible for this particular patient.

36 Substance Abuse and Mental Health Services Administration. Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends.

VI.

APPENDICES

Appendix I: MAT Quality Planning Tool

Appendix II: Objective Opiate Withdrawal Scale (OOWS)

Appendix III: Subjective Opiate Withdrawal Scale (SOWS)

Appendix IV: Clinical Opiate Withdrawal Scale (COWS)

Appendix V: Sample Treatment Agreement

Appendix VI: Consent Form

APPENDIX I: MAT Quality Planning Tool

To download a fillable form, visit:
http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2018/04/FINAL_MAT_Quality_Planning_Tool_3-30-18.pdf

I. PROGRAM DEVELOPMENT

STAFFING

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed & Regularly Implementing	Not Applicable		
1. Establish a core team to deliver MAT (to include at least one prescriber, behavioral health clinician, care coordinator, administrative support)	# of Prescribers # of Non-Prescribing Healthcare Providers # of BH Clinicians # of Care Coordinators	☐	☐	☐	☐	☐		17 - 21
2. Develop clearly defined, written roles and responsibilities for each member of the MAT team	Written Protocol (e.g. workflow, job descriptions)	☐	☐	☐	☐	☐		17 - 21
3. Ensure prescribers become waivered to prescribe buprenorphine	Total # of Waivered Prescribers # of MDs/Dos # of NPs # of PAs	☐	☐	☐	☐	☐		19
4. Provide training to each prescriber on FDA approved opioid and alcohol use disorder medications (e.g. pharmacotherapy, contraindications)	# and Types of Trainings % of Providers in Attendance by Provider Type	☐	☐	☐	☐	☐		23 - 25
5. Provide initial training and resources related to substance use disorders and MAT to all staff, including administrative staff	# and Types of Trainings % of Staff in Attendance	☐	☐	☐	☐	☐		23 - 25

APPENDIX I: MAT Quality Planning Tool

I. PROGRAM DEVELOPMENT

POLICY AND PROCEDURES

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed & Regularly Implementing	Not Applicable		
6. Develop procedures to evaluate patients for eligibility onto MAT (e.g. screening, assessment, physical exam)	Documentation of Procedures Assessment Instrument Identified Screening Tool Identified	☐	☐	☐	☐	☐		30 - 34
7. Establish a process to routinely review and share PDMP data with prescriber (e.g. frequency, person responsible for checking PDMP)	Written Procedure Documentation of Checklist of Items to Review in PDMP Role Identified for Checking and Sharing Data	☐	☐	☐	☐	☐		32 - 33
8. Develop drug testing policies and procedures (e.g. frequency, testing type, responding to expected and unexpected test results, method of collection)	Documentation of Drug Testing Policy	☐	☐	☐	☐	☐		48 & 49
9. Develop written induction procedures	Documentation of Induction Procedures	☐	☐	☐	☐	☐		40 & 41
10. Establish billing policies and procedures	Documentation of Billing Policy	☐	☐	☐	☐	☐		27 & 28
11. Establish policies and procedures specific to communicating with team, external providers, and patients (e.g. confidentiality, documentation)	Documentation of Communication Policies	☐	☐	☐	☐	☐		55
12. Develop diversion control policies and procedures	Documentation of Diversion Policy	☐	☐	☐	☐	☐		24
13. Create patient consent form that is compliant with 42 C.F.R., part 2 requirements	Consent Form	☐	☐	☐	☐	☐		52 & 53
14. Create patient treatment agreement	Treatment Agreement	☐	☐	☐	☐	☐		37
15. Establish continued patient practice participation guidelines (including for non-adherent patients, voluntary discharge, treatment completion)	Documentation of Continued Patient Practice Participation Guidelines	☐	☐	☐	☐	☐		36 - 38

APPENDIX I: MAT Quality Planning Tool

I. PROGRAM DEVELOPMENT

OTHER INFRASTRUCTURE NEEDS

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed & Regularly Implementing	Not Applicable		
16. Make modifications to electronic health record to collect, track, and measure patient outcomes	Description of New Fields Added Successful retrieval of data (e.g. data reports)	☐	☐	☐	☐	☐		program specific
17. Establish agreements with external behavioral health providers	Written Agreement(s)	☐	☐	☐	☐	☐		43 - 46
18. Establish agreements with external peer recovery support service providers	Written Agreement(s)	☐	☐	☐	☐	☐		43 - 46
19. Establish collaborative relationships with ancillary service providers (e.g. transportation, childcare)	Written Agreement(s)	☐	☐	☐	☐	☐		43 - 46
20. Identify process for determining treatment and recovery support and social service resources	Resources Identified	☐	☐	☐	☐	☐		43 - 46
21. Determine mechanism for referring patients to higher levels of care and other supports, as needed	Role Identified for Managing Referrals	☐	☐	☐	☐	☐		43 - 46

APPENDIX I: MAT Quality Planning Tool

II. PROGRAM IMPLEMENTATION

STAFFING

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed & Regularly Implementing	Not Applicable		
22. Establish team meetings at least once a week	Regular Meeting Time # of Meetings Held	☐	☐	☐	☐	☐		55

II. PROGRAM IMPLEMENTATION

TRAINING

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		No Staff Trained/ Informed	Some Staff Trained/ Informed	Most Staff Trained/ Informed	All Staff Trained/ Informed	Not Applicable		
23. Provide ongoing training and resources related to substance use disorders and MAT to all staff, including administrative staff	# and Types of Trainings % of Staff in Attendance	☐	☐	☐	☐	☐		23 - 25
24. Assess patients using ASAM dimensions	Assessment Instruments Used	☐	☐	☐	☐	☐		30 & 31
25. Screen patients routinely for co-occurring disorders	Screening Tool(s) Used Documentation of Screening Results	☐	☐	☐	☐	☐		36 - 38
26. Conduct physical exam, at a minimum identifying for Intoxication, impairment or withdrawal	Documentation of Physical Exam Documentation of Withdrawal Risk Assessment(s)	☐	☐	☐	☐	☐		31
27. Draw labs to include testing for infectious disease, pregnancy, liver function and blood counts	Documentation of Lab Results	☐	☐	☐	☐	☐		32
28. Conduct drug tests	Documentation of Test Results	☐	☐	☐	☐	☐		48 & 49
29. Determine diagnosis of opioid use disorder	Documentation of Diagnosis	☐	☐	☐	☐	☐		30 - 34
30. Query PDMP	Documentation of PDMP Review (e.g. field in EHR, administrative note)	☐	☐	☐	☐	☐		32 & 33
31. Inform patients about MAT medications available and recommended as most appropriate	Documentation of Discussion	☐	☐	☐	☐	☐		36

APPENDIX I: MAT Quality Planning Tool

II. PROGRAM IMPLEMENTATION

TREATMENT DELIVERY

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		None of the Time	Some of the Time	Most of the Time	All of the Time	Not Applicable		
32. Develop written individualized treatment plan with each patient	Documentation of Treatment Plan	☐	☐	☐	☐	☐		36 - 38
33. Obtain signed treatment agreement from all patients	Signed Agreement	☐	☐	☐	☐	☐		37
34. Obtain signed 42 CFR Part 2 compliant consent forms from all patients to allow for communication with external providers	Signed Consent Forms	☐	☐	☐	☐	☐		52 & 53
35. Start patient on medication assisted treatment (induct as needed)	Documentation of Induction	☐	☐	☐	☐	☐		40 & 41
36. Schedule patients with routine prescriber visits based on treatment progress/recovery status and other factors	Progress Notes	☐	☐	☐	☐	☐		36 - 38
37. Query the PDMP each time a prescription is written	Documentation of PDMP Check	☐	☐	☐	☐	☐		32 & 33
38. Conduct drug tests	Documentation of Test Results	☐	☐	☐	☐	☐		48 & 49
39. Conduct random drug tests	Documentation of Test Results	☐	☐	☐	☐	☐		48 & 49
40. Conduct random pill/ film counts	Documentation of Random Check	☐	☐	☐	☐	☐		36 - 38
41. Review treatment plan at every visit for each patient	Documentation of Review	☐	☐	☐	☐	☐		36 - 38
42. Update treatment plan as needed for each patient	Documentation of Updated Treatment Plan	☐	☐	☐	☐	☐		36 - 38
43. Actively refer patients to SUD treatment services as needed	Documentation of Treatment Services #/% of Patients Referred to Treatment Services #/% of Referrals By Level of Care	☐	☐	☐	☐	☐		43 - 46
44. Actively refer patient to peer recovery support services as needed	Documentation of Recovery Support Services #/% of Patients Referred to Recovery Support Services	☐	☐	☐	☐	☐		43 - 46

APPENDIX I: MAT Quality Planning Tool

II. PROGRAM IMPLEMENTATION

TREATMENT DELIVERY (CONTINUED)

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		None of the Time	Some of the Time	Most of the Time	All of the Time	Not Applicable		
45. Provide care coordination to patients for other needs (e.g. mental health provider, primary care services)	Documentation of Care Coordination #/% of Patients Referred to Other Services #/% of Referrals By Service Type	☐	☐	☐	☐	☐		20 & 21
46. Communicate regularly with external provider(s)	Documentation of Communication with External Provider(s)	☐	☐	☐	☐	☐		55
47. Provide routine support to patients outside of office visits (e.g. phone check-ins)	Documentation of Communication	☐	☐	☐	☐	☐		36 - 38

APPENDIX II: Objective Opiate Withdrawal Scale (OOWS)

Observe the patient during a 5 minute observation period then indicate a score for each of the opioid withdrawal signs listed below (items 1-13).
Add the scores for each item to obtain the total score

DATE							
TIME							

1	**Yawning** 0 = no yawns 1 = ≥ 1 yawn							
2	**Rhinorrhoea** 0 = < 3 sniffs 1 = ≥ 3 sniffs							
3	**Piloerection** (observe arm) 0 = absent 1 = present							
4	**Perspiration** 0 = absent 1 = present							
5	**Lacrimation** 0 = absent 1 = present							
6	**Tremor** (hands) 0 = absent 1 = present							
7	**Mydriasis** 0 = absent 1 = ≥ 3 mm							
8	**Hot and cold flushes** 0 = absent 1 = shivering / huddling for warmth							
9	**Restlessness** 0 = absent 1 = frequent shifts of position							
10	**Vomiting** 0 = absent 1 = present							
11	**Muscle twitches** 0 = absent 1 = present							
12	**Abdominal cramps** 0 = absent 1 = Holding stomach							
13	**Anxiety** 0 = absent 1 = mild - severe							
	TOTAL SCORE							

Source: Handelsman et. al, 1987

APPENDIX III: Subjective Opiate Withdrawal Scale (SOWS)

Please indicate if you are having any of the following withdrawal symptoms by rating its severity.							How long **AFTER** your last dose did you begin to feel this symptom?
	Symptom	Not at all	A Little	Moderate	Quite a bit	Extremely	Onset (hrs)
1	**Anxious/Nervous**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
2	**Body Aches & Pains**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
3	**Constipation**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
4	**Diarrhea**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
5	**Drug Hunger/Craving**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
6	**Goosebumps**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
7	**Hot/Cold Flashes**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
8	**Muscle Twitching**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
9	**Nausea**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
10	**Restlessness**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
11	**Runny Nose**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
12	**Sedation/Sleepiness**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
13	**Shaking**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
14	**Stomach Cramps**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
15	**Sweating**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
16	**Teary Eyes**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
17	**Vomiting**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
18	**Yawning**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24
	Total						

Mild withdrawal is considered to be a score of 1-10.
Moderate withdrawal is considered to be a score of 11-20.
Severe withdrawal is considered to be 21-30.

Adapted from: Handelsman, L., Cochrane, K.J., Aronson, M.J. et al. (1987) Two New Rating Scales for Opiate Withdrawal, American Journal of Alcohol Abuse, 13, 293-308

APPENDIX IV: Clinical Opiate Withdrawal Scale (COWS)

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Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. *For example*: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____ Date: _____

Buprenorphine Induction: _____

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Times of Observation:			
Resting Pulse Rate: Record Beats per Minute				
Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below • 2 = pulse rate 101-120 1 = pulse rate 81-100 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity				
0 = no report of chills or flushing • 3 = beads of sweat on brow or face 1 = subjective report of chills or flushing • 4 = sweat streaming off face 2 = flushed or observable moistness on face				
Restlessness Observation During Assessment				
0 = able to sit still • 3 = frequent shifting or extraneous movements of legs/arms 1 = reports difficulty sitting still, but is able to do so • 5 = Unable to sit still for more than a few seconds				
Pupil Size				
0 = pupils pinned or normal size for room light • 2 = pupils moderately dilated 1 = pupils possibly larger than normal for room light • 5 = pupils so dilated that only the rim of the iris is visible				
Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored				
0 = not present • 2 = patient reports severe diffuse aching of joints/muscles 1 = mild diffuse discomfort • 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies				
0 = not present • 2 = nose running or tearing 1 = nasal stuffiness or unusually moist eyes • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour				
0 = no GI symptoms • 3 = vomiting or diarrhea 1 = stomach cramps • 5 = multiple episodes of diarrhea or vomiting 2 = nausea or loose stool				
Tremor Observation of Outstretched Hands				
0 = no tremor • 2 = slight tremor observable 1 = tremor can be felt, but not observed • 4 = gross tremor or muscle twitching				
Yawning Observation During Assessment				
0 = no yawning • 2 = yawning three or more times during assessment 1 = yawning once or twice during assessment • 4 = yawning several times/minute				
Anxiety or Irritability				
0 = none • 2 = patient obviously irritable/anxious 1 = patient reports increasing irritability or anxiousness • 4 = patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh Skin				
0 = skin is smooth • 5 = prominent piloerection 3 = piloerection of skin can be felt or hairs standing up on arms				
Score: 5-12 = Mild 13-24 = Moderate 25-36 = Moderately Severe More than 36 = Severe Withdrawal	Total score			
	Observer's initials			

The National Alliance of Advocates for Buprenorphine Treatment
PO Box 333 • Farmington, CT 06034 • MakeContact@naabt.org
naabt.org

*Source: Wesson et al. 1999.

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APPENDIX IV: Clinical Opiate Withdrawal Scale (COWS)

naabt.org

The National Alliance of Advocates for Buprenorphine Treatment

Precipitated Withdrawal. What it is. How to avoid it.

What Is Precipitated Withdrawal?

It is a **rapid and intense onset** *of withdrawal symptoms initiated by a medication.* In the case of Buprenorphine, because it has a higher binding strength at the opioid receptor, it competes for the receptor, "kicks off" and replaces existing opioids. If a significant amount of opioids are expelled from the receptors and replaced, the opioid physically dependent patient will feel the rapid loss of the opioid effect, initiating withdrawal symptoms.

More precisely, precipitated withdrawal can occur when an antagonist (or partial agonist, such as Buprenorphine) is administered to a patient who is physically dependent on full agonist opioids. Due to the high *affinity* but low *intrinsic activity* of Buprenorphine at the μ-receptor, the partial agonist displaces full agonist opioids from the μ-receptors, but activates the receptor to a *lesser* degree than full agonists which results in a net *decrease* in agonist effect, thereby precipitating withdrawal.[1]

Full Agonist Opioid. Perfect receptor fit. Maximum intrinsic activity (opiate effect).

Partial Agonist Opioid (Buprenorphine). Imperfect Fit. Less intrinsic activity (opiate effect).

A common misconception is that the naloxone in the buprenorphine/naloxone combination medication initiates precipitated withdrawal. Naloxone may only initiate withdrawal if *injected* into a person physically dependent on opioids. Taken sublingually, as directed, naloxone is clinically insignificant and has virtually no effect. (Except in rare cases of an allergic reaction or naloxone hypersensitivity.[2])

Avoiding Precipitated Withdrawal

Patient education and developing realistic expectations are essential before beginning treatment.

To **avoid** precipitated withdrawal, physically dependent patients must no longer be experiencing the agonist effects of an opioid. One way to gauge this is to observe objective symptoms of withdrawal sufficient to score a minimum of 5 to 6 on the COWS (Clinical Opioid Withdrawal Scale). Scores of >10 are preferable. Due to patient individuality, required abstinent times may vary considerably from patient to patient. Only use the time since last use as an estimate to anticipate the onset of withdrawal symptoms.[4]

The **induction begins** by assessing last use of all opioids, short and long acting, objective and subjective symptoms and a COWS score calculation. If not in sufficient withdrawal (mild to moderate: COWS of 5 to 24), it is in the patient's best interest to wait. Long-acting opioids will require a longer period of abstinence, than short-acting opioids.

Short-acting Opioids

(Heroin, Crushed OxyContin®, Percocet®, Vicodin®, Oxycodone and others)

Prior to induction, patients must abstain from all short-acting opioids for 12 to 24 hours ***and/or*** have objective withdrawal symptoms sufficient to produce a score of 5 to 24 on the COWS.[1]

Long-acting Opioids

OxyContin® (Taken Orally)

Discontinue use for at least 24 hours prior to induction. A minimal score of at least 5 on the COWS is recommended, although some physicians prefer scores of 15 or higher.[5]

Methadone

It is recommended that patients transitioning from methadone to Buprenorphine slowly taper to 30 mg./day of methadone, for at least one week. Last dose must be no less than 36 hours prior to induction, and may be 96 hours or more. A minimal score of at least 5 on the COWS is recommended, although some physicians prefer scores of 15 or higher.[5]

Patients transferring from methadone or another long-acting opioid to Buprenorphine may experience discomfort for several days and dysphoria for up to 2 weeks.[3]

The **goal of induction** is to safely suppress opioid withdrawal as rapidly as possible with adequate doses of Buprenorphine. Failure to do so may cause patients to use opioids or other medications to alleviate opioid withdrawal symptoms or may lead to early treatment dropout.[3] To achieve this, some physicians have found they may need to dose as high as 32 mgs. the first day with some methadone to Buprenorphine transfers.[5]

[1] Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40.* DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. http://naabt.org/links/TIP_40_PDF.pdf

[2] FDA. Full Prescribing Information on Subutex® (buprenorphine)/ Suboxone® (buprenorphine/naloxone) www.fda.gov/cder/foi/label/2002/20732lbl.pdf

[3] *Dosing Guide Maintenance therapy for Opioid Dependence.* Suboxone®/Subutex® www.suboxone.com/pdfs/DosingGuides.pdf

[4] *Practical Considerations for the use of Buprenorphine* Hendrée E. Jones, Ph.D., Johns Hopkins University School of Medicine, Baltimore, MD

[5] Physician Clinical Support System: www.pcssmentor.org *Transfer from Methadone to Buprenorphine,* Paul P. Casadonte, MD, PCSS guidance paper, 8/9/2006 http://www.pcssmentor.org/pcss/documents2/PCSS_MethadoneBuprenorphineTransfer.pdf

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APPENDIX V: Sample Treatment Agreement

Sample Treatment Agreement

Treatment agreements are often employed in the treatment of addiction to make explicit the expectations regarding patient cooperation and involvement in the treatment process. Below is a sample addiction treatment agreement that may be a useful tool in working with patients in an office-based setting.

As a patient receiving opioid use disorder treatment with [medication name], I freely and voluntarily agree to accept this treatment agreement, as follows:

- ☐ I agree to keep, and be on time to, all my scheduled appointments with the prescriber and other providers.
- ☐ I agree to conduct myself in a courteous manner in the office.
- ☐ I agree not to arrive at the office intoxicated or under the influence of substances. If I do, the provider will not prescribe any medication until my next scheduled appointment.
- ☐ I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
- ☐ I agree not to deal, steal, or conduct any other illegal or disruptive activities in the office.
- ☐ I agree that my medication (or prescriptions) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
- ☐ I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
- ☐ I agree not to obtain medications from any prescribers, pharmacies, or other sources without informing my treating prescriber. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.
- ☐ I agree to take my medication as instructed and not to alter the way I take my medication without first consulting my prescriber.
- ☐ I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in psychosocial treatment and recovery support services to support my recovery.

Patient Name: _____

Patient Signature: _____Date: _____

Center for Substance Abuse Treatment. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2004. (Treatment Improvement Protocol (TIP) Series, No. 40.) Appendix H Sample Treatment Agreement/ Contract. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64238/

APPENDIX VI: Consent Form

Draft 2017- For Reference Purposes Only
For Use and Review by IDNs Participating in UNH Privacy Bootcamp
SAMHSA has promised but has not yet published sub-regulatory guidance or draft Forms consistent with the 42 CFR Part 2 regulations published January 2017. Any Form should be reviewed with and revised by your provider's leadership/compliance team and counsel as necessary.

School of Law / Institute for Health Policy & Practice
Health Law & Policy

SUBSTANCE USE DISORDER SERVICES:

AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

DRAFT Form B

Name: _____ Date of Birth:_____

Medical Record # (if known):_____

I understand my care providers at ***[Name of SUD/Part 2 ENTITY making disclosure]***_____[*If part of hospital system, include affiliated entities if necessary, i.e., "I am a patient of Mount Ida Primary care, Mount Ida Capital partners and affiliated entities"]* will be providing and helping to coordinate aspects of my care and treatment and will therefore need to share certain private health information about my referral, diagnosis and/or treatment for substance use disorder [and mental health] with my treatment team, with other treating providers, with other individuals or entities involved in my care and/or recovery, with entities responsible for payment and with others listed below as authorized by me or by law.

I authorize [my Part 2 Program treatment team] to access, use, disclose and communicate both verbally and in writing, private substance use disorder and mental health information [*which is maintained as part of my integrated electronic health record*], including:
[Check all the apply]

- ☐ My health care record
- ☐ Intake, progress and discharge reports and notes
- ☐ Evaluations and assessments by my providers
- ☐ Test, lab and radiology results
- ☐ Referrals for treatment
- ☐ Medications
- ☐ Case management and treatment plans (including addendums)
- ☐ *Other:(specify)*_____
- ☐ *Other:(specify)*_____

Substance Use Disorder Privacy Workbook: 42 CFR Part 2. Draft consent form. Health Law and Policy Programs at UNH School of Law, Institute for Health Policy and Practice, and the NH Citizens Health Initiative Accessed at: https://chhs.unh.edu/sites/chhs.unh.edu/files/departments/institute_for_health_policy_and_practice/pdfs/sud_privacy_part_2_idn_workbook_unh_1017.pdf

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I understand disclosures and re-disclosures both verbally and in writing may be made to and from my past, current and/or future treating providers for the purpose of *my ongoing treatment and recovery and helping me manage my care*, including but not limited to:
[Check all that apply]

- ☐ My Care Coordinator(s) at: _____
- ☐ [IDN Treating Provider Entity 1]
- ☐ [IDN Treating Provider Entity 2]
- ☐ [IDN Treatment Provider Entity 3]
- ☐ [IDN Treatment Provider Entity 4]
- ☐ [IDN Treatment Provider Entity 5]
- ☐ [IDN Treatment Provider Entity 6]
- ☐ [IDN Treatment Provider Entity 7]
- ☐ *Other: (specify)*_____
- ☐ *Other:(specify)*_____

I also authorize [my treatment team] to access, use, disclose and communicate both verbally and in writing the following private substance use disorder and mental health information [*which is maintained as part of my integrated electronic health record*], including:
[check all that apply]

- ☐ My medical events, care management plan and medication list
- ☐ My attendance at my recovery program
- ☐ Information confirming my compliance with my care and recovery plan
- ☐ *Other:*_____
- ☐ *Other:*_____

To and from the following individuals involved in my well-being and recovery:

- ☐ [My treating providers through the [Health Information Exchange]]: (Name/Title of Supervisor of HIE)_____
- ☐ Agency: (Title/Name of Individual/Tel #)_____
- ☐ Agency: (Title/Name of Individual/Tel #) _____
- ☐ Agency: (Title/Name of Individual/Tel #)_____
- ☐ Agency: (Title/Name of Individual/Tel #)_____
- ☐ *Other:*_____
- ☐ *Other:* _____

For the purpose of: [check all that apply]

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☐ Monitoring and supporting my ongoing recovery
☐ Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training
☐ Confirming compliance with court ordered treatment, probation or parole
☐ For the purpose of the care and treatment of my children
☐ *Other:*_____
☐ *Other:*_____

I authorize [my treatment team] to use, disclose and communicate both verbally and in writing any and all information about my care and treatment to and from my health insurance company or other entity responsible for my medical bills for the purpose of eligibility and payment. *[Either insert the name of the payer or refer to your program's policy regarding notification of payment]:*
_____

Authorization to Discuss Health Status with Family, Friends or Advocates Members
If I am not present or available, I authorize [ENTITY] affiliated treating providers and staff to discuss my relevant health information, including my substance use disorder [and mental health] treatment, with the family members, friends and/or advocates named below.

Authorized individuals (please provide full names):

Name: _____ Tel #_____
Name: _____ Tel#_____
Name: _____ Tel #_____
Name: _____ Tel#_____
Name: _____ Tel #_____
Name: _____ Tel#_____

Acknowledgement of Rights
I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the

APPENDIX VI: Consent Form

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Health Law & Policy
SAMHSA has promised but has not yet published sub-regulatory guidance or draft Forms consistent with the 42 CFR Part 2 regulations published January 2017. Any Form should be reviewed with and revised by your provider's leadership/compliance team and counsel as necessary.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if my treating providers disclose my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of non-disclosure.

I also understand that I may revoke this consent, orally or in writing by contacting [APPROPRIATE ENTITY INFORMATION MANAGEMENT OFFICE_____] at [PHONE NUMBER_____] at any time except to the extent that action has been taken in reliance on it. We are unable to take back any disclosures we have already made with your consent and we are required to retain as records of the care we provide to you.

If not already revoked, this consent will expire on _____ *[Example: One year/specified date/upon my death.]*

Upon request, I can inspect or obtain a copy of the information I am authorizing to be released.

[I understand that I may be denied services if I refuse to consent to a disclosure for purposes of my treatment [or payment]. I will not be denied services if I refuse to consent to a disclosure for other purposes.][1]

If I have any questions about disclosure of my private health information, I can contact _____ at [PHONE NUMBER].

I understand I can ask for a copy of this authorization and consent form.

_____ _____
Signature of Patient or legal representative or guardian Date and Time

_____
Authority/Relationship of representative to patient
(Attach copy of documentation of authority)

[1] This provision is not necessary and may be different depending upon the type of provider offering services.

ICSI Institute for Clinical Systems Improvement

Health Care Guideline

Depression in Primary Care

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Health Care Guideline:
Adult Depression in Primary Care

Seventeenth Edition
March 2016

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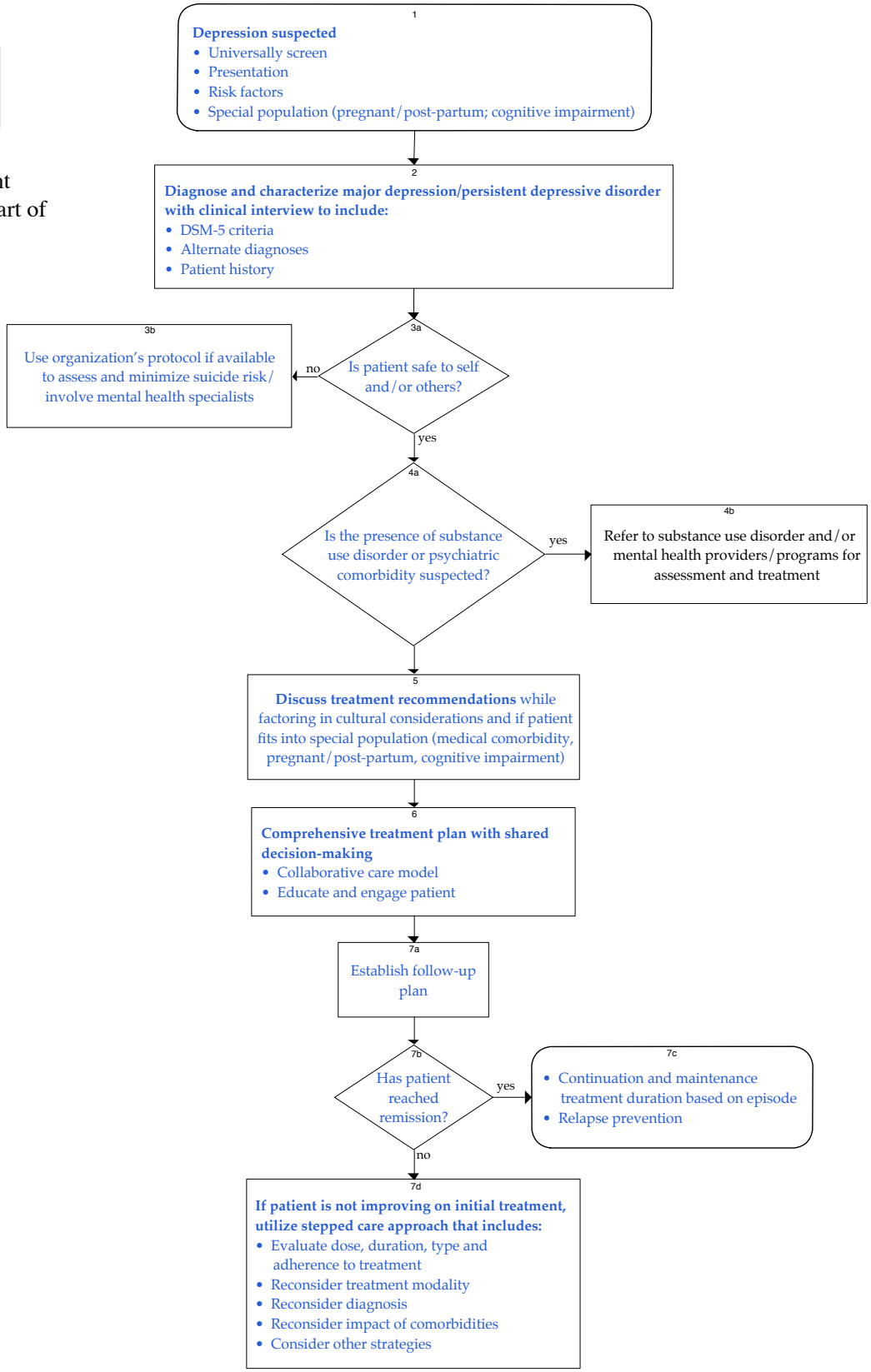

Return to Table of Contents

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Table of Contents

Work Group Leader
Michael Trangle, MD
Psychiatry, HealthPartners Medical Group and Regions Hospital

Work Group Members
Allina Medical Clinic
Daniel Kessler, LP
Psychology

Essentia Health
Jeffrey Hardwig, MD
Psychiatry
Todd Hinnenkamp, RN
Internal Medicine

Fairview Health Services
Robert Haight, PharmD, BCPP
Pharmacy

Mayo Clinic
Mioki Myszkowski, MD
Family Medicine

North Memorial Health Care
Nicky Mack, RN
Family Medicine

Olmsted Medical Center
Jeffrey Gursky, MD
Psychiatry

ICSI
Jodie Dvorkin
Project Manager/Health Care Consultant
Senka Hadzic
Clinical Systems Improvement Facilitator

Algorithms and Annotations 1-57
- Algorithm 1
- Evidence Grading 3-4
- Foreword
  - Introduction 5-6
  - Scope and Target Population 7
  - Aims 7
  - Recommendations Table 8-10
  - Summary Table of Recommendations for Major Depressive Disorder and Persistent Depressive Disorder 11
  - Implementation Recommendation Highlights 12-13
  - Related ICSI Scientific Documents 13
- Annotations 14-57

Quality Improvement Support 58-83
- Aims and Measures 59-60
  - Measurement Specifications 61-76
- Implementation Recommendations 77-78
- Implementation Tools and Resources 79
- Implementation Tools and Resources Table 80-83

Supporting Evidence 84-125
- References 85-105
- Appendices 106-125
  - Appendix A – Patient Health Questionnaire (PHQ-9) 106-107
  - Appendix B – ICSI Shared Decision-Making Model 108-114
  - Appendix C – Specialized Therapies 115-117
  - Appendix D – Special Populations 118-125

Disclosure of Potential Conflicts of Interest 126-128

External Review and Acknowledgements 129

Document History and Development 130-131
- Document History 130
- ICSI Document Development and Revision Process 131

Evidence Grading

Literature Search

A consistent and defined literature search process is used in the development and revision of ICSI guidelines. Two literature searches were conducted for this guideline. The searches were conducted in PubMed, Ovid and PsychInfo.

The first search included systematic reviews, meta-analyses, randomized controlled trials and observational studies from January 2013 – February 2015. The search was limited to adults over 18 years of age. The search excluded animal studies and non-English language studies. The terms included screening; patient health questionnaire-9 (PHQ-9); insomnia; therapeutic alliance in depressed patients; psychotherapies; antidepressants; implementation and best practices; special populations and disparities; telepsychiatry and outcomes; complementary medicine; integrated care, coordinated care, collaborative care; continuity of patient care, follow-up, office visits and frequency; effective treatments for adults with major depression who also have diabetes; prevalence and treatment of depression in patients who had stroke; after care; follow-up; remission; remission induction; functional impairment; cognitive impairment; genomics, genetics and pharmacogenetics; shared decision-making; and TMS (transcranial magnetic stimulation).

The second literature search was specific to treatment recommendations for major depressive disorder and persistent depressive disorder and included systematic reviews, meta-analyses and randomized controlled trials. It covered the period between January 2005 and September 2015 and was limited to adults over 18 years of age. The search excluded animal studies and non-English language studies. The terms included treatment, treatment outcomes and multiple treatment comparison; psychological treatment and supportive therapy, cognitive behavioral therapy; antidepressant agents, pharmacotherapy and drug therapy; combined treatment; duration of treatment, acute phase, continuation phase, maintenance phase; depression and major depression; dysthymia disorder and persistent depressive disorder, chronic depression and chronic major depression.

In addition to the literature searches, articles were obtained by work group members and ICSI staff. Those vetted by the work group were included in the guideline when appropriate.

Return to Table of Contents

GRADE Methodology

ICSI utilizes the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology system.

GRADE has advantages over other systems including the former system used by ICSI. Advantages include:

- development by a widely representative group of international guideline developers;
- explicit and comprehensive criteria for downgrading and upgrading quality of evidence ratings;
- clear separation between quality of evidence and strength of recommendations that includes a transparent process of moving from evidence evaluation to recommendations;
- clear, pragmatic interpretations of strong versus weak recommendations for clinicians, patients and policy-makers;
- explicit acknowledgement of values and preferences; and
- explicit evaluation of the importance of outcomes of alternative management strategies.

GRADE involves systematically evaluating the quality of evidence (high, moderate, low, very low) and developing a strength of recommendation (strong, weak). For more detailed information on GRADE, please go to: http://www.gradeworkinggroup.org/.

Category	Quality Definitions	Strong Recommendation	Weak Recommendation
High Quality Evidence	Further research is very unlikely to change our confidence in the estimate of effect.	The work group is confident that the desirable effects of adhering to this recommendation outweigh the undesirable effects. This is a strong recommendation for or against. This applies to most patients.	The work group recognizes that the evidence, though of high quality, shows a balance between estimates of harms and benefits. The best action will depend on local circumstances, patient values or preferences.
Moderate Quality Evidence	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.	The work group is confident that the benefits outweigh the risks but recognizes that the evidence has limitations. Further evidence may impact this recommendation. This is a recommendation that likely applies to most patients.	The work group recognizes that there is a balance between harms and benefits, based on moderate quality evidence, or that there is uncertainty about the estimates of the harms and benefits of the proposed intervention that may be affected by new evidence. Alternative approaches will likely be better for some patients under some circumstances.
Low Quality Evidence	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change. The estimate or any estimate of effect is very uncertain.	The work group feels that the evidence consistently indicates the benefit of this action outweighs the harms. This recommendation might change when higher quality evidence becomes available.	The work group recognizes that there is significant uncertainty about the best estimates of benefits and harms.

Return to Table of Contents

Foreword

Introduction

In 2016, the U.S. Preventive Services Task Force (USPSTF) updated its recommendations to include routine screening for depression of the general adult population, pregnant and postpartum women *(Siu, 2016)*. There was moderate evidence that screening pregnant and postpartum women reduced depression prevalence and increased remission and treatment response even in the absence of additional treatment supports. Outcomes were better with such supports. There was low to moderate evidence showing the same for the general adult primary care population but insufficient evidence to show benefit in older adults. They concluded that generalizing from evidence in all adults to older adults may be reasonable *(O'Connor, 2016)*. Furthermore, the American College of Preventive Medicine (ACPM) supports this recommendation and adds that all primary care practices should have such systems of care in place *(Nimalasuriya, 2009)*. Given that the outcomes are better when reliable systems and supports are put in place to diagnose, follow-up and modify treatment as needed, this guideline will be highlighting evidence-based, effective ways to implement such supports *(O'Connor, 2016)*.

A reasonable way to evaluate whether a system is successfully functioning in its diagnosis, treatment and follow-up of major depression would be to consider the following:

1. **Diagnosis**: The clinic or medical group should have a reliable process for routine evaluation and documentation of DSM-5 criteria for major depression.
2. The clinic or medical group should have a systematic way to provide and document:
   a. **Engagement and Education:** The patient and his/her family are actively educated, engaged and participating in self-management, based on knowledge of the nature of the disease, risk/benefits of treatment options and consideration of patient preferences.
   b. **Ongoing Contacts:** A documented system is in place to ensure ongoing contacts with the patient during the first 12 months of care (scheduled follow-up appointments, phone calls and some way to react and/or reach out if the patient drops out of treatment), based on use of a standardized, objective tool used at each contact to document and track treatment response.
3. **Outcomes:** The system should have a way to reliably and consistently monitor and improve outcomes for individuals and to improve systemwide individual care and the effectiveness of the clinical practice overall.

Importance of Major Depression Focus in Primary Care

Major depression is a treatable cause of pain, suffering, disability and death, yet primary care clinicians detect major depression in only one-third to one-half of their patients with major depression *(Williams Jr, 2002; Schonfeld, 1997)*. Additionally, more than 80% of patients with depression have a medical comorbidity *(Klinkman, 2003)*. Usual care for depression in the primary care setting has resulted in only about half of depressed adults getting treated *(Kessler, 2005)* and only 20-40% showing substantial improvement over 12 months *(Unützer, 2002; Katon, 1999)*. Approximately 70-80% of antidepressants are prescribed in primary care, making it critical that clinicians know how to use them and have a system that supports best practices *(Mojtabai, 2008)*.

At any given time, 9% of the population has a depressive disorder, and 3.4% has major depression *(Strine, 2008)*. In a 12-month time period, 6.6% of the U.S. population will have experienced major depression, and 16.6% of the population will experience depression in their lifetime *(Kessler, 2005)*.

Return to Table of Contents

Additionally, major depression was second only to back and neck pain for having the greatest effect on disability days, at 386.6 million U.S. days per year *(Merikangas, 2007)*.

In a WHO study of more than 240,000 people across 60 countries, depression was shown to produce the greatest decrease in quality of health compared to several other chronic diseases. Health scores worsened when depression was a comorbid condition, and the most disabling combination was depression and diabetes *(Moussavi, 2007)*.

A 2011 study showed a relationship between the severity of depression symptoms and work function. Data was analyzed from 771 depressed patients who were currently employed. The data showed that for every 1-point increase in PHQ-9 score, patients experienced an additional mean productivity loss of 1.65%. And, even minor levels of depression symptoms were associated with decrements in work function *(Beck, 2011)*.

Cultural Considerations

Clinicians should acknowledge the impact of culture and cultural differences on physical and mental health. There is evidence that non-majority racial and cultural groups in the U.S. are less likely to be treated for depression than European Americans. In an epidemiological study that compared rates of diagnosing and treating depression in the early 1990s to patterns 10 years later, only 4.9% of minorities were treated with antidepressants compared with 12.4% of non-Hispanic Caucasians *(Mojtabai, 2008)*.

A person's cultural and personal experiences influence his/her beliefs and therefore attitudes and preferences. If these experiences are taken into consideration, openness to and readiness to change (including readiness to seek and adhere to treatment) will be enhanced. People of differing racial/ethnic groups are optimally treated using currently available evidence-based interventions when differential personal elements, from biological to environmental to cultural, are considered during the treatment planning process *(Schraufnagel, 2006)*.

Assessment and treatment tools

- Many **assessment tools** may not be useful for certain populations. Screening instruments are validated in certain groups. Use caution because a tool may not be applicable to all groups.
- Most empirically supported **therapies** have been evaluated with Caucasian, middle-class, English-speaking populations.

Cultural beliefs and common presentations

- When dealing with patients from diverse cultures, the impact of patient's cultural beliefs around depression, cultural stigma and manifestation of depression in physical symptoms vs. psychological can play a role in how patients perceive depression and subsequently seek treatment *(Kleinman, 2004)*.
- Clinicians can create a more comfortable environment for a patient of another culture by acknowledging the impact of culture and cultural differences on physical and mental health *(Muñoz, 2005; Miranda, 2004)*.
- Bodily idioms of distress are very common in many cultures. In place of psychosomatic theories that emphasize individuals' inner conflict, many traditions of medicine have sociosomatic theories that link bodily and emotional distress to problems in the social world *(Kirmayer, 2001)*.
- The concept of depression varies across cultures. For example, in many cultures, for depression to become a problem for which a person seeks medical treatment, symptoms may include psychosis, conversion disorders or significant physical ailments *(Karasz, 2005)*.

Return to Table of Contents

Scope and Target Population

The purpose of this guideline is to assist primary care in developing systems that support effective assessment, diagnosis and ongoing management of initial and recurrent major depression and persistent depressive disorder in adults age 18 years and over, and assist patients to achieve remission of symptoms, reduce relapse and return to previous level of functioning. This guideline does not address the pediatric population. Diagnoses with significant overlap of symptoms outside the scope of this guideline include anxiety disorder, adjustment disorder and bipolar disorder.

Return to Table of Contents

Aims

The aims and measures in this guideline are based upon evidence supporting impact of system elements and process elements, and promoting actual symptom and functional patient improvement and outcomes, and are aligned with MN Community Measurement where there is overlap. The work group has elected to use PHQ-9 in the measures, since it is broadly utilized by various organizations. There are other evidence-based tools that may be used. If other tools are chosen for measurement, they should be sensitive, specific, reliable and valid for measuring intensity levels and response and remission rates.

1. Increase the percentage of patients accurately diagnosed with major depression or persistent depressive disorder. *(Annotation #2)*
2. Decrease the number of completed suicides in patients with major depression or persistent depressive disorder managed in primary care. *(Annotation #3a)*
3. Increase the percentage of patients with major depression or persistent depressive disorder who are screened for substance use disorders. *(Annotation #4a)*
4. Increase the screening for major depression or persistent depressive disorder of primary care patients presenting with additional high-risk conditions such as diabetes, cardiovascular disease, post-stroke, chronic pain and all perinatal women. *(Appendix D)*
5. Improve communication between the primary care physician and the mental health care clinician (if patient is co-managed). *(Annotation #7a)*
6. Increase the percentage of patients with major depression or persistent depressive disorder who have improvement in outcomes from treatment for major depression or persistent depressive disorder. *(Annotations #5, 6)*
7. Increase the percentage of patients with major depression or persistent depressive disorder who have follow-up to assess for outcomes from treatment. *(Annotations #5, 6, 7a)*

Return to Table of Contents

Recommendations Table

The following table is a list of evidence-based recommendations for the Adult Depression in Primary Care guideline.

Note: Other recommendation language may appear throughout the document as a result of work group consensus but is not included in this evidence-based recommendations table.

Topic	Quality Of Evidence	Recommendations	Strength of Recommendation	Annotation Number	Relevant References
Suspect and screen for major depression	Low	Clinicians should routinely screen all adults for depression using a standardized instrument.	Strong	1	*O'Connor, 2016; Kroenke, 2010; Duffy, 2008; Gilbody, 2006; Rush, 2003*
Diagnose and characterize major depression	Good Practice Statement	Clinicians should use the DSM-5 criteria to determine diagnosis of major depression, persistent depressive disorder, other specified depressive disorder, and unspecified depressive disorder.	Strong	2	*American Psychiatric Association, 2013; Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*
Treatment for major depression 1	Moderate	Consider combining pharmacotherapy and psychotherapy treatments for patients with major depressive disorder when practical, feasible, available and affordable.	Weak	5	*Cuijpers, 2014b; Hollon, 2014; Peeters, 2013; Spijker, 2013; van Hees, 2013; Cuijpers, 2012; Jakobsen, 2012b; Guidi, 2011; Oestergaard, 2011; Cuijpers, 2009a; Cuijpers, 2009c; de Maat, 2008*
Treatment for major depression 2	Moderate	When unable to do combined therapy due to patient preferences, availability and affordability of the treatments: 1. Consider starting with psychotherapy for mild to moderate major depression; 2. Consider starting with pharmacotherapy for severe major depression.	Weak	5	*Cuijpers, 2015; Kuyken, 2015; Biesheuvel-Leliefeld, 2015; Menchetti, 2014; Steinert, 2014 Cuijpers, 2013; Piet, 2011; Segal, 2010; Dobson, 2008*

Return to Table of Contents

Topic	Quality Of Evidence	Recommendations	Strength of Recommendation	Annotation Number	Relevant References
Treatment for persistent depressive disorder 1	High	Consider starting with medication in pure dysthymia patients. The work group feels that it is reasonable to consider stepped care, which includes augmenting medications and adding psychotherapy for patients who don't improve.	Strong	5	*Kriston, 2014; von Wolff, 2013; Cuijpers, 2012; Levkovitz, 2011; Cuijpers, 2010b; Cuijpers, 2009b; Imel, 2008; Markowitz, 2005; Browne, 2002;*
Treatment for persistent depressive disorder 2	High	For patients with chronic major depression, start with combined antidepressant medication and psychotherapy.	Strong	5	*Kriston, 2014; Weirsma, 2014; Spijker, 2013; Cuijpers, 2012; Cuijpers, 2010b; Kocsis, 2009a; Imel, 2008; Browne, 2002*
Collaborative Care Model	High	Collaborative care approach is recommended for patients with depression in primary care.	Strong	6	*Fortney, 2013; Archer, 2012; Gjerdingen, 2007; Katon, 2008; Gilbody, 2006; Hunkeler, 2006; Belnap, 2006; Simon, 2001a; Katon, 1999*
Patient engagement and shared decision-making	Low	Before initiating treatment, it is important to establish a therapeutic alliance with the patient regarding diagnosis and treatment options (in which there is overlap in the patient's and clinician's definition of the problem and agreement on which steps are to be taken by each).	Strong	6	*Kocsis, 2009b; Loh, 2007; Krupnick, 1996*

Topic	Quality Of Evidence	Recommendations	Strength of Recommendation	Annotation Number	Relevant References
Establish follow-up plan. Use of PHQ-9 as monitor and management tool	Low	Clinicians should establish and maintain follow-up with patients.	Strong	7a	*Trivedi, 2006b; Unützer, 2002; Hunkeler, 2000; Simon, 2000*
Pregnant and post-partum women	Low	Clinicians should screen and monitor depression in pregnant and post-partum women.	Strong	Appendix D	*O'Connor, 2016; Yonkers, 2009; Vesga-López, 2008; Gjerdingen, 2007; Gaynes, 2005*

Return to Table of Contents

Summary Table of Recommendations for Major Depressive Disorder and Persistent Depressive Disorder

At every level of severity, add education, physical activity and behavioral activation to standard treatment recommendations.

Severity	PHQ-9 Scores	Possible Diagnoses	Treatment Recommendations
Undefined	Initial Score: 5-9	Does not meet criteria for major depressive disorder Consider for persistent depressive disorder	Stay in touch: a) If no improvement after one or more months, consider treating or referral to behavioral health. b) If symptoms deteriorate, start treatment or make a referral.
	Follow-up Score: 5-9	Partial remission	Continue stepped therapies approach.
Per DSM-5: Few, if any, symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.	10-14	Mild major depression	Combined psychotherapy and pharmacotherapy treatment. When unable to do combined therapy due to patient preferences, availability and affordability of the treatments, start with psychotherapy. Initially consider weekly contacts to ensure adequate engagement, then at least monthly.
Per DSM-5: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."	15-19	Moderate major depression	Combined psychotherapy and pharmacotherapy treatment. When unable to do combined therapy due to patient preferences, availability and affordability of the treatments, start with psychotherapy. Initially consider weekly contacts to ensure adequate engagement, then at least every 2-4 weeks.
Per DSM-5: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.	≥20	Severe major depression	Combined psychotherapy and pharmacotherapy treatment. When unable to do combined therapy due to patient preferences, availability and affordability of the treatments, start with pharmacotherapy. Weekly contacts until less severe.
Meets DSM-5 criteria for persistent depressive disorder		Pure dysthymia	Consider starting with medication. Consider stepped care, which includes augmenting medications and adding psychotherapy for patients who don't improve.
Meets DSM-5 criteria for persistent depressive disorder		Chronic major depression	Combined psychotherapy and pharmacotherapy treatment.

This table is designed to translate the PHQ-9 scores into DSM-5 categories and then integrate evidence-based best practice. It does not directly correspond to the PHQ-9 Scoring Guide in Appendix A, "Patient Health Questionnaire (PHQ-9)."

(Cuijpers, 2015; Kuyken, 2015; Biesheuvel-Leliefeld, 2015; Cuijpers, 2014b; Hollon, 2014; Kriston, 2014; Menchetti, 2014; Steinert, 2014; Wiersma, 2014; American Psychiatric Association, 2013: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; Cuijpers, 2013; Peeters, 2013; Spijker, 2013; van Hees, 2013; von Wolff, 2013; Cuijpers, 2012; Jakobsen, 2012b; Guidi, 2011; Levkovitz, 2011; Oestergaard, 2011; Piet, 2011; Cuijpers, 2010b; Fournier, 2010; Kroenke, 2010; Segal, 2010; Cuijpers, 2009a; Cuijpers, 2009c; Kocsis, 2009a; Dobson, 2008; de Maat, 2008; Imel, 2008; Cuijpers, 2007; Markowitz, 2005; Browne, 2002)

Referral or co-management with mental health specialty clinician if patient has:

- High suicide risk
- Inadequate treatment response
- Other psychiatric disorders such as bipolar, substance abuse, etc.
- Complex psychosocial needs

If the primary care clinician is seeing some improvement, continue working with that patient to increase medication dosage or augment with psychotherapy or medication to reach remission. This can take up to three months. Stay connected through consultation or collaboration, and take the steps needed to get the patient to remission. This can take longer and can take several medication interventions or other steps. The STAR*D study has shown that primary care can be just as successful as specialty care *(Trivedi, 2006a)*.

Return to Table of Contents

Implementation Recommendation Highlights

The following system changes were identified by the guideline work group and represent a collaborative care model as key strategies for health care delivery systems to incorporate in support of the implementation of this guideline. The following points have not been updated during this revision.

See Annotation #6, "Comprehensive Treatment Plan with Shared Decision-Making," for definitions of the collaborative care model.

See below for health care cost analysis of a collaborative care model compared to outpatient primary care depression care as usual and review of the cost analysis for enhanced collaborative care and the impact on the workplace, e.g., absenteeism.

- Detection and diagnosis
  - Systems in place to reliably determine if a patient is depressed
  - Use of DSM-5 criteria and structured questionnaires (such as PHQ-9)
- Patient-centered care, education and self-management programs
  - Structured attention to patient preferences
  - Patient and family education materials/protocols
  - Patient self-management skills such as journal writing or self-monitoring
  - When appropriate, encourage family or loved ones to attend appointments for patient support and advocacy.
  - Involving families, as well, in care management programs
  - Care manager role to coordinate the disease management for patients with depression including such things as patient contacts, education, self-management tools and tips
- Mental health/behavioral medicine specialist involvement
  - Shared care – collaborative care between behavioral health specialists and primary care clinicians in the primary care setting. Care manager and /or primary care clinician consulting with psychiatry on a regular basis regarding the caseload of patients with depression managed in the depression care management program.
  - Appointment availability – access to behavioral health in timely manner
- Outcomes measurement
  - Build in plans for outcome measures, as well as ongoing process measures
  - Response rate to various treatments
  - Remission rates – improvement in response is stable over time
- Systems to coordinate care, ensure continuity and keep clinicians informed of status
  - Build automated processes for the first four core elements wherever possible
  - Reduce dependence on human behavior to ensure delivery of patient care processes
  - Use of components of the chronic care model for depression care, e.g., use of registries, community outreach

Return to Table of Contents

- Structured, frequent monitoring and follow-up with patient
- Nurse/care manager phone care and use of other modalities for patient follow-up

Cost-Effectiveness Impact of Collaborative Care Models

In a collaborative care model, the primary treatment for depression is provided by a multidisciplinary team. Most studies have concluded that creating and implementing a collaborative care model will increase effectiveness – producing significant and sustained gains in "depression-free days" *(Katon, 2005; Simon, 2001a; Simon, 2001b)*. The six-month and one-year studies show increased cost to the outpatient care system. This is balanced by continuous accumulation of clinical and economic benefits over time. One of the factors is the decrease in the utilization of general medical services in patients with chronic medical comorbidities. The two-year studies show mixed results possibly indicating a turning point *(Dickinson, 2005)*, and the only longer-term study conducted was the IMPACT study. This was a well-done study analyzing the costs of performing collaborative care for one year over a four-year period. The study illustrated a cost savings of $3,363 per patient over the four-year period *(Unützer, 2008)*.

Almost all the studies done on this aspect have compared enhanced/collaborative care with care as usual. Typically, enhanced care has involved creating a list of depressed patients under treatment, having a care manager provide education, calling or meeting with patient periodically to ensure compliance with medications and/or psychotherapy, and reliably ensuring follow-up visits and measurement of outcomes. Some have involved varying participation of physicians, behavioral health professionals and/or patients.

Workplace Impact of Collaborative Care Models

These randomized controlled trials looked at cost of doing enhanced care and specifically tallied decreases of "absenteeism" and improved work performance (which means that employees are present and effectively achieving good work results, sometimes referred to as decreasing "presenteeism") *(Wang, 2007; Schoenbaum, 2001)*. Some studies monetized the results and compared them to usual care. The significance of these studies and this analysis is that in the U.S., depression costs employers $24 billion in lost productive work time *(Stewart, 2003)*.

In two randomized controlled trials, employers received significant return on investment (ROI) from collaborative care treatment of depression by increasing productivity/decreasing absenteeism in the workplace. Increased productivity in one study ranged from 2.6 hours to 5.6 hours per week after one year. Studies going out to two years showed continued gains in year two *(Lo Sasso, 2006; Rost, 2004)*.

Several of the articles recommend consideration of coverage of collaborative care to ensure better patient outcomes and the ROI illustrated.

Return to Table of Contents

Related ICSI Scientific Documents

Guidelines

- Assessment and Management of Chronic Pain
- Healthy Lifestyles
- Heart Failure in Adults
- Management of Type 2 Diabetes Mellitus
- Palliative Care for Adults
- Preventive Services for Adults
- Stable Coronary Artery Disease

Return to Table of Contents

Algorithm Annotations

Screening

1. Depression Suspected

Recommendation	Quality of Evidence and Strength of Recommendation
Clinicians should routinely screen all adults for depression using a standardized instrument.	Quality of Evidence: Low Strength of Recommendation: Strong
Benefit: There is evidence that screening adults whom one suspects as being depressed improves outcomes. There is low to moderate evidence that screening all adults, pregnant and postpartum women improves outcomes even in the absence of treatment protocols, care managers and specialty trained providers. There is less evidence supporting this recommendation with geriatric patients. The benefit is that one would be finding and treating many more depressed patients and improving their outcomes/functioning not only for depression but for the other medical diseases with depression as a co-morbidity. There is also some evidence that this might save overall medical costs for depressed patients. The optimum interval at which to screen for depression is unknown; more evidence for all populations is needed to identify ideal screening intervals. **Harm:** The only harm identified is the cost of screening patients who are not depressed. **Benefit-Harms Assessment:** Although direct evidence of the isolated health benefit of depression screening in primary care is weak, the totality of the evidence supports the benefits of screening in pregnant and postpartum and general adult populations, particularly in the presence of additional treatment supports such as treatment protocols, care management and availability of specially trained depression care providers. Evidence is least supportive of screening in older adults, where direct evidence is most limited.	
Relevant Resources: *O'Connor, 2016; Kroenke, 2010; Duffy, 2008; Gilbody, 2006; Rush, 2003*	

Overview. Major depressive disorder is characterized by discrete episodes of at least two weeks' duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition and neurovegetative functions and inter-episode remissions. A diagnosis based on a single episode is possible, although the disorder is a recurrent one in the majority of cases. Careful consideration is given to the delineation of normal sadness and grief from a major depressive episode. Bereavement may induce great suffering, but it does not typically induce an episode of major depressive disorder. When they do occur together, the depressive symptoms and functional impairment tend to be more severe, and the prognosis is worse compared with bereavement that is not accompanied by major depressive disorder. Bereavement-related depression tends to occur in persons with other vulnerabilities to depressive disorders, and recovery may be facilitated by antidepressant treatment *(American Psychiatric Association, 2013)*.

A more chronic form of depression, persistent depressive disorder (dysthymia), can be diagnosed when the mood disturbance continues for at least two years in adults or one year in children. This diagnosis, new in DSM-5, includes both the DSM-IV diagnostic categories of chronic major depression and dysthymia *(American Psychiatric Association, 2013)*.

Suspect Depression

Many patients with major depression do not initially complain of depressed mood or anehdonia *(American Psychiatric Association, 2013)*. Clinicians need to suspect this diagnosis based on a profile of common presentations and risk factors, taking into account cultural considerations *(American Psychiatric Association, 2013)*.

Return to Algorithm *Return to Table of Contents*

Common Presentations

Common presentations for patients not complaining of major depression or anhedonia include *(American Psychiatric Association, 2013)*:

- Multiple (more than five per year) medical visits
- Multiple unexplained symptoms
- Work or relationship dysfunction
- Dampened affect
- Changes in interpersonal relationships
- Poor behavioral follow-through with activities of daily living or prior treatment recommendations
- Weight gain or loss
- Sleep disturbance
- Fatigue
- Memory/other cognitive complaints such as difficulty concentrating or making decisions
- Irritable bowel syndrome
- Volunteered complaints of stress or mood disturbance

The close relationship of mind and body results in the presentation of medical illness with major depression in various forms: *(American Psychiatric Association, 2013)*

- Medical illness may be a biological cause (e.g., thyroid disorder, stroke).
- Medical illness or the patient's perception of his/her clinical condition and health-related quality of life may trigger a psychological reaction to prognosis, pain or disability (e.g., in a patient with cancer).
- Medical illness may exist coincidentally in a patient with primary mood or anxiety disorder.

Non-Mood Presentations

Non-mood presentations of major depression include fatigue, pain or other somatic complaints, sleep disturbances, sexual dysfunction, multiple medical visits and work or relationship dysfunction. Fatigue is the seventh most common symptom in primary care, and up to 24% of all patients surveyed in primary care clinics indicate that fatigue is a major problem *(Kroenke, 1988)*.

A mood disorder (major depression, persistent depressive disorder or bipolar) may be present in 39% of patients with a presenting complaint of chronic fatigue (fatigue present at least half the time for at least one month) *(Manu, 1988)*.

Major depression may also be associated with medical disorders or the patient's perception of his/her clinical condition. Although thyroid function abnormalities may cause depressive symptoms, screening for thyroid disease in all patients with major depression is not necessary because the prevalence of unidentified thyroid disease in patients with major depression is the same as in the general population *(Garrard, 2001; Briggs, 1993)*.

Irritable bowel syndrome (IBS) is strongly correlated with psychiatric illness. Treatment of the underlying psychiatric disease may provide more than adequate management of IBS *(Garakani, 2003)*.

For women, severe obesity (body mass index greater than 40) has been strongly associated with depression *(Onyike, 2003)*.

Major depression is also seen in elderly patients with comorbid illnesses, such as cerebrovascular accident (CVA), cancer, dementia or disabilities.

Return to Algorithm *Return to Table of Contents*

Risk Factors

Risk factors for major depression include:

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Stressful life events that include loss (death of a loved one, divorce)
- Traumatic events (example: car accident)
- Major life changes (examples: job change, financial difficulties)
- Domestic abuse or violence

Note: Genomics: There have been a number of genome-wide association studies for major depression. So far there have been no robust, replicable, single nucleotide polymorphisms identified for depression *(Major Depressive Disorder Working Group of the Psychiatric GWAS Consortium, 2013)*.

One previous episode of major depression is associated with a 50% chance of a subsequent episode, two episodes with a 70% chance, and three or more episodes with a 90% chance *(NIMH/NIH Consensus Development Conference Statement, 1985)*.

Most studies indicate that in 40 to 60% of patients, a major life event precedes the first episode of major depression *(Post, 1992)*.

Domestic abuse and violence. In a recent survey, a stronger association was found between depressed symptoms and ever being afraid of a partner compared with depressed symptoms and hazardous drinking in both men and women, even after adjusting for age group, income, employment status, marital status, living alone and education level *(Gilchrist, 2010)*.

No single tool has been identified as the gold standard for screening of domestic violence or abuse. These two questions are commonly used in assessments:

1. Does your partner put you down or try to control what you can do?
2. In the past year have you ever been hit, pushed, restrained or choked during an argument?

For more information on domestic violence screening, see the ICSI Preventive Services for Adults guideline.

Whenever You Suspect Depression, Screen for it

Validated and reliable tools can help clinicians identify and systematically monitor patients with major depression. Use screening and tracking tools to enhance but not replace the clinical interview.

Either the PHQ-2 or the PHQ-9 can be used to screen for depression. There is stronger evidence supporting the use of the PHQ-9 in patients with chronic disease.

Use the Patient Health Questionnaire (PHQ) two-question tool in routine screening settings *(Gilbody, 2007)*.

Over the past two weeks, have you been bothered by:

- Little interest or pleasure in doing things?
- Feeling down, depressed or hopeless?

PHQ-2 scores can range from 0 to 6, and a cutpoint ≥ 3 suggests clinically significant depression which should prompt either completion of the full PHQ-9 or a clinical interview to assess for MDD *(Kroenke, 2010; Gilbody, 2007)*.

The PHQ-9 has been validated for measuring depression severity *(Kroenke, 2001; Spitzer, 1999)* and is validated as a tool for both detecting and monitoring depression in primary care settings *(Kroenke, 2010; Wittkampf, 2007)*. It has a sensitivity (false negative) of 0.77 and specificity (false positive) of 0.85 when using the screened item scoring method. Two other tools with good utility in case finding, aiding diagnosis and severity grading are the Structural Clinical Interview DSM-IV Axis-I Disorders (SCID-I) with a sensitivity of 85% and specificity 82% and the Mini International Neuropsychiatric Interview (MINI) with a sensitivity of 78% and specificity of 85% *(Pettersson, 2015)*.

It can be administered telephonically *(Pinto-Meza, 2005)* and read to the patient. Elderly patients with mild cognitive impairment can reliably fill out the PHQ-9 *(Löwe, 2004)*. A recent study found the PHQ-9 is useful in psychiatric practices, as well. PHQ-9 scores influenced clinical decision-making for 93% of more than 6,000 patient contacts *(Duffy, 2008)*. The PHQ-9 tool can be found on www.phqscreeners.com or Appendix A of this guideline.

Other recognized and validated tools include the Beck Depression Inventory (http://www.beckinstitute.org/beck-inventory-and-scales/), Hamilton Rating Scale for Depression (HAM-D) (http://www.ids-qids.org/) and the Quick Inventory of Depressive Symptomatology Self-Report (QID-SR) (http://www.ids-qids.org/) *(Rush, 2003)*.

Regardless of the screening tool chosen, it is crucial to document that the patient meets the criteria of at least five symptoms for at least two weeks as defined by the DSM-5 criteria for major depression. One of the symptoms must be depressed mood or loss of interest or pleasure.

The primary objective is to use a standardized instrument that will quantify baseline intensity and document future progress, including response and remission rates.

Use of tools with diverse populations. The factor structure of the nine items in the PHQ-9 is comparable when tested with African Americans, Chinese Americans, Latino and non-Hispanic white patient groups *(Huang, 2006)*. Language versions that are validated for use in primary care are Spanish *(Wulsin, 2002)* and Chinese *(Yeung, 2008)*. A Thai-language version has also been validated; however, the sensitivity is low (53%). This version could therefore be a useful and reasonable tool to help confirm a suspected depression but less so to screen general populations *(Lotrakul, 2008)*. The PHQ-9 has also been validated in Korean-American patients, although a cutoff point of 5 is suggested for elderly Korean-Americans *(Han, 2008; Donnelly, 2007)*.

The tool and many other language versions can be found at http://www.phqscreeners.com. When administering the PHQ-9, be aware of cultural factors and involve an interpreter if needed. As research develops on risk adjustment and stratification using this tool, the work group will report and refine recommendations.

Clinicians should choose the screening method that best fits their personal preference, the patient population served and the practice setting.

Special Populations

See Appendix D, "Special Populations," for more information regarding screening for the following conditions/populations, as applicable: 1) cardiovascular and cerebrovascular disease, 2) diabetes, 3) chronic pain, 4) geriatrics [includes dementia/cognitive impairment], and 5) pregnant and postpartum women.

Return to Algorithm *Return to Table of Contents*

Diagnosis

2. Diagnose and Characterize Major Depression/Persistent Depressive Disorder with Clinical Interview

Recommendation	Quality of Evidence and Strength of Recommendation
Clinicians should use the DSM-5 criteria to determine diagnosis of major depression, persistent depressive disorder, other specified depressive disorder, and unspecified depressive disorder.	Quality of Evidence: Good Practice Statement Strength of Recommendation: Strong
Benefit: Proper use of diagnostic criteria assists in accurately diagnosing and directing the treatment plan toward appropriate evidence-based interventions. **Harm:** There is a risk of exclusively utilizing the criteria in a checklist manner, which could lead to inappropriate diagnosis and treatment. **Benefit-Harms Assessment:** With proper training and education, the proper use of the diagnostic criteria from the DSM-5 aids in driving the correct diagnosis and proper evidence-based interventions, which outweighs any potential harm.	
Relevant Resources: *American Psychiatric Association, 2013; Diagnostic and Statistical Manual of Mental Disorders, 5th edition*	

The content in this entire annotation comes from the American Psychiatric Association, 2013: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

This section begins with the lists of specific criteria required for diagnosing major depression, persistent depressive disorder, other specified depressive disorder and unspecified depressive disorder. Next, it offers guidance on considering alternative diagnoses. Finally, this section provides guidance on obtaining an appropriate patient history, including history of present illness, medical history and medication history, including any substance abuse/dependence.

Introduction

Sadness is a part of human existence that the majority of the time does not necessitate treatment. These periods should not be diagnosed as a depressive episode if they do not met criteria for severity and duration, and include clinically significant distress or impairment *(American Psychiatric Association, 2013)*.

Depressed mood or anhedonia (diminished interest or pleasure in activities) is necessary to diagnose major depression.

The use of a mnemonic may be helpful for remembering the symptoms of major depression and persistent depressive disorder. SIGECAPS or SIG + Energy + CAPS is easily remembered and can be used in the clinical interview. Developed by Dr. Carey Gross of Massachusetts General Hospital, it stands for:

Sleep disorder (increased or decreased)
Interest deficit (anhedonia)
Guilt (worthlessness, hopelessness, regret)
Energy deficit
Concentration deficit
Appetite disorder (increased or decreased)
Psychomotor retardation or agitation
Suicidality

Return to Algorithm *Return to Table of Contents*

Criteria Required for Diagnosis

DSM-5 Criteria: Major Depressive Episode

To qualify for a diagnosis of major depressive episode, the patient must meet criteria A through E:

A. Five or more of the following symptoms have been present and documented during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

   Note: Do not include symptoms that are clearly attributable to another medical condition.

   1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful)

   2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)

   3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

   4) Insomnia or hypersomnia nearly every day

   5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

   6) Fatigue or loss of energy nearly every day

   7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

   8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

   9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a mixed episode.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

   Note: Criteria A-C represent a major depressive episode.

   Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include feelings of intense sadness, rumination about the loss, insomnia, poor appetite and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history of and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

Return to Algorithm *Return to Table of Contents*

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Severity is based on the number of criterion, the severity of those symptoms and the degree of functional disability.

- Mild, single episode ICD-10 F32.0, recurrent episode ICD-10 F33.0: Few, if any symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.
- Moderate, single episode ICD-10 F32.1, recurrent episode ICD-10 F33.1: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."
- Severe, single episode ICD-10 F32.2, recurrent episode ICD-10 F33.2: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

Further specifications include:

- In partial remission, single episode ICD-10 F32.4, recurrent episode ICD-10 F33.41: Symptoms of the immediately previously major depressive episode are present, but full criteria are not met, or there is a period lasting less than two months without any significant symptoms of a major depressive episode following the end of such an episode.
- In full remission, single episode, recurrent episode ICD-10 F33.42: During the past two months, no significant signs or symptoms of the disturbance were present.

DSM-5 Criteria: Persistent Depressive Disorder

This disorder represents a consolidation of the DSM-IV-defined chronic major depressive disorder and dysthymic disorder, ICD-10 F34.1. To qualify for a diagnosis of persistent depressive disorder, the patient must meet criteria A through H:

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account of observation by others, for at least two years.

B. Presence while depressed of two or more of the following:

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

C. During the two-year period of the disturbance, the individual has never been without the symptoms in criteria A and B for more than two months at a time.

Return to Algorithm *Return to Table of Contents*

D. Criteria for major depressive disorder may be continuously present for two years.

E. There has never been a manic episode or hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder, a very limited number of individuals will have depressive symptoms that have persisted longer than two years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder is warranted.

Severity is based on the number of criterion, the severity of those symptoms and the degree of functional disability.

- Mild: Few, if any symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.
- Moderate: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."
- Severe: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

(American Psychiatric Association, 2013)

Other specified depressive disorder ICD-10 F32.8

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The other specified depressive disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific depressive disorder. This is done by recording "other specified depressive disorder" followed by the specific reason (e.g., "short-duration depressive episode").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. Recurrent brief depression – Depressed mood and at least four other symptoms of depression for 2-13 days at least once/month (not associated with menstrual cycle for at least 12 months)
2. Short-duration depressive episode – Depressed mood plus greater than or equal to four other symptoms of depression for 4-13 days
3. Depressive episode with insufficient symptoms – Depression with greater than or equal to one other symptom with clinically significant distress/impairment for more than two weeks

Unspecified Depressive Disorder ICD-10 F32.9

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The unspecified depressive disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific depressive disorder, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings). It should also be noted that premenstrual dysphoric disorder is now a separate diagnosis.

Consider Alternate Diagnoses

Anxiety or somatic symptom and related disorders

Presentations particularly suggestive of an anxiety or somatoform disorder include medically unexplained symptoms such as:

- Cardiac (chest pain, atypical chest pain, palpitations, shortness of breath, hyperventilation)
- Gastrointestinal (epigastric distress chronic nausea, bloating vomiting)
- Neurologic (headache, dizziness, paresthesias) pseudoseizures, paralysis, aphonia, blindness
- Sexual or reproductive symptoms (other than pain)
- Panic attacks

The text of the fifth edition of DSM-5 includes seven specific somatic symptom and related disorders: somatic symptom disorder, illness anxiety disorder, conversion disorder, psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder. Refer to the DSM-5 for a full description of each somatic symptom and related disorder. Treatment of these disorders falls out of the scope of this guideline.

Adjustment disorder

Adjustment disorder is the development of emotional or behavioral symptoms in response to an identifiable stressor. The symptoms occur within three months of the onset of the stressor and last less than six months after the termination of the stressor. These symptoms or behaviors are in excess of what would be expected from exposure to the stressor, and they cause significant impairment in social and occupational functioning. In adjustment disorder with depressed mood, predominant symptoms such as low mood, feelings of hopelessness and tearfulness are exhibited. Treatment of adjustment disorder falls out of the scope of this guideline.

Bipolar disorder

Many patients with bipolar disorder experience hypomania or mania before their first major depressive episode. Ask patients about personal history of mania or hypomania. If any, ask about family history and, if any consider using MDQ, if any, to assess further. The diagnostic criteria for an episode of major depression in bipolar disorder are the same as the criteria for unipolar major depressive disorder. Use DSM-5 criteria when considering a diagnosis of unipolar major depressive disorder:

A) A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

Return to Algorithm *Return to Table of Contents*

B) During the period of mood disturbances and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (e.g., feels rested after only three hours of sleep)
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
- Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions or foolish business investments)

C) The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D) The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode, and therefore, a bipolar I diagnosis.

Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

In addition to screening for hypomania and mania, consider the following historical elements that are more likely to occur in bipolar depression than unipolar depression: a family history of bipolar disorder, onset of depressive symptoms before 25 years of age, and more frequent depressive episodes of shorter duration *(Goodwin, 2007)*. Hypersomnia and hyperphagia may also be more common features of bipolar depression than early morning awakening and reduced appetite, which are more typical of unipolar depression *(Frye, 2011; Goodwin, 2007)*. For more guidance on diagnosing and treating bipolar depression, consider psychiatric consultation.

One screening tool for further assessment is the Mood Disorder Questionnaire (MDQ) *(Hirschfeld, 2000)* for bipolar disorder. Treatment for bipolar disorder falls out of the scope of this guideline.

The M-3 (My Mood Monitor) Checklist, has been created to assess for the presence of depression, anxiety, bipolar disorder and post-traumatic stress disorder *(Gaynes, 2010)*. It has similar specificity and sensitivity to the single-disorder screens currently in use, with the advantage of being a single page that the patient can complete. More than 80% of clinicians were able to review it in 30 seconds or less. It needs further validation but is a promising tool for primary care in screening for mental health disorders.

Post-traumatic stress disorder (PTSD)

PTSD may include symptoms shared by a depressive episode and may also be comorbid with a depressive episode. PTSD is associated with exposure to actual or threatened death, serious injury, and/or sexual violence. It includes intrusive flashbacks, nightmares, psychological and/or physical reactivity to cues of

the event, avoidance of cues of the event (both internal and external), negative alterations in mood, and hyperarousal and reactivity *(American Psychiatric Association, 2013)*.

Obtain Patient History

An appropriate patient history includes information about the present illness, the medical history and medication history, including any substance abuse or dependence.

History of present illness

Determine history of present illness:

- **Onset** may be gradual over months or years or may be abrupt.
- **Severity** of symptoms and degree of functional impairment:

  People diagnosed with major depression have a heterogeneous course from self-limiting to life-threatening. Predictors of poor outcome include higher severity at initial assessment, lack of reduction of social difficulties at follow-up and low educational level.

  Categorize severity of symptoms and degree of functional impairment as follows:

  Mild: Few, if any, symptoms in excess of those required to make the diagnosis and only minor impairment in occupational and/or social functioning

  Moderate: Symptoms or functional impairment between mild and severe

  Severe: Several symptoms in excess of those necessary to make the diagnosis and marked interference with occupational and/or social functioning

- Determine prior history: Number and severity of previous episodes, treatment responses and suicide attempts.
- Ask about concurrent psychiatric conditions. Obtaining a past psychiatric history is important in terms of understanding prognosis and risk factors. For example, knowing past episodes of major depression, past co-occuring mental/behavioral health conditions, and past self-harm attempts helps establish risk and need to involve other mental health professionals.
- Assess psychosocial stressors (significant loss, conflict, financial difficulties, life change, abuse). Consider duration and severity of stressor(s) and likelihood for spontaneous improvement.

For short-term subclinical and mild cases, close follow-up and monitoring are still needed *(Fournier, 2010)*. Ongoing utility of behavioral activation, skill building and self-management practices is recommended *(Mazzucchelli, 2009; Vittengl, 2009; Cuijpers, 2007)*.

Medical history

It is important to consider medical conditions that may mimic or directly cause symptoms of depression. A past medical history and brief review of systems is generally sufficient to rule out medical disorders causing major depression.

Examples of such disorders include:

- Dementia
- Delirium
- Hypothyroidism
- Parkinson's disease

- Stroke
- Connective tissue diseases

A review of the patient's medication and substance use may also provide an explanation for depressive symptoms. Sedatives, withdrawal from stimulants and other specific medications (e.g., interferon alpha, varenicline) may be contributing.

Review of the patient's medical history may find conditions that can impact pharmacological treatments: for example, prostatism, cardiac conduction abnormalities and impaired hepatic function.

Perform a focused physical examination and diagnostic testing as indicated by the review of systems. The benefit of screening laboratory tests, including thyroid tests, to evaluate major depression has not been established.

Consideration of laboratory tests should be greater if:

- the medical review of systems detects symptoms that are rarely encountered in mood or anxiety disorders,
- the patient is older,
- the first major depressive episode occurs after the age of 40, or
- the depression does not respond fully to routine treatment.

Medication history and substance abuse/dependence

Determine medication history and substance abuse/dependence:

- Medications such as steroids, interferon, alpha-methyldopa, isotretinoin, varenicline and hormonal therapy may be associated with major depression.
- Use of alcohol and hypnotics might mimic and/or induce depression, and comorbidity is common *(Davis, 2006)*.
- Withdrawal from cocaine, anxiolytics and amphetamines may mimic depression.
- Idiosyncratic reactions to other medications can occur. If possible, a medication should be stopped or changed if depression develops after beginning its use. If symptoms persist after stopping or changing medication, reevaluate for a primary mood or anxiety disorder.

Return to Algorithm *Return to Table of Contents*

3a. Is Patient Safe to Self and/or Others?

Ensure Patient Safety First: Assess, Develop and Use Suicide Protocol to Minimize Suicide Risk/Involve Mental Health Specialists

The estimated lifetime prevalence of suicide in those ever hospitalized for suicidality is 8.6%. The lifetime risk is 4% for affective disorder patients hospitalized without specification of suicidality *(Bostwick, 2000)*.

This section provides guidance and references on assessing suicidal tendencies, developing a clinic suicide protocol, risk factors for suicide and interventions to reduce suicide ideation.

Assess Suicidal Tendencies

Assessing suicidal tendencies is a critical but often difficult process with a depressed patient. Consider asking and documenting the following progression of questions.

1. Do you feel that life is worth living?

Return to Algorithm *Return to Table of Contents*

2. Do you wish you were dead?
3. Have you thought about ending your life?
4. If yes, have you gone so far as to think about how you would do so? Be specific, what method would you use?
5. Do you have access to a way to carry out your plan?
6. What keeps you from harming yourself?

Many patients will not answer #4 directly or will add, "But I'd never do it." Give them positive feedback (e.g., "I'm glad to hear that") but do not drop the subject until she/he has told you the specific methods considered (e.g., gun, medication overdose, motor vehicle accident).

Return to Algorithm *Return to Table of Contents*

3b. Use Organization's Protocol if Available to Assess and Minimize Suicide Risk/Involve Mental Health Specialists

Develop a Suicide Protocol

It is important for a health care clinic to develop its own suicide protocol, taking into account the organization's workflow and resources. Each individual clinic should determine:

- A clear process for risk assessment
- When to involve the on-call mental health clinician
- When and how to use local or national hotlines
- When to use on-site security, if available
- When and how to access 911, and what to with the patient while waiting

A recommended resource for establishing a clinic-based protocol to assess and minimize suicide risk is Bonner L, et al., Suicide Risk Response: Enhancing Patient Safety Through Development of Effective Institutional Policies. Advances in Patient Safety: From Research to Implementation. Vol 3, February 2005.

More About Risk Factors for Suicide

Literature suggests that a history of self-harm attempts, in combination with a history of well-developed suicide plans, place the patient at a greater eventual risk of completing a suicide attempt *(Bostwick, 2000)*.

In a national clinical survey, suicides were found to be most frequent in the first two weeks following hospital discharge. The highest suicide completion rate occurred on the first day post-discharge. Additional suicide risk factors included patients being less likely to continue community care, more likely to have missed the last follow-up appointment, and more often out of contact with services at the time of suicide (*Meehan, 2006)*.

The clinician should consider previous history of suicide attempts; chemical dependency; personality disorder and/or physical illness; family history of suicide; single status; recent loss by death, divorce or separation; insomnia; panic attacks and/or severe psychic anxiety; diminished concentration; anhedonia; hopelessness post-traumatic stress disorder (PTSD); or suicidal ideation *(Claassen, 2007)*. Circumstances such as clear past examples of a sense of competence to execute an attempt, a sense of courage to make the attempt, behaviors that ensure the availability of means and opportunity to complete, concrete preparations to enact the suicide plan, and a current episode of severe depression combine to pose a greater danger of eventual completed suicide.

Return to Algorithm *Return to Table of Contents*

Patients with comorbid major depressive episode and PTSD are more likely to have attempted suicide. Women with both disorders were more likely than men with both disorders to attempt suicide *(Oquendo, 2003)*.

In addition to the risk factors listed above, the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study found that previous suicide attempters had more concurrent general medical and psychiatric comorbidities, an earlier age of onset of the first depressive episode, as well as more depressive episodes. The study found no racial or ethnic distinctions between previous attempters and non-attempters, when controlled for age, gender and severity of depressive symptoms *(Claassen, 2007)*.

More About Interventions to Prevent Suicide

In the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) study, suicidal ideation rates declined in patients who receive care based on treatment guidelines and who used a care manager *(Bruce, 2004)*.

In the Improving Mood Providing Access to Collaborative Treatment (IMPACT) Study, 1,801 primary care patients were randomly assigned to collaborative care or usual care. Intervention subjects had less suicidal ideation at 6 and 12 months, and there were no completed suicides for either group in 18 months *(Unützer, 2006)*.

Another study found suicide attempt incidences highest in patients who received medication from psychiatry (1,124 per 100,000 patients) versus from primary care (301 per 100,000 patients) *(Simon, 2007)*.

Involve Mental Health Specialists

Involve same-day mental-health for any of these situations:

- Suicidal thoughts and/or plans that make the clinician uncertain of the patient's safety
- Assaultive or homicidal thoughts and/or plans that make the clinician uncertain about the safety of the patient or others
- Recent loss of touch with reality (psychosis)
- Inability to care for self/family

Involvement could include:

- Appointment with psychiatrist and/or psychotherapist
- Phone consultation with psychiatrist and/or psychotherapist
- Referral to the emergency department

(Dieserud, 2001; Whooley, 2000)

Return to Algorithm *Return to Table of Contents*

4a. Is the Presence of Substance Use Disorder or Psychiatric Comorbidity Suspected?

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen adults ages 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse (Grade B recommendations) *(U.S. Preventive Services Task Force, 2014)*.

Return to Algorithm *Return to Table of Contents*

Substance Use Disorders Prevalence

According to DSM-5, 12-month prevalence of specific substance use disorder among adults is following: *(American Psychiatric Association, 2013)*

- Alcohol use disorder: 8.5%
- Cannabis use disorder: 1.5%
- Phencyclidines use disorder: 1.3 – 2.9%
- Opioid use disorder: 0.37%
- Sedative, hypnotic or anxiolytic use disorder: 0.2%
- Stimulants use disorder: 0.2%

Alcoholism and major depressive disorder are distinct clinical entities. They are not different expressions of the same underlying condition. Within the general population, substance abuse prevalence ranges from 8% to 21%. In people with major depression, it is about 7.8% *(Davis, 2006)*. However, alcohol-use disorders are under reported in primary care (for example, higher risk drinking 1% males, 0.5% females) in comparison with Opinions survey (8% males, 7% females) *(Hawkins, 2007)*.

Screening for Alcohol and Other Drug Use (CAGE, CAGE-AID, AUDIT, AUDIT-C, DAST-10)

CAGE and CAGE-AID

The CAGE tool questions are sensitive and specific in screening for alcohol dependence. One positive response has a sensitivity of 85% and a specificity of 89%, and two positive responses have a specificity of 96% *(Bush, 1987)*. Additionally, a 2000 systematic review showed that the CAGE questions were superior in detecting alcohol abuse and dependence compared to the AUDIT tool (sensitivity, 43%-94%; specificity, 70-97%) *(Fiellin, 2000)*.

The CAGE-AID questionnaire broadens the CAGE to include other drugs. One or more Yes responses had sensitivity of 79% and specificity of 77% in detecting alcohol abuse and dependence *(Brown, 1995)*. Two or more Yes responses had sensitivity of 70% and specificity of 85% *(Brown, 1995)*. The CAGE tool shows promise in identifying pregnant, low-income women at risk for heavier drug use *(Midanik, 1998)*.

AUDIT and AUDIT-C

The Alcohol Use Disorder Identification Test (AUDIT) is a widely used screening tool that consists of 10 questions; it can be self-administered, or the questions can be read aloud *(Babor, 2001)*. The AUDIT tool questions are most effective in identifying patients with at risk, hazardous or harmful drinking (sensitivity, 51-97%; specificity, 78-96%) *(Fiellin, 2000)*. The AUDIT-C is a modified three-question version of the AUDIT tool.

DAST-10

The Drug Abuse Screening Test (DAST) is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST questionnaire. See the following reference for details: Gavin DR, Ross HE, Skinner HA, "Diagnostic validity of the Drug Abuse Screening Test in the assessment of DSM-III drug disorders," *Brit J Addiction* 1989;84:301-07.

Treatment

The medical literature does not support definitive statements about the best way(s) to treat patients who are diagnosed with both major depression and substance abuse/dependence. Based on the majority of studies

reviewed, success in treating dependency on alcohol, cocaine and other abused substances is more likely if accompanying depression is simultaneously treated.

Fewer investigators have looked at whether treating substance abuse is helpful in reducing depression. There is some evidence that patients with major depression that is secondary to their substance abuse may have remission of their depressed mood once the substance abuse is treated. However, it is difficult to separate secondary depression from primary depression that predates or is separate from the substance use.

Additional Resources. A complete discussion of evaluation and treatment for chemical dependency is beyond the scope of this guideline. However, **SBIRT (Screening, Brief Intervention, Referral and Treatment)** is a process wherein a care coordinator uses motivational interviewing to assist patients who have high-risk drinking behavior. The National Institute on Alcohol Abuse and Alcoholism and other agencies offer tools to guide primary care-based medical treatment of alcohol abuse. For more information, see also the ICSI Healthy Lifestyles guideline and the following online resources by Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Psychiatric Comorbidity

Bipolar disorder

Be aware of ongoing mental illness diagnosis or other mental health illnesses and comorbidities. Patients with a history of manic (bipolar) symptoms now presenting with major depression may be destabilized if treated only with antidepressant drugs. If a manic or hypomanic episode occurs while treating a patient for depression, change the diagnosis to bipolar affective disorder and treat accordingly *(Judd, 2002)*. Behavioral health involvement is advised with these patients unless a patient has a prior history of successful primary care management.

Generalized anxiety disorder and panic disorder

Depressed patients may present with comorbid panic symptoms and generalized worries. Primary care clinicians should screen for symptoms of these disorders and potential causes. Assess for the following:

- Excessive use of stimulant containing products such as energy drinks or shots and caffeinated beverages
- Presence of medical causes of symptoms:
  - Thyroid disease
  - Cardiac disease
  - Irritable bowel syndrome
  - Migraines
  - Vestibular disorders
  - Respiratory and pulmonary disorders
- Use of medications like psychostimulants
- Use of or withdrawal of substances like cocaine, methamphetamine, THC or alcohol

Other disorders

Major depression may also be associated with other psychiatric problems including personality disorders, psychosis, eating disorders and substance abuse. Patients with these conditions may need specialty care services, and details of treatment are beyond the scope of this guideline.

Return to Algorithm *Return to Table of Contents*

Treatment

5. Discuss Treatment Recommendations

Primary goal. When considering treatment options, the primary goal is to achieve remission or to get the patient to be predominately symptom-free (i.e., a PHQ-9 score of less than five*) (Kroenke, 2001)*.

Shared decision-making. Shared decision-making is a practice that guides patients, families and physicians through a reliable process that incorporates patient values, priorities and goals into discussions of risks and benefits of treatment options *(O'Connor, 2007)*.

Patient participation in shared treatment decision-making improves depression treatment adherence and clinical outcomes in depressed patients *(Loh, 2007)*. There is also evidence that mental health patients want to participate in health care decisions and to have more information about their illness and potential treatments *(Adams, 2007; Hamann, 2005; Garfield, 2004)*. For more information, see the ICSI Shared Decision-Making Model in Appendix B.

Major Depressive Disorder Treatment Recommendation 1

Recommendation	Quality of Evidence and Strength of Recommendation
Consider combining pharmacotherapy and psychotherapy treatments for patients with major depressive disorder when practical, feasible, available and affordable.	Quality of Evidence: Moderate Strength of Recommendation: Weak
Benefit: The preponderance of moderate quality literature shows that outcomes are better when pharmacotherapy and psychotherapy treatments are combined than either treatment alone. **Harm:** The potential negative cumulative impact of time away from work and family to do psychotherapy, office visits to do psychotherapy, and potential side effects of medications could affect the patients. **Benefit-Harms Assessment:** When balancing better outcomes of the combined treatment with negative impacts of treatment on patients, the group felt the benefits of combined treatment outweigh the potential harms.	
Relevant Resources: *Cuijpers, 2014b; Hollon, 2014; Peeters, 2013; Spijker, 2013; van Hees, 2013; Cuijpers, 2012; Jakobsen, 2012b; Guidi, 2011; Oestergaard, 2011; Cuijpers, 2009a; Cuijpers, 2009c; de Maat, 2008*	

The decision to combine both antidepressants with psychotherapy is often individually decided for each patient, and many factors including patient preference, treatment availability, psychosocial factors and cost-effectiveness are often considered by clinicians.

Many times the clinician is faced with consideration of adding psychotherapy to patients who are treated with antidepressants. We reviewed 12 studies in regard to this and found 11 to show superiority of combined treatment in comparison to antidepressant-only treatment of depression *(Cuijpers, 2014a; Hollon, 2014; Spijker, 2013; van Hees, 2013; Cuijpers, 2012; Jakobsen, 2012b; Guidi, 2011; Oestergaard, 2011; Cuijpers, 2009b; Cuijpers, 2009c; de Maat, 2008)*. However, this superiority of combined treatment was limited and unlikely to be of consistent clinical relevance.

Conversely, clinicians are also faced with the consideration of adding antidepressants to patients treated with psychotherapy. We reviewed six studies, which all showed superiority of combined treatment over psychotherapy alone *(Cuijpers, 2014; Peeters, 2013; Spijker, 2013; Cuijpers, 2009b; Cuijpers, 2009c; de Maat, 2008)*. Similarly, this superiority also was of limited clinical significance.

Return to Algorithm *Return to Table of Contents*

Although many of these studies suggest that combining antidepressants and psychotherapy regularly for the treatment of depression may have limited added benefit, each decision should be made individually for each patient. There may be patients that respond better to combined treatment in comparison to either antidepressants or psychotherapy alone. In addition to this, patients being treated for depression may have other areas in need of treatment that either antidepressants or psychotherapy may not treat alone, such as comorbid mental health disorders or psychosocial stressors or medical issues.

Major Depressive Disorder Treatment Recommendation 2

Recommendation	Quality of Evidence and Strength of Recommendation
When unable to do combined therapy due to patient preference or availability/affordability of the treatments: **1. Consider starting with psychotherapy for mild to moderate major depression; 2. Consider starting with pharmacotherapy for severe major depression.**	Quality of Evidence: Moderate Strength of Recommendation: Weak
Benefit: Generally, the evidence shows that both medication and therapy are reasonably effective. For mild to moderate major depression, psychotherapy alone may lengthen the time to relapse and patients may be more successfully withdrawn from the medications. For severe major depression, it appears that medications have a significantly higher effect size than psychotherapy. **Harm:** For mild to moderate major depression, disruptions include taking time for office visits to do psychotherapy, and time away from work and family. For severe major depression, these are the potential side effects of medications. **Benefit-Harms Assessment:** Even though the quality of the majority of individual articles are moderate to high, the overall literature is quite weak in documenting harms, availability and costs to the individual patient. There was no scientific or easy way to directly compare the benefits to costs. The seasoned clinicians in the group chose to go with the benefits in terms of somewhat better outcomes based upon the literature but qualify this by making the recommendations weak. This is an area where shared decision-making is likely to be especially valuable.	
Relevant Resources: *Cuijpers, 2015; Kuyken, 2015; Biesheuvel-Leliefeld, 2015; Menchetti, 2014; Steinert, 2014; Cuijpers, 2013; Piet, 2011; Segal, 2010; Dobson, 2008*	

Major depressive disorder is often a chronic disorder, and treatments need to reduce symptoms over long periods of time. There is evidence that an acute course of psychotherapy may lengthen the period of time before relapse or recurrence *(Biesheuvel-Leliefeld, 2015; Steinert, 2014)*. In addition to this, Cuijpers, 2013 and Dobson, 2008 found acute phase-only cognitive behavioral therapy (CBT) without maintaining patients on antidepressants to be equal in efficacy to maintaining patients on antidepressants for 6-18 months after remission *(Cuijpers, 2013; Dobson, 2008)*.

It appears that antidepressants may have a significantly higher effect size in patients with severe depression *(Fournier, 2010)*. In addition to this, there is some evidence that patients with mild depression may preferentially respond to psychotherapy, while patients with moderate to severe depression may preferentially respond to antidepressants *(Spielmans, 2011)*.

Segal, 2010 and Kuyken, 2015 found patients given psychotherapy and withdrawn off of antidepressants to have comparable rates of relapse to those remaining on maintenance antidepressant treatment for up to 24 months *(Kuyken, 2015; Segal, 2010)*.

Generally, antidepressants and psychotherapy appear to be equally effective in the acute treatment of depression *(Spielmans, 2011)* and the selection of the treatment modality may be affected by patient preference, treatment availability and relative cost.

Return to Algorithm *Return to Table of Contents*

Persistent Depressive Disorder

The majority of the literature on persistent depressive disorder is based on DSM-IV criteria and divides it into the following categories:

1) Pure dysthymia for the whole duration
2) Major depression that is chronic for at least two years
3) Eecurrent major depression without inter-episode recovery
4) Major depression that is superimposed on a pre-existing dysthymic disorder (persistence for at least two years defines this category)

DSM-5 consolidated DSM-IV and included dysthymic disorder and chronic major depressive disorder into one large category called persistent depressive disorder. DSM-5 details four subsets of persistent depressive disorder, which are a slight variation of the above.

However, for treatment purposes, the subsets of chronic depressive disorders/persistent depressive disorder can be placed into two main categories – pure dysthymia and chronic disorders involving major depression. Available literature indicates that pure dysthymia responds differently to treatment than the three other subsets of chronic depressive disorders involving major depression.

Pure Dysthymia Treatment Recommendation

Recommendation	Quality of Evidence and Strength of Recommendation
Consider starting with medication in pure dysthymia patients. The work group feels that it is reasonable to consider stepped care, which includes augmenting medications and adding psychotherapy for patients who don't improve.	Quality of Evidence: High Strength of Recommendation: Strong
Benefit: Antidepressant treatment of pure dysthymia outperforms both placebo and psychotherapy in acute trials and can begin to reverse the symptoms, suffering and impairment of a condition that can go on for decades left untreated. **Harm:** A significant percentage of patients will fail to respond and require additional treatment. For those who ultimately require a trial of psychotherapy and benefit from it, starting medication first will have represented a delay in receiving effective care. Antidepressants and augmenting agents have side effects and adverse interactions with other drugs. It is not clear how long to continue psychotherapy that has not yet started to work. **Benefit-Harms Assessment:** Evidence supports starting with antidepressant medication and one can choose later to add psychotherapy for those who fail to respond or recover. It is reasonable to start with antidepressant medication since it tends to work more quickly than psychotherapy. Access to high-quality psychotherapy is not available in many primary care settings.	
Relevant Resources: *Kriston, 2014; von Wolff, 2013; Cuijpers, 2012; Levkovitz, 2011; Cuijpers, 2010b; Cuijpers, 2009b; Imel, 2008; Markowitz, 2005; Browne, 2002*	

The impact of dysthymia with lifetime prevalence of 3-6% is often underestimated even though the cumulative burden after years of symptoms results in greater impairment in functioning than that seen in briefer major depressive episodes that remit. Consequences include loss of well-being; increased psychiatric comorbidity; more impairments in social, psychological and emotional functioning; increased health care utilization; and more suicide attempts and hospitalizations *(Kriston, 2014)*.

Meta-analyses by von Wolff, 2013 and Levkovitz, 2011 show that antidepressant treatment was significantly more effective than placebo in pure dysthymia. This was due in part to the lower placebo response rate in

dysthymia patients compared to patients with major depression (29.9 vs. 37.9%). The authors believe this may be because many dysthymic patients have been depressed so long they no longer expect to recover *(von Wolff, 2013; Levkovitz, 2011)*.

Further literature showed that medication alone was significantly more effective than psychotherapy alone in pure dysthymia in meta-analyses *(Kriston, 2014; Cuijpers, 2012; Cuijpers, 2010b; Imel, 2008)* and a randomized control study *(Browne, 2002)*.

Medication alone was equal to combined psychotherapy and medication in meta-analyses *(Cuijpers, 2012; von Wolff, 2013)* when the subjects were dysthymic patients. Similarly, in the study *(Browne, 2002)*, medication alone was superior to combined treatment in terms of symptom reduction, but the difference was not statistically significant. In that study, one-third of the patient sample suffered from pure dysthymia.

Chronic Major Depression Treatment Recommendation

Recommendation	Quality of Evidence and Strength of Recommendation
For patients with chronic major depression, start with combined antidepressant medication and psychotherapy.	Quality of Evidence: High Strength of Recommendation: Strong
Benefit: Antidepressant treatment with psychotherapy outperforms either treatment as monotherapy and more rapidly begins the process of reversing symptoms, suffering and functional impairment in a condition that can go on for decades untreated. Psychotherapy can produce quality-of-life improvements and lower health and human services costs. **Harm:** Combined medication and psychotherapy increase short-term costs. Access to high-quality psychotherapy is not available in many primary care settings. In the Keller, 2000 study of chronic major depression, which excluded pure dysthymic disorder, the overall drop-out rate was the same for the three treatment groups, but reasons for dropping out varied. More patients dropped out of the medication-alone arm because of adverse events, and more psychotherapy patients withdrew consent because therapy was too time consuming, they did not want psychotherapy, or they wanted medication. This highlights the need to consider patient preferences. The benefits of psychotherapy are delayed and may cause some patients to give up on it prematurely. **Benefit-Harms Assessment:** The chronic nature of persistent depressive disorder, which produces serious life consequences that are often underestimated, justifies the combination of medication and psychotherapy. In the Keller, 2000 study, those in the combined treatment group had fewer dropouts than the medication-alone group due to adverse events (14% vs. 7%). There is some evidence that although benefits of psychotherapy are delayed, they continue even after psychotherapy is stopped.	
Relevant Resources: *Kriston, 2014; Weirsma, 2014; Spijker, 2013; Cuijpers, 2012; Cuijpers, 2010b; Kocsis, 2009a; Imel, 2008; Browne, 2002*	

Persistent depressive disorders that include major depression can be summarized in the following categories: chronic major depression, recurrent major depression without inter-episode recovery, and major depression superimposed on preexisting dysthymic disorder.

The higher the ratio of chronic major depression to dysthymic disorder in the patient groups studied, the greater the likely advantage of combined treatment over medication alone *(Kriston, 2014)*.

Combined psychotherapy and medication was superior to medication alone in meta-analyses *(Kriston, 2014; Cuijpers, 2010b)* (both involving mixed samples of dysthymia and chronic depression), *(Spijker, 2013; Kocsis, 2009)* (both involving chronic major depression).

Combined treatment was superior to psychotherapy alone in a 2010 meta-analysis by Cuijpers.

The differential response to treatment in dysthymia compared to chronic depression also held true in a meta-analysis, where combined treatment was superior to psychotherapy alone for chronic depression but not superior in dysthymia, at least in the short term *(Cuijpers, 2012)*.

The evidence is promising for CBASP (Cognitive Behavioral Analysis System of Psychotherapy), which was superior in a head-to-head comparison with interpersonal psychotherapy (IPT) *(Schramm, 2011)*. It also was superior to a robust "care as usual" comparison of medication combined with other psychotherapy at 52 weeks (borderline significance) in patients with chronic major depression *(Wiersma, 2014)*. Here, too, the differential influence of depressive subtype may have come into play. Spijker, 2013 notes that the literature is mixed on the question of which psychotherapy is best and that most evidence-based psychotherapies in combination with medication can enhance results.

Shortcomings of the literature. Psychotherapy was of relatively short term in most studies, and there was not always long-term follow-up data.

In some studies and meta-analyses comparing psychotherapy with medication and combination treatment, psychotherapy was stopped and medication was continued. For example, Browne's 2002 study compared subjects on sertraline, sertraline plus interpersonal therapy, and interpersonal therapy alone. The 10 interpersonal psychotherapy sessions were complete at six months, but subjects were allowed to continue sertraline in the 18-month naturalistic follow-up. The authors suggest that further investigation into maintenance IPT would be useful. In spite of the short duration of therapy, the two groups receiving IPT had lower health and human service costs during the first six months, and total cost of treatment was less in the IPT alone group.

Imel, 2008 questions whether it is reasonable to expect a short-term treatment to reverse the signs and symptoms that in some cases have been present for decades. The author also adds that the length of follow-up after psychotherapy, at least in chronic depression, was predictive of a positive outcome, indicating that results take time. He noted that quality-of-life outcomes were significantly better with combined treatments *(Imel, 2008)*.

There was a dose-response effect with psychotherapy for chronic major depression and dysthymia, with 18 sessions estimated to realize optimal effect sizes. Cuijpers, 2010 and Imel, 2008 reported finding that an average of 31 sessions of psychotherapy were necessary to treat dysthymia to remission *(Cuijpers, 2010b; Imel, 2008)*.

Another shortcoming is that this literature does not address treatment resistance. Only one study in Cuijpers, 2012 meta-analysis focused on treatment-resistant patients, and combined treatment was superior to medication alone in that study. A study by Keller, 2000 of 681 randomized patients on the advantage of combined treatment (73% response rate) over monotherapy with CBASP or the antidepressant nefazodone in chronic major depression (both groups had a 48% response rate) excluded both pure dysthymic patients and treatment resistant patients, limiting its generalizability to those populations.

Spijker, 2013 wrote that there were likely more treatment-resistant patients among chronic depressives compared with pure dysthymics. Spijker, 2013 meta-analysis cites a randomized controlled study of 801 patients with chronic major depression seeking treatment in a mental health center in which only 33% had received an adequate trial of antidepressants. Dysthymic patients may be even less likely to have had a medication trial *(Spijker, 2013)*.

Clinicians should be aware of the high risk of treatment resistance in chronic depressive disorder. Even combined treatment can fail, and referral for specialty treatment may be necessary. Psychotherapy may take longer to be effective, and there is some indication that positive results are delayed relative to medication. There is also some evidence that long-term benefits occur that remain even after psychotherapy is stopped, which is not the case with stopping medication *(Wiersma, 2014; Imel, 2008; Keller, 2000)*.

Longer-term studies of psychotherapy are needed, and better treatments for treatment resistance must be found.

More About Individual Treatments

- Behavioral activation
- Appropriate physical activity
- Psychotherapies
- Pharmacotherapy
- Integrative medicine

Behavioral Activation

Contact with others and engaging in activities are often seen by depressed patients as unpleasant or undesirable. Because of this discomfort, depressed patients often avoid pleasurable or even routine activities. This may have the impact of increasing depressive symptoms. Behavioral activation seeks to interrupt this process and bring about symptom relief through increasing positive interactions with others and their environment. Two meta-analyses of a combined 50 studies published over the past 40 years have demonstrated that behavioral activation produces improvement in depression comparable with other manualized treatments for depression (such as cognitive behavioral therapy). Moreover, follow-up assessments showed that the improvements in depression persisted after the active treatment had been discontinued *(Mazzucchelli, 2009; Cuijpers, 2007)*.

The efficacy of behavioral activation is fairly clear as compared with traditional psychotherapy. It may even be as effective as antidepressant medications *(Dimidjian, 2006)*. Given the problem of medication side effects, behavioral activation provides for an attractive intervention for the treatment of depression. It is also a relatively easy treatment to administer, furthering its appeal.

Activity scheduling is an attractive treatment approach for individuals who may be difficult to treat, such as depressed dementia patients or depressed elderly patients. Regular outings and get-togethers, participation in a senior day care program, participation in available nursing home activities, etc., are all likely to reduce depression in the elderly *(Cuijpers, 2007)*.

Given the benefits of this procedure, low risks and the relative ease of incorporating it into ongoing treatment, whether with traditional psychotherapy, antidepressant medications or both, it seems that this would be a prudent intervention to add almost across the board.

Based on the work group members' experience with using behavioral activation, consider following when doing behavioral activation with the patients:

- The role of the clinician is to help patients increase their exposure to the positive life experiences they had prior to onset of depression. Reinforce the positive to slowly replace the negative coping skills they have learned.
- Goals should be focused on external factors (resuming activities that patients have been avoiding) and not on internal factors (waiting for patients to be motivated to make a change).
- Help patients set priorities for long- and short-term goals and to understand the difference.
- Help patients decide what changes are necessary to reach their goal – the what, when, where. Goals should be SMART (specific, measurable, attainable, realistic, timely).
- Do not recommend new life or health goals (smoking cessation, weight loss, etc.) even though this may feel like a great time to encourage them to reinvent themselves.

Return to Algorithm *Return to Table of Contents*

- If the patient recommends a new goal, discourage him/her from taking on a new life challenge. This sets patients up for high risk of failure and frustration, which will only worsen their depression. Use language: "That sounds like a very challenging goal. I think it would be better if we started with something a little less complex. How does that sound to you?"
- When you see patients for follow-up, ask them about the progress on their goals. It reinforces that you care and that you find all their effort important (positive experience).
- If they don't achieve the goal, congratulate them on their efforts and whatever parts they did accomplish. Ask them about what they struggled with. It provides insight into the hurdles they face on a daily basis, which is likely having an effect on the other aspects of their health care.

More about generating goal ideas:

- What was the patient doing when he/she was not depressed? One way to ask is this: "When you think back to when you were last happy, what did your life look like?" (Ask him/her to describe the environment – what was he/she doing, who is around him/her, etc.).
- What activities have they been avoiding – work, time with friends, hobbies, hygiene, housework, parenting, etc.?
- What activities have they found to be fun in the past? Choosing a fun goal can help them rebuild positive experiences. They may not initially find the activity as fun as it had been in the past, but it is the baby steps that will help get them back on track.

More about setting goals with the patients:

1. Help patients break down their goal idea into action steps.
2. Help them arrange the steps from simple to complex.
3. Set a goal with one simple step to accomplish the first week. It is important that you start this process with a goal that has a high likeliness of success, as early wins will encourage them to keep going and tackle more complex goals that were identified in step 2.
4. Week two goal is to accomplish the second action step identified in step 2 above, week three builds on week two goal, etc.
5. Encourage patients to set a reward at the end of the week for accomplishing goals. For some patients, they may struggle at this initially because they don't find themselves worthy of a reward.

Appropriate Physical Activity

Evidence suggests that physical activity at a dose consistent with public health recommendations is a useful tool for easing major depression symptoms (*Dunn, 2005; Babyak, 2000)*. Exercise has been shown to work well as monotherapy or adjuvant to medication in moderate depression. Exercise has shown promise as adjuvant therapy in treatment-resistant major depression in women, and there is a small but growing body of evidence of some long-term as well as preventive attributes *(Schuch, 2011)*.

When prescribing exercise either alone or as an adjunct to medication and psychotherapy, the complexity and the individual circumstances of each patient must be considered. When creating an exercise prescription, several caveats apply:

- Aerobic exercise was not more effective than resistance (weight lifting) training *(Danielsson, 2013; Rethorst, 2013; Silveria, 2013)*. Other research found a larger effect size for mixed aerobic and resistance training than either alone *(Cooney, 2013)*.
- The largest effect size was observed for 13-36 sessions, but there was an observable benefit for less (0-12) *(Cooney, 2013)*.

Return to Algorithm *Return to Table of Contents*

- Total calories expended may be more important than frequency *(Rethorst, 2013)*.
- Like medication, it must be continued to have an antidepressant effect. In eight studies with long-term follow-up, only a small effect size remained, suggesting the benefits are lost if exercise is stopped *(Cooney, 2013)*.

Psychotherapies

A preponderance of randomized controlled trials (RCTs) and meta-analyses show that various psychotherapies – interpersonal (IP), psychodynamic (PD), cognitive behavioral (CBT), behavioral activation, problem-solving therapies and mindfulness-based cognitive therapies, brief psychotherapies – are effective at reducing depressive symptoms *(Cuijpers, 2014b; Churchill, 2013; van Hees, 2013; Jakobsen, 2012a; McCarney, 2012; Cuijpers, 2011b; Jakobsen, 2011a; Jakobsen, 2011b; Manicavasgar, 2011; Cuijpers, 2010a; Driessen, 2010; Hofmann, 2010; Cuijpers, 2009b; Bortolotti, 2008; Cuijpers, 2008; Ekers, 2008; Haby, 2006)*. (A separate section discusses comparisons with antidepressants.) A number of these articles highlight that results tend to be overestimated due to selection bias and potential random errors *(Cuijpers, 2014a; Jakobsen, 2011b, Jakobsen, 2011a; Jakobsen, 2011c; Cuijpers, 2010a)*. Individual RCTs and meta-analyses also looked at whether a specific psychotherapy was better than another or better for a subpopulation such as age, severity or comorbidities. When one looks at a large sample of such studies, it does not appear that there is sufficient evidence to definitely recommend one over another *(Cuijpers, 2014a; Flückiger, 2014; Okumura, 2014; Churchill, 2013; van Hees, 2013; Jakobsen, 2012a; McCarney, 2012; Cuijpers, 2011a; Cuijpers, 2011b; Jakobsen, 2011a; Jakobsen, 2011b; Jakobsen, 2011c; Manicavasgar, 2011; Cuijpers, 2010a; Driessen, 2010; Hofmann, 2010; Bortolotti, 2008; Cuijpers, 2008; Ekers, 2008; Haby, 2006)*. There were mixed results in claims about how effective psychotherapies are for severe depression *(Cuijpers, 2011a; Cuijpers, 2011b; Driessen, 2010)*.

Pharmacotherapy

Medications

The acute treatment phase is focused on treating the patient to remission. Acute therapy typically lasts 6-12 weeks but should last until remission is reached *(American Psychiatric Association, 2013; Diagnostic and Statistical Manual of Mental Disorders, 5th Edition)*.

Definition: Full remission is defined as a two-month period devoid of major depressive signs and symptoms *(American Psychiatric Association, 2013; Diagnostic and Statistical Manual of Mental Disorders, 5th Edition)*.

For antidepressant medications, treatment adherence and achieving clinical goals are more important than the specific medication selected. Successful treatment often involves dosage adjustments and/or trial of a different medication to maximize response and minimize side effects *(American Psychiatric Association, 2010)*.

Selection of an antidepressant medication

The overall effectiveness of antidepressant medications is generally equivalent between and within classes of medications *(American Psychiatric Association, 2010)*. However, there are distinct differences in individual patient response to and side effects caused by the classes of medications and individual agents.

Antidepressant drug selection should be based on:

- The patient's and family history of response to previous antidepressant medications (if any)
- Patient preferences
- Side effect profile (e.g., sedating, activating, weight gain, impact on sex life)

Return to Algorithm *Return to Table of Contents*

- Antidepressant medications with anticholinergic side effects contribute to dry mouth/xerostoma, caries, gingivitis and periodontal disease *(Tschoppe, 2010; Shinkai, 2006)*. This risk should be discussed with patients prior to initiation of these medications.
- Safety in overdose (e.g., 10 days of a TCA can be a lethal overdose)
- Availability and costs
- Drug-drug interactions
- Positive or negative impacts on the patient's comorbid psychiatric or medical conditions (for example, smoking cessation, ADHD or anxiety). See Annotation #4a, "Is the Presence of Substance Use Disorder or Psychiatric Comorbidity Suspected?" for more information on psychiatric comorbidities.

Medications and Genomics. The genetic differences in the metabolism of certain medications including antidepressants can be determined by cytochrome P450 genetic testing. This testing may identify individual patients who may be more sensitive to serious adverse reactions or medications with narrow therapeutic windows of specific medications. However, the clinical significance and applicability to daily clinical practice has not yet been established *(Narasimhan, 2012; Porcelli, 2011)*.

Is medication needed? A meta-analysis of efficacy of acute (three-month) treatment with antidepressants *(Fournier, 2010)* for depression found the magnitude of benefit from antidepressant medications increased with the severity of a patient's depressive symptoms. If a patient's initial symptoms are minimal or qualified as mild or moderate depression, symptom benefits from antidepressants may not significantly differ from placebo. They suggested that for short-term and less-severe patients, behavioral activation plus lifestyle modifications may be enough. For patients with very severe depression, the authors found the benefit of medications over placebo is substantial *(Fournier, 2010)*.

Classes of Medications

Selective serotonin reuptake inhibitors (SSRIs) and other antidepressants

SSRIs and other second-generation antidepressants such as venlafaxine, duloxetine, desvenlafaxine, mirtazapine, bupropion, levomilnacipran, vilazolone and vortioxetine are frequently recommended as first-line antidepressant treatment options due to the quality and quantity of published data, relative tolerability of side effects compared to TCAs and MAOIs, and their overall relative safety *(American Psychiatric Association, 2010; Trivedi, 2001)*. They generally lack the common adverse reactions (anticholinergic, sedative effects) of the tricyclics antidepressants and cause fewer problems when taken in overdose. However, they may cause headache, nervousness, insomnia and sexual side effects *(von Wolff, 2013)*. Newer antidepressant agents such as vilazodone, vortioxetine and levomilnacipran are available, but data on their long-term use is limited. They may also be more expensive or not routinely covered by insurance plans for some patients.

The current evidence does not support the choice of one second-generation antidepressant over another due to differences in efficacy or effectiveness. The choice of medication may depend on onset of action and adverse events *(Gartlehner, 2008)*.

Secondary amine tricyclics (TCAs)

The literature clearly supports the effectiveness of tricyclics. Because of associated side effects, TCAs are used less frequently as first-line agents.

Secondary (nortriptyline) amine tricyclics cause less orthostatic hypotension and sedation than do tertiary (amitriptyline) amine tricyclics.

These medications should be monitored cautiously in patients with heart problems, or in patients with potential for drug interactions. Monitoring blood levels and EKG may be advised.

Monoamine oxidase inhibitors (MAOIs)

MAOIs, in general, should be restricted for patients who do not respond to other treatments, because of the potential for serious side effects and the necessity of dietary restrictions. Patients who have major depressive disorders with atypical features are one group for whom several studies suggest MAOIs may be particularly effective. However, in clinical practice, many psychiatrists start with SSRIs in such patients because of the more favorable adverse effect profile. Consider a dietary and/or psychiatry consultation if prescribing MAOIs.

Atypical antipsychotics

The atypical antipsychotics are recommended by the American Psychiatric Association as second-line augmentation options *(American Psychiatric Association, 2010)*. Three atypical antipsychotics have been approved for the adjunctive treatment of major depressive disorder: aripiprazole, quetiapine and the combination of olanzapine and fluoxetine. There is some evidence regarding the use of quetiapine as monotherapy for the treatment of major depression *(Zhornitsky, 2011)*. Unfortunately, the adverse effects of atypical antipsychotics may concern some patients *(Wright, 2013)*. In a review of three randomized, placebo-controlled studies of quetiapine extended-release monotherapy in adults with major depressive disorder, the authors found it effective in response and remission of symptoms of depression. However, quetiapine was associated with a higher rate of side effects compared to placebo *(Maneeton, 2012)*. When used as part of an augmentation strategy, doses should be individualized and safety (and efficacy) should be frequently reassessed *(Wright, 2013)*.

Adherence, Patient Interaction and Monitoring

Adherence is important. For antidepressant medications, adherence to a therapeutic dose and meeting clinical goals are more important than the specific drug selected. Successful treatment often involves dosage adjustments and/or trial of a different medication at some point to maximize response and minimize side effects *(American Psychiatric Association, 2010)*.

Key messages for patients using antidepressant therapy. When antidepressant therapy is prescribed, the following key messages should be highlighted to support medication adherence and completion of treatment goals:

- Side effects from medication often precede therapeutic benefit and typically recede over time. It is important to expect side effects prior to symptom benefit.
- Most people should be on medication at least 6-12 months after adequate response to symptoms *(American Psychiatric Association, 2010)*.
- Patients may have symptom improvement after two weeks but will need a longer length of time for full response and remission.
- Take the medication as prescribed, even after you feel better. Premature discontinuation of antidepressant treatment has been associated with a 77% increase in the risk of relapse/recurrence of symptoms *(Melfi, 1998)*. The probability of recurrence of depressive symptoms was found to be 25% after one year, 42% after two years, and 60% after five years in one study *(Solomon, 2000)*. Each episode of recurrence increased the risk of subsequent episodes by 16% *(Solomon, 2000)*.
- Do not stop taking the medication without calling your clinician. Side effects often can be managed by changes in the dosage or dosage schedule.

Adherence strategies. Consider increasing education, engagement and follow-up for patients who are at higher risk for not adhering to treatment. For antidepressant treatment, this includes patients who are newly diagnosed with depression, in the midst of their first depression, or who have lapsed in the middle of

a previous course of treatment *(Vanelli, 2008)*. In addition to medication monitoring, clinical management of patients placed on antidepressants should include the clinician's support and reassurance.

Duration of Pharmacotherapy

Without long-term antidepressant treatment, major depressive relapses and recurrences occur in 50-80% of patients *(American Psychiatric Association, 2010)*. Double-blind discontinuation studies reveal that antidepressants decrease the risk of relapse and recurrence; such studies have repeatedly shown antidepressants to be more efficacious than placebo substitution.

The dose of antidepressant medication that leads to satisfactory acute therapeutic response should be maintained during long-term treatment to reduce the risk for relapse and recurrence of depression *(Sonawalla, 2001; Flint, 2000; Frank, 1993)*.

Discuss with the patient the specific side effect profiles, costs and benefits of different antidepressants, including generics. Cost implications for patients need to be discussed between clinician and patient.

There is no difference between brand versus generic medications based on adverse clinical outcomes.

When considering how long to continue medication after the remission of acute symptoms, two issues need to be considered: maintenance and prophylactic treatment. Patients who require several medication changes to achieve remission of an acute major depressive episode have a higher rate of relapse and a shorter period of time until relapse in comparison with patients who require fewer medication changes to achieve remission *(Rush, 2006)*.

A recent review of maintenance trials for patients with major depression found continuing medication treatment after initial response to an antidepressant was successful in significantly reducing relapse rates compared with placebo. Mean relapse rates were 18% for antidepressants and 37% for placebo *(Borges, 2014)*.

Significant data support the efficacy of antidepressants in preventing the recurrence of a major depressive episode. Although more research needs to be conducted, findings indicate that patients who are at highest risk of future episodes have had multiple prior episodes or were older at the time of the initial episode *(Keller, 1998)*. These patients are candidates for long-term or lifetime prophylactic treatment. Analysis suggests that recurrence rates are reduced by 70% when patients are maintained on antidepressants for three years following their previous episode (average recurrence on placebo is 41% versus 18% on active treatment) *(Hirschfeld, 2001; Greden, 1993)*.

Depression Medication Treatment Duration Based on Episode

Episode	Treatment Duration
1st episode (major depression, single episode)	• Continue medication treatment for 4-9 months once remission is reached. • Total = approximately 6-12 months
2nd episode (major depression, recurrent)	Continue medication treatment for 2-3 years once remission is reached. Withdraw gradually.
Persistent depressive disorder or 3+ episodes or 2 episodes (major depression, recurrent) with complicating factors such as: • Rapid recurrent episodes • Patients with partial/inadequate response to initial treatment	Continue medication treatment indefinitely.

(Sources: National Institute for Health and Care Excellence, 2012; American Psychiatric Association, 2010; Hirschfield, 2001; Keller, 1998; Greden, 1993)

Discontinuation of Pharmacotherapy

Premature treatment discontinuation can be triggered by a number of factors, including lack of adequate education about the disease, failure on the part of either physician or the patient to establish goals for follow-up, psychosocial factors and adverse side effects. **Appropriate ongoing collaborative care for depression can increase remission rates to as much as 76% by 24 months** *(Rost, 2002; Schoenbaum, 2002)*.

Complicating factors are those situations where evidence either shows or suggests higher rates of recurrence after stopping antidepressants. Such factors include:

- pre-existing persistent depressive disorder,
- inability to achieve remission, and
- recurrence of symptoms in response to previously attempted lowering dose or discontinuation of pharmacotherapy.

(Paykel, 1995)

If discontinuation of treatment is thought to be appropriate or necessary despite the known risks, a plan of action should be in place for prompt intervention if relapse occurs *(Greden, 1993)*.

In general, it is recommended that the dose be tapered over a period of weeks to several months when discontinuing an antidepressant. (Note that this approach is only feasible when the starting dose is lower than the therapeutic dose.)

The various existing antidepressants exhibit a wide array of half-lives and therapeutic dose ranges. Therefore, a discussion of detailed discontinuation strategies is beyond the scope of this guideline.

Risks

Clinicians should be alert for worsening of symptoms. Health care clinicians should carefully evaluate their patients in whom depression persistently worsen, or emergent suicidality is severe or abrupt in onset, or was not part of the presenting symptoms. Reassessment is required to determine what intervention, including discontinuing or modifying the current drug therapy, is indicated.

The clinician should instruct the patient and the patient's caregiver to be alert for the emergence of agitation, irritability and other symptoms. The emergence of suicidality and worsening depression should be closely monitored and reported immediately to the clinician.

See also Annotation #3a, "Is Patient Safe to Self and/or Others?"

Risks Related to Special Populations

Children, adolescents and young adults

The U.S. Food and Drug Administration has requested manufacturers of antidepressants include a warning statement regarding antidepressants increasing the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents and young adults. The full warning statement can be found at http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/UCM096273.

Be alert for worsening of symptoms. Health care clinicians should carefully evaluate their patients in whom depression persistently worsen, or emergent suicidality is severe or abrupt in onset, or was not part of the presenting symptoms. Reassessment is required to determine what intervention, including discontinuing or modifying the current drug therapy, is indicated.

The clinician should instruct the patient and the patient's caregiver to be alert for the emergence of agitation, irritability and other symptoms. The emergence of suicidality and worsening depression should be closely monitored and reported immediately to the clinician.

See also Annotation #3a, "Is Patient Safe to Self and/or Others?"

Return to Algorithm *Return to Table of Contents*

Elderly patients

Because of the potential for decreased renal and hepatic function, and also for concomitant diseases and medications, the elderly are at higher risk of significant side effects or drug interactions with antidepressant medications. For elderly patients with moderate to severe depression, TCAs such as nortriptyline continue to be regarded as the most effective treatment *(Alpert, 2003; Gastó, 2003)*. Consider starting at the lowest possible dose and increasing slowly to effective dose or until side effects appear. Tertiary amine tricyclics should generally be avoided in elderly patients because of the high incidence of orthostatic hypotension, sedation, cognitive problems and cardiac effects with these agents.

Risks of Medication Interactions

Many antidepressant agents have clinically significant drug interactions, particularly those agents that undergo cytochrome P450 enzymatic metabolism in the liver. A complete discussion of this topic is beyond the scope of this guideline. Practitioners are advised to consult references such as the Physician's Desk Reference, American Hospital Formulary Service, Epocrates or Micromedex for more information about drug interactions with specific agents, and to assess the significance of the interaction prior to prescribing antidepressants.

Risks Associated with Specific Medications

Citalopram warning

In 2011, the Food and Drug Administration (FDA) published a "Medwatch" drug safety alert regarding the potential risk of abnormal heart rhythms associated with citalopram doses greater than 40 mg a day due to concerns about prolonged QT interval prolongation and the risk for torsades de pointes. Prescribers were initially told to avoid using citalopram doses higher than 40 mg and discouraged from using it at all in patients with congenital long QT syndrome, bradyarrhythmias, congestive heart failure, or at risk for developing hypokalemia or hypomagnesemia. In March 2012 this was revised by downgrading the warning from "contra-indicated" to "not recommended" for patients with congenital long QT syndrome because patients with this condition have few viable alternative treatments. Ongoing monitoring was suggested, a maximum dose of 20 mg/day was recommended for age > 60, and discontinuation was recommended when QTc > 500ms.

A recent review of Veterans Health Administration patients who were prescribed citalopram between 2004 and 2009 (N=618,450) found daily doses of citalopram greater than 40 mg a day were associated with lower risks of ventricular arrhythmias, all-cause mortality and non-cardiac mortality compared with lower doses of citalopram. Overall, no increased risks of cardiac mortality were observed. These results were similar when compared with a cohort of patients prescribed sertraline (N=365,898) during the same time period *(Zivin, 2013)*.

Serotonin syndrome

Serotonin syndrome is a potentially life-threatening, pharmacodynamic drug interaction resulting in excessive nervous system levels of serotonin. Patients experiencing this reaction may present with mental status changes such as anxiety, confusion, delirium or coma. Autonomic symptoms may include tachycardia, labile blood pressure and hyperthermia. Muscle rigidity, ataxia, tremor, myoclonus and other neurologic symptoms are also common.

Serotonin syndrome has often been inaccurately reported and erroneously attributed to various serotonergic medications. Specific diagnostic criteria have been developed to assist prescribers in the diagnosis of the "toxidrome" *(Evans, 2010; Gillman, 2006)*. Rather than an idiosyncratic reaction, serotonin syndrome or serotonin toxicity is the result of drug-induced elevations of intrasynaptic serotonin. Not all serotonergic agents are capable of producing the intrasynaptic elevation of serotonin associated with true serotonin toxicity *(Gillman, 2006)*.

Return to Algorithm *Return to Table of Contents*

The primary criterion for an accurate diagnosis and risk assessment is recent exposure to a serotonergic agent or combination of agents able to produce significant elevations of synaptic serotonin. According to the Hunter Area Toxicology Service (HATS) data, the higher levels of intrasynaptic serotonin caused by combinations of MAOIs with an SSRI are likely to cause hyperpyrexia and death. The combinations of clomipramine, imipramine or venlafaxine with an MAOI have also been associated with fatalities *(Gillman, 2006)*.

In 2006, the FDA issued a warning about the life-threatening risk of combining SSRIs with triptans (for the treatment of migraine headaches). The warning included 29 case reports. Most of the case reports were incomplete and often did not meet established diagnostic criteria for serotonin syndrome. Current evidence does not support limiting the use of triptans with SSRIs or SNRIs *(Evans, 2010; Gillman, 2010; Wenzel, 2008)*.

Integrative Medicine

While there are many integrative treatments available, our discussion highlights some of the types of treatments. They include acupuncture, yoga, herbs and dietary supplements. They were selected because they are evidence based and/or more commonly utilized.

Acupuncture

There is considered to be high-level evidence to support the use of acupuncture during pregnancy for the treatment of depressive episodes *(Sniezek, 2013)*. An open, parallel-arm, randomized study showed acupuncture to result in equal efficacy in comparison to counseling with a significant reduction in depressive symptoms for both in comparison to usual care *(MacPherson, 2013)*. Existing meta-analyses and systematic reviews vary with respect to acupuncture protocol (manual, electroacupuncture or sham), methodological soundness and efficacy results *(Freeman, 2010)*. Both sham and active acupuncture participants generally report symptomatic depression improvement *(Freeman, 2010)*. Serious adverse events from acupuncture are very uncommon, which may appeal to those who seek to avoid side effects associated with traditional treatments (e.g., medication side effects).

Yoga

Yoga has been shown to be effective as an adjunctive treatment to decrease symptom severity *(Ravindran, 2009)*. It has yet to be determined what aspects of yoga are responsible for any potential depressive symptom improvements *(Louie, 2014)*.

Tai Chi

Limited evidence suggests that Tai Chi may be effective for psychological well-being measures that include depressive symptoms *(Wang, 2014)*. There is yet insufficient evidence, though, to recommend Tai Chi for the treatment of depressive episodes.

Herbals and dietary supplements

Caution: Many drugs interact with St. John's Wort, including other antidepressants, warfarin, oral contraceptives, antiretroviral, anti-cancer and anti-rejection drugs. Care should be taken to ask all patients what medications they are taking, including over-the-counter and supplements, to avoid these interactions.

Herbal products and nutritional supplements are not evaluated or regulated by the U.S. Food and Drug Administration for safety, efficacy or bioavailability.

St. John's Wort and Sam-E. In a meta-analysis *(Morgan, 2008)*, S-adenosylethione (Sam-E) and hypericum perforatum (St. John's Wort) were found to have indications for mild to moderate depression but not major depression. Sam-E and St. John's Wort should not be taken in combination with other antidepressant medications. A Cochrane meta-analysis concluded that there is insufficient evidence to recommend the use of St.

John's Wort in the treatment of major depression. Research is limited by lack of large scale RCTs and high risk of bias in the majority of trials meeting inclusion criteria for the meta-analysis *(Smith, 2010; Linde, 2008)*.

Saffron (Crocus sativus L.)

A recent meta-analysis show potential efficacy of saffron in comparison to placebo, with possible equal efficacy to fluoxetine and imipramine. The studies included were small and only studied the acute phase of treatment *(Hausenblas, 2013)*. It will require further study to adequately assess the acute efficacy, as well as establish the safety, tolerability and durability of efficacy in the continuous and maintenance phases of therapy.

Possible link between deficiency and depression. A number of researchers have published studies and review articles regarding an increased risk of depression in patients with low levels of zinc, omega-3 fatty acid or magnesium. Unfortunately, studies on appropriate supplementation of these dietary aides are often inconsistent in their design and results. While the replacement of zinc, omega-3 fatty acid and magnesium in patients with known deficiencies and who have major depression is often recommended, the exact dosages and durations of supplementation are not known *(Appleton, 2010; Siwek, 2010; Colangelo, 2009)*.

Omega-3 fatty acid not helpful as treatment. A recent meta-analysis of randomized, placebo-controlled trials of omega-3 fatty acid (FA) in the treatment of major depressive disorder was designed to analyze the efficacy of omega-3 FAs in the treatment of MDD and to examine possible sources of heterogeneity between trials. The meta-analysis demonstrated no significant benefit of omega-3 FA treatment compared with placebo and significant heterogeneity in study design, as well as publication bias *(Bloch, 2012)*.

Vitamin D. At this time, there is insufficient evidence on the antidepressant effects of vitamin D *(Shaffer, 2014; Li, 2014; Thacher, 2011)*.

Medical cannabis

There is insufficient evidence to support use of cannabis in treatment of depression. A systematic review and meta-analysis of randomized, clinical trials of cannabinoids for the treatment of several indications, including depression, was published in June 2015. No studies of cannabinoids for the treatment of depression met the authors' inclusion criteria. The authors evaluated five studies of other primary indications (chronic pain and spasticity in multiple sclerosis) that reported depression as an outcome measure. Three of the studies found no difference between cannabinoids (dronabinol and nabiximols) in depression outcomes, compared with placebo. The majority of these studies were found to have a high risk of bias *(Whiting, 2015)*.

Special Populations

See Appendix D, "Special Populations," for more information regarding treatment for the following conditions/populations, as applicable: 1) cardiovascular and cerebrovascular disease; 2) diabetes; 3) chronic pain; 4) geriatrics [includes dementia/cognitive impairment]; and 5) pregnant and postpartum women.

Return to Algorithm *Return to Table of Contents*

6. Comprehensive Treatment Plan with Shared Decision-Making

Collaborative Care Model

Recommendation	Quality of Evidence and Strength of Recommendation
A collaborative care approach is recommended for patients with depression in primary care.	Quality of Evidence: High Strength of Recommendation: Strong
Benefit: Collaborative care model has demonstrated improvement in treatment adherence, patient quality of life and depression outcomes. It has demonstrated beneficial impact on direct and indirect economic benefits. Evidence suggests the collaborative care model is also effective for depression during pregnancy and postpartum period. **Harm:** There are challenges in providing the collaborative care model, such as identifying depressed patients, identifying care managers with the right experience and background, establishing the responsibilities and scope of practice of the care managers, whether to locate care managers in a clinic vs. centrally based, determining the level of psychiatric supervision, seeking adequate reimbursement for services provider to ensure program sustainability, and feasibility of small clinics to employ on-site mental health specialists or full-time care managers. **Benefit-Harms Assessment:** Collaborative care has shown to improve patient outcomes and provider satisfaction while decreasing cost outweighing the challenges of implementing a collaborative care program.	
Relevant Resources: *Fortney, 2013; Archer, 2012; Katon, 2008; Gjerdingen, 2007; Belnap, 2006; Gilbody, 2006; Hunkeler, 2006; Simon, 2001a; Katon, 1999*	

Randomized controlled trials have demonstrated the effectiveness of the collaborative care model, in which primary care treatment of depression is provided by a team (depression care manager, primary physician, consulting psychiatrist and others). The work group recommends three key references *(Gilbody, 2006; Hunkeler, 2006; Katon, 1999)*. This model has demonstrated improvement in treatment adherence, patient quality of life and depression outcomes *(Archer, 2012; Gilbody, 2006; Hunkeler, 2006; Katon, 1999)*.

Beneficial impact on direct medical costs can also be found. Further dissemination of this model has been recommended *(Simon, 2001a)*. Katon, 2008 summarizes and solidifies the argument for collaborative care in the treatment of depression, the direct and indirect economic benefits of collaborative care, as well as improved outcomes *(Katon, 2008)*. Evidence suggests the collaborative care model is also effective for depression during pregnancy and postpartum *(Gjerdingen, 2007)*.

Improved Patient Outcomes

Better medication compliance and reduced risk of relapse. The use of a collaborative care model can help with medication compliance by providing closer follow-up than is possible without a care manager. Three or more follow-up visits in the first three months reduced the risk of relapse/recurrence of depression, as did continuous use of antidepressants *(Kim, 2011)*. Care management facilitates continuous use of antidepressants by providing close follow-up and early intervention when side effects occur.

Reduced suicidal ideation. In the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) study, suicidal ideation rates declined in patients receiving care based on treatment guidelines and use of a care manager *(Bruce, 2004)*.

In the Improving Mood Providing Access to Collaborative Treatment (IMPACT) study, 1,801 primary care patients were randomly assigned to collaborative care or usual care. Intervention subjects had less suicidal ideation at 6 and 12 months, and there were no completed suicides for either group in 18 months *(Unützer, 2006)*.

Return to Algorithm *Return to Table of Contents*

Improved Provider Satisfaction

The rewards for health care organizations that implement collaborative care models for their depressed patients are substantial, not only for the patients, but also for physician satisfaction. Of physicians participating in the IMPACT trial *(Levine, 2005)*, only 54% were satisfied with the resources they had to treat depressed patients before the trial. This satisfaction was independent of practice setting (fee-for-service versus capitated).

Sixty-four percent of physicians self-rated their ability to provide at least "very good" depression care before IMPACT. Eighty-five percent of clinicians before IMPACT felt that a collaborative care model would be helpful in treating patients with depression, diabetes or heart failure *(Levine, 2005)*.

Afterwards, 90% of physicians described the collaborative care program as helpful in treating patients with depression. Ninety-three percent of physicians were at least somewhat satisfied with the resources available for treating depressed patients assigned to the IMPACT model, whereas only 61% were somewhat satisfied if their patients were assigned to usual care *(Levine, 2005)*.

Ninety-four percent of clinicians rated the care managers as somewhat or very helpful in treating depression, and 82% indicated that IMPACT program improved their patients' clinical outcomes. Clinicians identified the two most helpful features of the program as "proactive patient follow-up" and "patient education" *(Levine, 2005)*.

Implementing a Collaborative Care Approach

Design. The design of a team-based collaborative care approach *(Unützer, 2002)* involves:

- Primary care clinicians using evidence-based approaches to depression care and a standard tool for measuring severity, response to treatment plan and remission
- A systematic way of tracking and reminding patients at appropriate intervals of visits with their primary care physician and monitoring of treatment adherence and effectiveness
- A team member (care manager role) to utilize the tracking system and make frequent contacts with the patients to provide further education and self-management support, and monitor for response in order to aid in facilitating treatment changes and in relapse prevention
- Communication between primary care team and psychiatry to consult frequently and regularly regarding patient under clinical supervision, as well as direct patient visits as needed

A 2013 systematic review and meta-analysis of nurse-delivered collaborative care showed that there was no statistical difference between deciding on type of delivery approach of intervention (phone versus in person) *(Ekers, 2013)*.

Telemedicine technologies now make possible the virtual co-location of mental health specialists and primary care providers. This is achieved using telephones, video conferencing and electronic health records. Compared with usual practice-based care, telemedicine has shown to have significantly and substantially greater treatment response, remission rates, reductions in depression severity, and increases mental health status and quality of life. These outcomes were achieved without increasing the number of primary care visits *(Fortney, 2013)*.

Challenges. There are challenges in providing the collaborative care model that need to be acknowledged and addressed by the health care organization. Some of these challenges include *(Belnap, 2006)*:

- Identifying depressed patients in the practice
- Identifying the desired background experience for care managers
- Establishing the responsibilities and scope of practice of the care managers

- Locating the care managers (centrally versus clinic-based)
- Determining level of supervision by psychiatrists
- Seeking adequate reimbursement for services provided to ensure program sustainability
- Clinic size: typically not feasible for small clinics to employ on-site mental health specialists or full time care managers *(Fortney, 2013)*

See the "Implementation Recommendations" and "Implementation Tools and Resources Table" sections of this guideline for suggestions and information on implementing the collaborative care model.

Educate and Engage Patient

Recommendation: Patient Engagement	Quality of Evidence and Strength of Recommendation
Before initiating treatment, it is important to establish a therapeutic alliance with the patient regarding diagnosis and treatment options (in which there is overlap in the patient's and clinician's definition of the problem and agreement on which steps are to be taken by each).	Quality of Evidence: Low Strength of Recommendation: Strong
Benefit: Therapeutic alliance is a potent predictor of treatment outcomes whether the treatment is psychotherapy or pharmacotherapy. Patient participation in shared decision-making improves adherence to treatment and clinical outcomes. When patients express a treatment preference, the use of that treatment, whether psychotherapy or pharmacotherapy, predicts a positive outcome. **Harm:** A therapeutic alliance can take time to develop, and time is difficult to find in a busy clinical practice. If treatment is delayed because of an uncertain alliance or initiated before an alliance is attained, it could adversely affect outcomes. Difficult experiences with the treatment of depression may cause clinicians to avoid treating depressed patients. **Benefit-Harms Assessment:** The benefits of a therapeutic alliance in terms of improved patient outcomes more than offsets the investment of time.	
Relevant Resources: *Kocsis, 2009b; Loh, 2007; Krupnick, 1996*	

Successful care of major depression as an illness requires active engagement of each patient and his/her family, plus ongoing patient education, beginning at the time of diagnosis.

Often, the depressed patient's pessimism, low motivation, low energy, and sense of social isolation and guilt may lead to non-adherence with treatment *(American Psychiatric Association, 2010)*.

However, there are ways to improve engagement and adherence.

Therapeutic alliance: It is essential to know the patient and cultivate a therapeutic alliance-defined as a collaborative bond between patient and clinician *(Krupnick, 1996)*. This alliance can have a greater effect on outcomes than the actual treatment used (psychotherapy vs. pharmacotherapy) and can have a large effect even when the treatment is pharmacotherapy *(Krupnick, 1996)*.

It is essential that both the patient and the clinician feel invested in the outcome. Within the context of what the clinician is able to recommend, patient's preferences matter. In a study by Kocsis, 2009, patients who preferred psychotherapy but received medication had a 7.7% remission rate vs 50.0% if they received psychotherapy. Those who preferred medication but received psychotherapy had a 22.2% remission rate vs 45.5% if they received medication *(Kocsis, 2009b)*.

Past history's influence on adherence

Accurate history-taking remains the cornerstone of medical treatment. A patient's past experience with depression predicts adherence to the treatment plan, and past history is common given the lifetime prevalence

Return to Algorithm *Return to Table of Contents*

of major depression of 17% *(Johnston, 2013)*. Other findings from Johnston's review of patients' experience influence on adherence include:

- Patients who had endured a prior episode of depression were found to have higher adherence to treatment with antidepressant agents.
- People who know someone with a history of depression tended to view depression as a biomedical condition and were more accepting of medication.
- Interactions with providers, receiving information, feeling heard and understood, and gaining experience with medication all have a major influence on decisions to continue treatment.
- Patient-provider relationships and overall treatment experience were crucial, especially when many realized that long-term treatment was likely required.

Patient Education

Topics to cover: Education topics should include:

- The cause, symptoms and natural history of major depression
- Treatment options and the process of finding the best fit for a given individual
- Information on what to expect during the course of treatment
- How to monitor symptoms and side effects
- Follow-up protocol (office visits and/or telephone contacts). See the "Establish Follow-Up Plan" section for information on frequency of follow-ups
- Early warning signs of relapse or recurrence
- Length of treatment
- Communication with the caregiver

Patient education should include diagnosis, prognosis and treatment options including costs, duration, side effects and expected benefits.

While the clinician goal of utilizing the PHQ-2 and PHQ-9 is detecting and diagnosing depression, these tools are, in real-world use, often used primarily in shared decision-making with patients to "suggest, tell, or convince patients to accept the diagnosis of depression" *(Baik, 2010)*.

Support and education in the primary care setting are critical and contribute to the likelihood of good follow-through on treatment. It may help patients understand their options and resources if the primary care clinic explains that the support-plus-education component of treatment is not the same as a course of psychotherapy. Clinic staff may also want to identify a family member or support person of the patient's choosing and establish his/her role within the patient's treatment plan.

Key messages for patients and families: Emphasize the following points:

- Depression is a medical illness, not a character defect.
- Treatment is effective for most patients.
- The aim of treatment is remission – being predominately free of symptoms.
- Relapse prevention is a key aspect of management – not just getting better, but also staying well. The risk of recurrence is significant: 50% after one episode, 70% after two episodes, 90% after three episodes *(NIMH/NIH Consensus Development Conference Statement, 1985)*. Patient and family

should be alert to early signs and symptoms of recurrence and seek treatment early if depression returns.

People of differing racial/ethnic groups can be successfully treated using currently available evidence-based interventions as long as distinctive personal elements, from biological to environmental to cultural, are considered during the treatment planning process *(Schraufnagel, 2006)*.

Patient Engagement

Patient self-management

It is important for the patient to consider and adopt some self-care responsibilities. These responsibilities may range from simply demonstrating reliable behavior in taking medications and notifying the clinician about side effects to agreeing to participate in sessions, or journaling and completing homework, which is necessary for some cognitive behavioral therapies. Written materials are helpful to reinforce information shared during the discussion. Bibliotherapy, a therapy approach wherein the patient is encouraged to read self-help books and other relevant materials, has modest empirical support for benefitting patients who are motivated to augment their professional care with self-help literature *(Bower, 2013; Anderson, 2005; Gregory, 2004)*.

See the "Implementation Tools and Resources Table" for examples of book titles.

Decision-making capacity

The ICSI shared decision-making model is a useful primer on the collaborative conversation with the main focus on things the clinician can do to assist the patient in making a shared decision regarding treatment. This means factoring in patient values and preferences in decisions regarding treatment. See Appendix B, "ICSI Shared Decision-Making Model," for full description of ICSI Shared-Decision Making model. It is important to keep in mind what is required of the patient in order to make informed decisions. Some patients, especially those with neurocognitive disorders, lack the required capacities to truly participate in the process. There are four abilities adults need in order to decide on treatments for depression *(Applebaum, 2007)*:

1. The ability to express a choice
2. The ability to understand information for treatment decision-making
3. The ability to appreciate the significance of that information for one's own situation, especially concerning one's illness and the probable consequences of one's treatment options
4. The ability to reason with the relevant information in order to engage in a logical process of weighing treatment options

Although competency is a legal termination, medical opinions regarding the patient's cognitive capacities are typically sought, and the ability to assess these capacities is a necessary skill set for physicians.

General vs. specific competency

When the clinician decides to consult psychiatry, referral questions should address a specific competency such as "Is this patient competent to refuse surgery?" rather than the general question "Is this patient competent?" A person can be competent to do some things (make a will) but incompetent to do others (live independently) *(Nichita, 2007)*.

In questions of competency, patients need to have had the information provided to them in order to make informed decisions. Since patients' abilities may fluctuate, it is important that the information is presented at least twice. A patient whose decisions vary each time lacks reliability *(Sorrentino, 2014)*.

Return to Algorithm *Return to Table of Contents*

Follow-Up

7a. Establish Follow-Up Plan

Recommendation	Quality of Evidence and Strength of Recommendation
Clinicians should establish and maintain follow-up with patients.	Quality of Evidence: Low Strength of Recommendation: Strong
Benefit: Appropriate, reliable follow-up is highly correlated with improved response and remission scores. It is also correlated with the improved safety and efficacy of medications and helps prevent relapse. **Harm:** Potential harms may include added expense and unnecessary visits. **Benefit-Harms Assessment:** Benefits appear to outweigh potential harms by a wide margin.	
Relevant Resources: *Trivedi, 2006b; Unützer, 2002; Hunkeler, 2000; Simon, 2000*	

Proactive follow-up contacts (in person, telephone) based on the collaborative care model have been shown to significantly lower depression severity *(Unützer, 2002)*. In the available clinical effectiveness trials conducted in real clinical practice settings, even the addition of a care manager leads to modest remission rates *(Trivedi, 2006b; Unützer, 2002)*. Interventions are critical to educating the patient regarding the importance of preventing relapse, safety and efficacy of medications, and management of potential side effects. Establish and maintain initial follow-up contact intervals (office, phone, other) *(Hunkeler, 2000; Simon, 2000)*.

PHQ-9 as monitor and management tool. The PHQ-9 is an effective management tool, as well, and should be used routinely for subsequent visits to monitor treatment outcomes and severity. It can also help the clinician decide if/how to modify the treatment plan *(Duffy, 2008; Löwe, 2004)*. Using a measurement-based approach to depression care, PHQ-9 results and side effect evaluation should be combined with treatment algorithms to drive patients toward remission. A five-point drop in PHQ-9 score is considered the minimal clinically significant difference *(Trivedi, 2009)*.

Every time that the PHQ-9 is assessed, suicidality is assessed, as well. If the suicidality was indeed of high risk, urgent referral to crisis specialty health care is advised. In case of low suicide risk, the patient can proceed with treatment in the primary care practice *(Huijbregts, 2013)*.

Collaboration with Mental Health

Consider collaborating with a behavioral health care clinician for the following:

- Patient request for psychotherapy
- Presence of severe symptoms and impairment in patient, or high suicide risk
- Presence of other psychiatric condition (e.g., personality disorder or history of mania)
- Suspicion or history of substance abuse
- Clinician discomfort with the case
- Medication advice (psychiatrist or other mental health prescriber)
- Patient request for more specialized treatment

Return to Algorithm *Return to Table of Contents*

7b. Has Patient Reached Remission?

The goals of treatment should be to achieve remission, reduce relapse and recurrence, and return to previous level of occupational and psychosocial function.

Full remission is defined as a two-month period devoid of major depressive signs and symptoms *(American Psychiatric Association, 2013: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition)*. If using a PHQ-9 tool, remission translates to PHQ-9 score of less than 5 *(Kroenke, 2001)*. Results from the STAR*D study showed that remission rates lowered with more treatment steps, but the overall cumulative rate was 67% *(Rush, 2006)*.

Response is defined as a 50% or greater reduction in symptoms (as measured on a standardized rating scale). Partial response is defined as a 25-50% reduction in symptoms. This definition is based on how the depression literature defines response.

Response and remission take time. In the STAR*D study, longer times than expected were needed to reach response or remission. In fact, one-third of those who ultimately responded did so after six weeks. Of those who achieved remission by Quick Inventory of Depressive Symptomatology (QIDS), 50% did so only at or after six weeks of treatment *(Trivedi, 2006b)*. If the primary care clinician is seeing some improvement, continue working with that patient to augment or increase dosage to reach remission. This can take up to three months.

A reasonable criterion for extending the initial treatment: assess whether the patient is experiencing a 25% or greater reduction in baseline symptom severity at six weeks of therapeutic dose. If the patient's symptoms are reduced by 25% or more, but the patient is not yet at remission, and if medication has been well tolerated, continue to prescribe. Raising the dose is recommended *(Trivedi, 2006b)*.

Improvement with psychotherapy is often a bit slower than with pharmacotherapy. A decision regarding progress with psychotherapy and the need to change or augment this type of treatment may require 8 to 10 weeks before evaluation *(Schulberg, 1998)*.

Return to Algorithm *Return to Table of Contents*

7c. Continuation and Maintenance Treatment Duration Based on Episode

Acute therapy is the treatment phase focused on treating the patient to remission. Acute therapy typically lasts 6-12 weeks but technically lasts until remission is reached *(American Psychiatric Association, 2010)*. Full remission is defined as a two-month period devoid of major depressive signs and symptoms *(American Psychiatric Association, 2013; Diagnostic and Statistical Manual of Mental Disorders, 5th Edition)*.

Continuation therapy is the four-to-nine month period beyond the acute treatment phase during which the patient is treated with antidepressants, psychotherapy, ECT or other somatic therapies to prevent relapse *(American Psychiatric Association, 2010)*. Relapse is common within the first six months following remission from an acute depressive episode; as many as 20-85% of patients may relapse *(American Psychiatric Association, 2010)*.

Maintenance therapy is the treatment phase that follows continuation therapy. The goal of maintenance therapy is to prevent recurrence of new or future episodes of major depression *(Rush, 1999)*. The best candidates for maintenance therapy are patients who meet any of these criteria:

- three or more previous episodes of major depression,
- two episodes of major depression and rapid recurrence of episodes,
- older in age at the onset of major depression (more than 60 years of age),
- severe episodes of major depression, family history of a mood disorder, or
- residual symptoms *(American Psychiatric Association, 2010)*.

Return to Algorithm *Return to Table of Contents*

Other risk factors for recurrence include the presence of a general medical condition, ongoing psychosocial stressors, negative cognitive styles and persistent sleep disturbance *(American Psychiatric Association, 2010)*.

Maintenance therapy should also be considered for at-risk patients with double depression and patients with a comorbid anxiety disorder or substance abuse. Patients whose major depression has a seasonal pattern are also at risk for recurrence and may benefit from seasonal reinstatement of light therapy or antidepressant therapy. For patients on maintenance medication, contacts can occur every 3 to 12 months if everything else is stable *(Oxman, 2002; Katon, 1999)*.

Relapse Prevention

The prevention of relapse is of primary importance in the treatment of major depression. From 50 to 80% of people who suffer an episode of major depression will have a recurrence, usually within two or three years *(American Psychiatric Association, 2010)*. Patients who have had three or more episodes of major depression are at 90% risk of having another episode. Relapse prevention interventions resulted in 13.9 additional depression-free days during a 12-month period *(Simon, 2002)*.

Psychotherapies. Focused psychotherapy through cognitive-behavioral therapy can reduce relapse by assisting patients with their depression-related beliefs *(Teasdale, 2001)*. In addition, focused psychotherapy can significantly reduce symptoms and restore psychosocial and occupational functioning in patients with major depression *(Leichsenring, 2004)*.

Pharmacotherapy. A Katon, 1996 study found that improving attitudes toward antidepressant medications, along with the patient's ability to handle medication side effects, are key factors in promoting greater adherence to maintenance treatment and thus greater likelihood of preventing relapse *(Katon, 1996)*. For information on duration of pharmacotherapy post-remission to prevent relapse, see the "Duration of Pharmacotherapy" section in Pharmacotherapy.

Return to Algorithm *Return to Table of Contents*

7d. If Patient is Not Improving on Initial Treatment, Utilize Stepped Care Approach

If remission has not been achieved when reevaluated up to six weeks later, consider:

1. Whether adequate engagement of patient/family exists and whether recommendations are being followed (adherence).
2. Optimize antidepressant dose. A systematic review and meta-analysis found higher doses of SSRIs were associated with an increased likelihood of response. Higher doses were also associated with an increased risk of side effects. The overall rate of treatment dropouts was reduced, possibly due to improved efficacy. Balancing these results, the authors recommended titrating SSRI doses in patients who had not responded to lower doses *(Jakubovski, 2016)*. Additionally, it has been well established that raising the dose of tricyclics or MAOIs may improve response. Similarly, a controlled study showed that raising the dose of fluoxetine (from 20 mg to 40 or 60 mg) in partially responsive patients was more effective than adding desipramine (25-50 mg per day) or lithium (300-600 mg daily). In non-responders, raising the fluoxetine dose was as effective as adding lithium, and both were more effective than adding desipramine *(Fava, 1994; Perry, 1994)*.
3. Switching to a different antidepressant medication. After a failed trial of citalopram, remission rates in the STAR*D study were 21.3% for bupropion SR, 17.6% for sertraline and 24.8% for venlafaxine XR *(Rush, 2006)*, although the differences were not statistically significant. Failure of a drug in one family does not rule out possible benefit from other drugs in that family. This is particularly true for SSRIs *(Bull, 2002; Thase, 1997; Brown, 1995)*.

Return to Algorithm *Return to Table of Contents*

4. Reconsider treatment modality:
   - Adding, switching or substituting treatment modality. A switch from an antidepressant to psychotherapy or vice versa appears useful for non-responders to initial treatment *(Schatzberg, 2005)*. If there is less than 25% reduction of symptoms after six weeks at therapeutic dose (i.e., partial positive response to medication), add, switch or substitute another treatment modality. If there is a partial medication response and side effects are not prohibitive, increase the dose. As part of the evaluation, use a standardized assessment tool to gauge progress.
   - Adding cognitive psychotherapy or adding another medication such as buspirone or bupropion. Both augmentation strategies showed similar improvement rates in the STAR*D study; however, the addition of medication resulted in a significantly more rapid response *(Thase, 2007)*.
5. Reevaluating the diagnosis and the possibility of a bipolar diagnosis. Bipolar patients require a different treatment approach and may not consistently come forward with their hypomanic, mixed or manic histories *(Sharma, 2005)*. Consult with a behavioral health clinician if personality disorders are present.
6. Looking for comorbidities, such as substance abuse issues, and involving addiction specialists as needed.
7. Augmentation strategies (such as lithium or low-dose thyroid, making a referral to psychiatry for possible MAOI treatment). Many patients unresponsive to tricyclics are responsive to monoamine oxidase inhibitors (MAOIs). Rarely, the combination of tricyclics and MAOIs is used. This combination should be undertaken with extreme caution. Studies measuring response to MAOIs in SSRI non-responders have not been done *(McGrath, 1994; McGrath, 1993)*. See the "Augmentation Therapy" section in this annotation for more information.
8. Other strategies: light therapy, ECT and hospitalization. See the "Consider Other Strategies" section in this annotation for more information.

Augmentation Therapy

Augmentation therapy is used for those situations in which the patient's depression is either treatment resistant or partially responsive to treatment. This is a good time to consult and/or refer to a mental health specialist. Augmentation strategies may be considered for partial responders, and combinations of antidepressants (when each has a different mechanism) have been shown to be options in those who fail to achieve remission.

Augmentation methods include:

- **Bupropion or buspirone-SSRI combination.**
  - Augmentation of citalopram with bupropion or buspirone after non-remission with a trial of citalopram alone yielded a remission rate of 29.7 and 30.1%, respectively, in the STAR*D study. These differences were statistically insignificant, but bupropion SR was better tolerated *(Trivedi, 2006a)*.
  - Three open series of cases and two other case reports have described beneficial results. The basis of this combination is the addition of a noradrenergic agent to a serotonergic agent to enhance effects; bupropion may also have dopaminergic actions *(Spier, 1998; Bodkin, 1997; Marshall, 1996)*.
  - Five open studies supported potential utility of this treatment, and a response rate of approximately 60% was observed *(Dimitriou, 1998; Bouwer, 1997)*.

Return to Algorithm *Return to Table of Contents*

- **Mirtazapine-SSRI combination.**
  - The addition of the alpha-2 antagonist mirtazapine is used to augment SSRI. Three controlled studies have found evidence of more rapid effects *(Maes, 1999; Dam, 1998; Cappiello, 1995)*.
- **T_3 augmentation of antidepressants.**
  - Antidepressant augmentation with T_3 had a remission rate of 24.7% in the STAR*D study *(Nierenberg, 2006)*. There was no significant difference between T_3 augmentation or lithium augmentation (13.2%), but T_3 was better tolerated, despite being more vigorously dosed *(Rush, 2009)*.
  - Placebo-controlled studies found mixed results. Usual dose of T_3 varied between 25 and 50 micrograms/day *(Nelson, 2000)*.
- **Stimulant augmentation of TCA-SSRI ("jump-start response").**
  - Some open label studies of modafinil augmentation of SSRI have reported benefit in sleepiness and fatigue, either disease-state-induced or secondary to the SSRI. The sample size and length of treatment are both small, and thus conclusions need to be taken with caution *(Schwartz, 2004; Ninan, 2004)*.
  - Further research with larger higher-quality trials is needed to establish the benefit of stimulant augmentation and the clinical situations where this might be indicated *(Candy, 2008; Dunlop, 2007; Fava, 2005)*.
  - Cases of sudden death, stroke and myocardial infarction have been reported in adults taking stimulant medications at usual doses for ADHD. Adults with serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease or other serious cardiac problems should not be treated with stimulant medications.
- **TCA-SSRI combination** (caution – elevated TCA level – to be monitored).
  - A 1991 study by Nelson reported this combination to be more rapidly effective and indicated that remission was more likely. The dose of TCA should be adjusted to achieve effective TCA levels because SSRIs may increase TCA levels. Fluoxetine and paroxetine raise TCA (desipramine) levels three- to fourfold, and citalopram and sertraline have modest effects *(Nelson, 1991; Preskorn, 1990)*.
  - If a combination is used, monitor side effects and consider checking blood levels.
- **Lithium augmentation with TCAs.** Lithium augmentation with SSRI (caution – case reports of serotonin syndrome).
  - Augmentation with lithium at stage 3 of STAR*D yielded remission rate of 15.9% *(Nierenberg, 2006)*.
  - Seven placebo control studies have found positive evidence of efficacy of lithium augmentation. Combination of lithium and SSRIs have been relatively well studied. In early studies, the usual dose of lithium was 300 mg three times a day. At this dose, serum lithium levels were usually above 0.4 mEq/L *(Delgado, 1998; Baumann, 1996; Katona, 1995; Joffe, 1993)*.
- **Atypical antipsychotic-antidepressant combination.**
  - Several studies have been published supporting the use of atypical antipsychotics as augmentation agents with antidepressants for treatment-resistant depression. A meta-analysis study of 1,500 treatment-resistant patients indicated pooled remission and response rates for atypical

antipsychotics and placebo were 47.4% vs. 22.3% and 57.2% vs. 35.4%, respectively. The atypical antipsychotics used were risperidone, olanzapine and quetiapine *(Papakostas, 2007)*.

- A meta-analysis of 16 trials that included a total of 3,480 patients with treatment-resistant, non-psychotic, unipolar major depressive disorder found augmentation with atypical antipsychotics was significantly more effective than placebo in measures of both response and remission. The agents reviewed included risperidone, olanzapine, quetiapine and aripiprazole. No significant differences in efficacy were noted among the reviewed medications. The rate of patient discontinuation due to adverse events was higher in patients receiving augmentation with atypical antipsychotics, compared with placebo *(Nelson, 2009)*.
- Aripiprazole, quetiapine and the olanzapine-fluoxetine combination are FDA-approved adjunctive agents for the acute treatment of major depressive disorder in adults. In two studies, patients diagnosed with major depressive disorder who had at least two documented trials of incomplete response to antidepressant medications were randomized to aripiprazole (2 mg to 20 mg a day) or placebo. Patients receiving aripiprazole experienced significant improvements in depression symptoms within one to two weeks of initiated aripiprazole. Average doses were approximately 10 mg a day by mouth. Patients receiving aripiprazole experienced higher rates of akathisia and fatigue, compared to those randomized to placebo *(Marcus, 2008; Berman, 2007)*.

Consider Other Strategies

- If patients do not respond to intensive outpatient treatment, partial or full hospitalization may be considered in patients who have not responded to outpatient management, particularly if safety issues are a concern.
- Electroconvulsive treatment is effective and can sometimes be administered safely in an outpatient setting.
- Use of bright light therapy for treatment of major depression with a seasonal specifier is well established.

Treatment-resistant depression has several definitions in the literature. It is important to distinguish treatment resistance from a lack of completion of a full course of treatment. The literature tends to focus on pharmacological treatments in the definition of treatment resistance without consistently incorporating psychotherapeutic modalities. True treatment resistance is seen as occurring on a continuum, from failure to reach remission after an adequate trial of a single antidepressant to failure to achieve remission despite several trials of antidepressants, augmentation strategies, ECT and psychotherapy. **For our purposes of making recommendations for primary care clinicians, we define true treatment resistance as failure to achieve remission with an adequate trial of therapy and three different classes of antidepressants at adequate duration and dosage** *(Nierenberg, 2006; Keller, 2005; Geddes, 2003)*.

Hospitalization

Partial or full hospitalization may be indicated in patients with unrelenting depressive symptoms, particularly if safety issues are a concern *(American Psychiatric Association, 2010)*.

The most important consideration from a primary care standpoint is the hospital communicating the details of partial and full hospitalization back to primary care, and patients having follow-up visits for chronic or acute physical and psychiatric problems arranged with their clinician prior to hospital discharge. Patients without a primary care provider should be connected with shortly after hospital discharge for a physical assessment and preventive interventions to help decrease the rate of readmission. If no medication reconciliation was done in the hospital, there should be follow-up on it during the primary care visit.

The following are most commonly referred from a primary care setting. For other specialized therapies, see Appendix C, "Specialized Therapies."

Electroconvulsive Therapy (ECT)

Response and remission rates are higher with ECT than with any other form of antidepressant treatment, with 70-90% of patients showing improvement *(Kellner, 2006; UK ECT Review Group, The, 2003)*. Patients may express a choice for ECT; shared decision-making should be engaged to determine if it is appropriate. Electroconvulsive treatment is usually performed on an inpatient basis, but for some individuals, it can be administered safely in an outpatient setting. A patient considering ECT would need to be able to tolerate anesthesia and should consult with a psychiatrist about the risks and benefits *(UK ECT Review Group, The, 2003; Sackeim, 2001a)*.

One study showed that 64.2% of patients referred for ECT achieved major depression remittance *(Kellner, 2006)*. In addition to its use as a treatment in the acute phase, ECT is an effective maintenance therapy for major depression. The same study compared continuous ECT with nortriptyline and lithium treatment and found no difference in relapse rates *(Kellner, 2006)*.

ECT is also effective for treating major mental illness during pregnancy, and the risks of adverse events are low. It should be strongly considered in pregnant women with severe symptoms of mental illness, such as psychotic symptoms, catatonia or strong suicidal urges *(Anderson, 2009)*. For more information regarding the treatment of depression in pregnant women, refer to Appendix D, "Special Populations."

Factors that may suggest a given patient may be an ECT candidate include:

- Geriatric depression *(Mitchell, 2005)*
- If antidepressant medications have not been tolerated or pose a significant medical risk
- If antidepressant medication trials have not been successful
- If ECT has been successful in previous episodes
- If catatonia is present
- When a rapid response is needed because of severe suicide risk or because the patient's health has been significantly compromised by the depression (e.g., severe cachexia, inability to attend to the activities of everyday living). ECT has been shown to be effective in resolving expressed suicidal intent *(Kellner, 2006)*.
- If depression has psychotic features
- If melancholic symptoms are predominant
- Depression and Parkinsonism

(National Institute for Clinical Excellence, 2003)

Common side effects associated with ECT include headaches, myalgias, nausea, drowsiness, confusion and amnesia. More serious and rare side effects include hypertension, tachycardia, myocardial infarction and cerebrovascular accident. ECT is a relatively safe and effective treatment for patients with treatment-refractory and severe depressive illness, and death is very rare.

Light Therapy

Use of bright light therapy for treatment of major depression with a seasonal specifier is well established *(Leppämäki, 2002; Golden, 2005)*. Additionally, there is evidence to support the use of bright light therapy for other types of depressive symptom patterns, including non-seasonal depression and milder variations of seasonal depressive patterns *(Jorm, 2002; Prasko, 2002)*. For non-seasonal depression, light therapy's benefit as an adjunctive treatment is more robust than its benefit as monotherapy *(Freeman, 2010)*. Bright

light therapy may also quicken and enhance the effects of antidepressant medication *(Benedetti, 2003)*. In two small pilot studies, promising results were seen in pregnant and postpartum women with non-seasonal depression *(Epperson, 2004; Oren, 2002)*.

Dosage. The standard starting dose for depression with a seasonal specifier is 10,000 lux for 30 minutes each morning *(Freeman, 2010)*. Research on bright light therapy for other types of depression has not necessarily utilized standard dosages and exposure times.

Side effects. The most common side effects are nausea, jitteriness and headache *(Freeman, 2010)*.

Equipment. It is important for light therapy treatment to utilize equipment that eliminates ultraviolet frequencies and produces bright light of known spectrum and intensity. For these reasons, use of client-constructed light therapy units is contraindicated.

Overall recommendation. The APA Task Force concluded that "light therapy is an evidence-based, effective, well-tolerated treatment for seasonal affective disorder, as well as an augmentation strategy for antidepressant treatment of nonseasonal depression" *(Freeman, 2010)*.

Additional Specialized Therapeutic Options

There are other more specialized therapies available, as well. Refer to psychiatry for consideration of vagus nerve stimulation (VNS), repetitive transcranial magnetic stimulation (rTMS), magnetic seizure therapy (MST) and deep brain stimulation (DBS). See Appendix C, "Specialized Therapies."

Return to Algorithm *Return to Table of Contents*

The Aims and Measures section is intended to provide guideline users with a menu of measures for multiple purposes, which may include the following:

- Population health improvement measures
- Quality improvement measures for delivery systems
- Measures from regulatory organizations such as The Joint Commission
- Measures that are currently required for public reporting
- Measures that are part of Center for Medicare Services Physician Quality Reporting initiative
- Other measures from local and national organizations aimed at measuring population health and improvement of care delivery

This section provides resources, strategies and measurement for use in closing the gap between current clinical practice and the recommendations set forth in the guideline.

The subdivisions of this section are:

- Aims and Measures
- Implementation Recommendations
- Implementation Tools and Resources

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Aims and Measures

The aims and measures in this guideline are based upon evidence supporting impact of system elements and process elements, and promoting actual symptom and functional patient improvement and outcomes, and are aligned with MN Community Measurement where there is overlap. The work group has elected to use PHQ-9 in the measures, since it is broadly utilized by various organizations. There are other evidence-based tools that may be used. If other tools are chosen for measurement, they should be sensitive, specific, reliable and valid for measuring intensity levels and response and remission rates.

1. Increase the percentage of patients accurately diagnosed with major depression or persistent depressive disorder. *(Annotation #2)*

   Measure for accomplishing this aim:

   a. Percentage of patients with a diagnosis of major depression or persistent depressive disorder with documentation of DSM-5 criteria at the time of the diagnosis.

2. Decrease the number of completed suicides in patients with major depresssion or persistent depressive disorder managed in primary care. *(Annotation #3a)*

   Measure for accomplishing this aim:

   a. Number of patients who commit suicide at any time while managed in primary care.

3. Increase the percentage of patients with major depression or persistent depressive disorder who are screened for substance use disorders. *(Annotation #4a)*

   Measure for accomplishing this aim:

   a. Percentage of patients who are screened for substance use disorders with an appropriate screening tool.

4. Increase the screening for major depression or persistent depressive disorder of primary care patients presenting with any additional high-risk conditions such as diabetes, cardiovascular disease, post-stroke, chronic pain and all perinatal women. *(Appendix D)*

   Measures for accomplishing this aim:

   a. Percentage of patients with type 2 diabetes with documentation of screening for major depression or persistent depressive disorder using PHQ-2 or PHQ-9.

   b. Percentage of patients with cardiovascular disease with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

   c. Percentage of patients who had a stroke with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

   d. Percentage of patients with chronic pain with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

   e. Percentage of perinatal patients with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

Return to Table of Contents

5. Improve communication between the primary care physician and the mental health care clinician (if patient is co-managed). *(Annotation #7a)*

   Measure for accomplishing this aim:

   a. Percentage of patients with major depression or persistent depressive disorder whose primary care records show documentation of any communication between the primary care clinician and the mental health care clinician.

6. Increase the percentage of patients with major depression or persistent depressive disorder who have improvement in outcomes from treatment for major depression or persistent depressive disorder. *(Annotations #5, 6)*

   Measures for accomplishing this aim *(the following are patient-reported outcomes)*:

   a. Percentage of patients who have had a response to treatment at six months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a PHQ-9 score decreased by 50% from initial score at six months (+/- 30 days).

   b. Percentage of patients who have reached remission at six months (+/- 30 days) after diagnosis or initiating treatment, e.g., had any PHQ-9 score less than 5 at six months (+/- 30 days).

   c. Percentage of patients who have had a response to treatment at 12 months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a PHQ-9 score decreased by 50% from initial score at 12 months (+/- 30 days).

   d. Percentage of patients who have reached remission at 12 months (+/- 30 days) after initiating treatment, e.g., had a PHQ-9 score less than 5 at 12 months (+/- 30 days).

7. Increase the percentage of patients with major depression or persistent depressive disorder who have follow-up to assess for outcomes from treatment. *(Annotations #5, 6, 7a)*

   Measures for accomplishing this aim:

   a. Percentage of patients whose symptoms are reassessed by the use of a quantitative symptom asessment tool (PHQ-9) at six months (+/- 30 days) after diagnosis or initiating treatment.

   b. Percentage of patients whose symptoms are reassessed by the use of a quantitative symptom assessment tool (such as PHQ-9) at 12 months (+/- 30 days) after diagnosis or initiating treatment.

Return to Table of Contents

Measurement Specifications

Measurement #1a

Percentage of patients with a diagnosis of major depression or persistent depressive disorder with documentation of DSM-5 criteria at the time of the diagnosis.

Population Definition

Patients age 18 years and older with a new primary care diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1.

Data of Interest

$$\frac{\text{\# of medical records containing documentation of DSM-5 criteria at the time of the initial diagnosis}}{\text{\# of medical records reviewed for patients newly diagnosed with major depression or persistent depressive disorder}}$$

Numerator/Denominator Definitions

Numerator: Number of records containing documentation of DSM-5 criteria documentation at the time of the initial diagnosis.

Denominator: Number of primary care patients age 18 years and older with new diagnosis of major depression or persistent depressive disorder during the measurement period and patient has not been treated for depression.

Note: Major depression and persistent depressive disorder ICD 10 codes include F32.x, F33.x and F34.1.

New diagnosis = patients diagnosed with major depression or persistent depressive disorder during the measurement period. Measurement period can be weekly, monthly, quarterly, annually or any other period that clinic determines needs to be for quality improvement.

Documentation of DSM-5 Criteria

Must have a total of five symptoms for at least two weeks. One of the symptoms must be depressed mood or loss of interest.

1. Depressed mood
2. Markedly diminished interest or pleasure in all or almost all activities
3. Significant (more than 5% body weight) weight loss or gain, or decrease or increase in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feeling of worthlessness or inappropriate guilt
8. Diminished concentration, or indecisiveness
9. Recurrent thoughts of death or suicide

Return to Table of Contents

Method/Source of Data Collection

Query the electronic medical records for patients newly diagnosed with major depression diagnosis or persistent depressive disorder during the measurement period. Determine if DSM-5 criteria were used to diagnose major depression or persistent depressive disorder. The presence of narrative comments reflecting application of DSM-5 criteria in making the diagnosis is acceptable evidence for this measure.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #2a

Number of patients who commit suicide at any time while managed in primary care.

Population Definition

Patients age 18 years and older with major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1.

Data of Interest

Number of patients under depression management in primary care who commit suicide at any time while managed in primary care.

Numerator and Denominator Definitions

Number of patients with major depression or persistent depressive disorder who are in active panel in primary care who commit suicide at any time while managed in primary care.

Method of Data Collection

Query electronic medical records or registry for patients diagnosed with depression or persistent depressive disorder and in active panel. Determine if any of those patients committed suicide while managed in primary care.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is an outcome measure, and the goal is zero.

Return to Table of Contents

Measurement #3a

Percentage of patients who are screened for substance use disorders with an appropriate screening tool.

Population Definition

Patients age 18 years and older with a new diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x, F34.1.

Data of Interest

$$\frac{\text{\# of patients who are screened for substance use disorders with an appropriate screening tool}}{\text{\# of patients diagnosed with major depression or persistent depressive disorder}}$$

Numerator/Denominator Definitions

Numerator: Number of patients who are screened for substance use disorders with an appropriate screening tool.

Denominator: Number of patients age 18 years and older who were newly diagnosed with major depression or persistent depressive disorder or had an existing diagnosis.

Method/Source of Data Collection:

Query electronic medical records for patients diagnosed with major depression or persistent depressive disorder diagnosis in the last 12 months from the measurement date. Determine from medical records if a patient was screened for substance use disorders with an appropriate screening tool.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #4a

Percentage of patients with type 2 diabetes with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

Population Definition

Patients age 18 years and older with a diagnosis of type 2 diabetes.

Data of Interest

$$\frac{\text{\# of patients who were screened for depression symptoms with PHQ-2 or PHQ-9}}{\text{\# of patients with type 2 diabetes}}$$

Numerator/Denominator Definitions

Numerator: Number of patients screened for depression symptoms with PHQ-2 or PHQ-9.

Denominator: Number of patients age 18 years and older with type 2 diabetes who had at least one contact with a clinician in primary care in the last 12 months from the measurement date. Diagnosis may be either new or existing.

Method/Source of Data Collection

Query electronic medical records to determine the number of patients with type 2 diabetes with at least one contact with a primary care clinician in the last 12 months from the measurement date. Determine if those patients were screened for depression symptoms with PHQ-2 or PHQ-9 at any of the contacts. Count only one screen.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #4b

Percentage of patients with cardiovascular disease with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

Population Definition

Patients age 18 years and older with a diagnosis of cardiovascular disease.

Data of Interest

$$\frac{\text{\# of patients who were screened for depression symptoms with PHQ-2 or PHQ-9}}{\text{\# of patients with cardiovascular disease}}$$

Numerator/Denominator Definitions

Numerator: Number of patients screened for depression symptoms with PHQ-2 or PHQ-9.

Denominator: Number of patients age 18 years and older with cardiovascular disease who had at least one contact with a clinician in primary care in the last 12 months from the measurement date. Diagnosis may be either new or existing.

Method/Source of Data Collection:

Query electronic medical records to determine the number of patients with cardiovascular disease with at least one contact with a primary care clinician in the last 12 months from the measurement date. Determine if those patients were screened with PHQ-2 or PHQ-9 for depression symptoms at any of the contacts. Count only one screen.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #4c

Percentage of patients who had a stroke with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

Population Definition

Patients age 18 years and older who had a stroke.

Data of Interest

$$\frac{\text{\# of patients who were screened for depression symptoms with PHQ-2 or PHQ-9}}{\text{\# of patients who had a stroke}}$$

Numerator/Denominator Definitions

Numerator: Number of patients screened for depression symptoms with PHQ-2 or PHQ-9.

Denominator: Number of patients age 18 years and older who had at least one contact with a clinician in primary care in the last 12 months from the measurement date. Diagnosis may be either new or existing.

Method/Source of Data Collection:

Query electronic medical records to determine the number of patients who had a stroke with at least one contact with a primary care clinician in the last 12 months from the measurement date. Determine if those patients were screened for depression symptoms with PHQ-2 or PHQ-9 at any of the contacts. Count only one screen.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #4d

Percentage of patients with chronic pain with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

Population Definition

Patients age 18 years and older with a diagnosis of chronic pain.

Data of Interest

$$\frac{\text{\# of patients who were screened for depression symptoms with PHQ-2 or PHQ-9}}{\text{\# of patients with chronic pain}}$$

Numerator/Denominator Definitions

Numerator: Number of patients screened for depression symptoms with PHQ-2 or PHQ-9.

Denominator: Number of patients age 18 years and older with chronic pain who had at least one contact with a clinician in primary care in the last 12 months from the measurement date. Diagnosis may be either new or existing.

Method/Source of Data Collection:

Query electronic medical records to determine the number of patients with chronic pain with at least one contact with a primary care clinician in the last 12 months from the measurement date. Determine if those patients were screened with PHQ-2 or PHQ-9 for depression symptoms at any of the contacts. Count only one screen.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #4e

Percentage of perinatal patients with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.

Population Definition

Patients age 18 years and older who are perinatal.

Data of Interest

$$\frac{\text{\# of patients who were screened for depression symptoms}}{\text{\# of patients who are perinatal}}$$

Numerator/Denominator Definitions

Numerator: Number of patients screened for depression symptoms with PHQ-2 or PHQ-9.

Denominator: Number of patients age 18 years and older who are perinatal who had at least one contact with a clinician in primary care in the last 12 months from the measurement date. Diagnosis may be either new or existing.

Method/Source of Data Collection:

Query electronic medical records to determine the number of patients who are perinatal with at least one contact with a primary care clinician in the last 12 months from the measurement date. Determine if those patients were screened with PHQ-2 or PHQ-9 for depression symptoms at any of the contacts. Count only one screen.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #5a

Percentage of patients with major depression or persistent depressive disorder whose primary care records show documentation of any communication between the primary care clinician and the mental health care clinician.

Population Definition

Patients age 18 years and older with a new or existing major depression diagnosis or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1.

Data of Interest

$$\frac{\text{\# of patients with documentation of communication between clinicians}}{\text{\# of patients with major depression or persistent depressive disorder}}$$

Numerator/Denominator Definitions

Numerator: Number of patients with documentation of communication between primary care clinician and mental health clinician during the measurement period.

Denominator: Number of patients age 18 years with a new or existing diagnosis of major depression or persistent depressive disorder during the measurement period.

Method/Source of Data Collection:

Query electronic medical records to determine the number of patients with new or existing diagnoses of major depression or persistent depressive disorder during the measurement period. Determine if patients' records indicate any communication between primary care clinician and mental health clinician during the measurement period.

Time Frame Pertaining to Data Collection

Quarterly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #6a

Percentage of patients who have had a response to treatment at six months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a PHQ-9 score decreased by 50% from initial score at six months (+/- 30 days).

Population Definition

Patients age 18 years and older with a diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1 and PHQ-9 > 9.

Data of Interest

$$\frac{\text{\# of patients whose PHQ-9 decreased by 50\% at six months after diagnosis or initiating treatment (+/- 30 days)}}{\text{\# of patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months earlier}}$$

Numerator/Denominator Definitions

Numerator: Number of patients whose PHQ-9 administered at six months (+/- 30 days) after diagnosis or initiating treatment decreased by 50% or more from initial PHQ-9 score administered.

Denominator: Number of patients age 18 years and older with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months earlier.

Diagnosis can be new or existing.

Method/Source of Data Collection:

Query electronic medical records for patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months from the measurement date. Determine if a patient had a follow-up contact at six months and PHQ-9 was done at six months, +/- 30 days. Determine if PHQ-9 decreased by 50% from the initial PHQ-9 done six months from the measurement date.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a patient reported outcome measure, and improvement is noted as an increase in the rate. This measure is aligned with MN Community Measurement depression measure for public reporting.

Return to Table of Contents

Measurement #6b

Percentage of patients who have reached remission at six months (+/- 30 days) after diagnosis or initiating treatment, e.g., had any PHQ-9 score less than 5 at six months (+/- 30 days).

Population Definition

Patients age 18 years and older with diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1 and PHQ-9 > 9.

Data of Interest

$$\frac{\text{\# of patients with a PHQ-9 score < 5 at six months after diagnosis or initiating treatment (+/- 30 days)}}{\text{\# of patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months earlier}}$$

Numerator/Denominator Definitions

Numerator: Number of patients whose PHQ-9 score was less than 5 at six months (+/- 30 days) after diagnosis or initiating treatment.

Denominator: Number of patients age 18 years and older with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months from the measurement date.

Diagnosis can be new or existing.

Method/Source of Data Collection:

Query electronic medical records for patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months from the measurement date. Determine if the patient had a follow-up contact at six months, PHQ-9 was done at six months, +/- 30 days. Determine if PHQ-9 done < 5 at six months, +/- 30 days.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a patient-reported outcome measure, and improvement is noted as an increase in the rate. This measure is aligned with MN Community Measurement depression measure for public reporting.

Return to Table of Contents

Measurement #6c

Percentage of patients who have had a response to treatment at 12 months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a PHQ-9 score decreased by 50% from initial score at 12 months (+/- 30 days).

Population Definition

Patients age 18 years and older with diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1 and PHQ-9 > 9.

Data of Interest

$$\frac{\text{\# of patients whose PHQ-9 decreased by 50\% at 12 months after diagnosis or initiating treatment (+/- 30 days)}}{\text{\# of patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9 12 months earlier}}$$

Numerator/Denominator Definitions

Numerator: Number of patients whose PHQ-9 administered 12 months (+/- 30 days) after diagnosis or initiating treatment decreased by 50% or more from initial PHQ-9 score administered.

Denominator: Number of patients age 18 years and older diagnosis and PHQ-9 > 9, with major depression or persistent depressive disorder 12 months earlier.

Diagnosis can be new or existing.

Method/Source of Data Collection:

Query electronic medical records for patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, 12 months from the measurement date. Determine if a patient had a follow-up contact at 12 months and PHQ-9 was done at 12 months (+/- 30 days). Determine if PHQ-9 done at 12 months decreased by 50% from the initial PHQ-9 done 12 months from the measurement date.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a patient-reported outcome measure, and improvement is noted as an increase in the rate. This measure is aligned with MN Community Measurement depression measure for public reporting.

Return to Table of Contents

Measurement #6d

Percentage of patients who reached remission at 12 months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a PHQ-9 score less than 5 at 12 months (+/- 30 days).

Population Definition

Patients age 18 years and older with diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1 and PHQ-9 > 9.

Data of Interest

$$\frac{\text{\# of patients with PHQ-9 < 5 at 12 months (+/- 30 days)}}{\text{\# of patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, 12 months earlier}}$$

Numerator/Denominator Definitions

Numerator: Number of patients whose PHQ-9 < 5 at 12 months (+/- 30 days) after diagnosis or initiating treatment.

Denominator: Number of patients age 18 years and older with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, 12 months from the measurement date.

Diagnosis can be new or existing.

Method/Source of Data Collection:

Query electronic medical records for patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, 12 months from the measurement date. Determine if a patient had a follow-up contact at 12 months from the diagnosis and PHQ-9 was done at 12 months (+/- 30 days). Determine if PHQ-9 < 5 at 12 months +/- 30 days.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a patient-reported outcome measure, and improvement is noted as an increase in the rate. This measure is aligned with MN Community Measurement depression measure for public reporting.

Return to Table of Contents

Measurement #7a

Percentage of patients whose symptoms are reassessed by the use of a quantitative symptom assessment tool (PHQ-9) at six months (+/- 30 days) after diagnosis or initiating treatment.

Population Definition

Patients age 18 years and older with diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x and F34.1 and PHQ-9 > 9.

Data of Interest

$$\frac{\text{\# of patients whose symptoms are reassessed with PHQ-9 at six months of diagnosis or initiating treatment}}{\text{\# of patients with major depression or persistent depressive disorder diagnosis and PHQ-9} > 9}$$

Numerator/Denominator Definitions

Numerator: Number of patients whose symptoms are reassessed with PHQ-9 at six months (+/- 30 days) after diagnosis or initiating treatment.

Denominator: Number of primary care patients age 18 years and older with new diagnosis of major depression or persistent depressive disorder and PHQ-9 > 9.

Diagnosis can be new or existing.

Method/Source of Data Collection:

Query electronic medical records for patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9, six months from the measurement date. Determine from medical records if a patient had a PHQ-9 done at follow-up contact at six months, +/- 30 days.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Measurement #7d

Percentage of patients whose symptoms are reassessed by the use of a quantitative symptom assessment tool (such as PHQ-9) at 12 months (+/- 30 days) after diagnosis or initiating treatment.

Population Definition

Patients age 18 years and older with diagnosis of major depression or persistent depressive disorder, ICD 10 codes include F32.x, F33.x, and F34.1 and PHQ-9 > 9.

Data of Interest

$$\frac{\text{\# of patients whose symptoms are reassessed with PHQ-9 at 12 months after diagnosis or initiating treatment}}{\text{\# of patients with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9}}$$

Numerator/Denominator Definitions

Numerator: Number of patients whose symptoms are reassessed with PHQ-9 at 12 months, +/- 30 days after diagnosis or initiating treatment.

Denominator: Number of primary care patients age 18 years and older with major depression or persistent depressive disorder diagnosis and PHQ-9 > 9.

Diagnosis can be new or existing.

Method/Source of Data Collection:

Query electronic medical records for patients with major depression or persistent depressive disorder, diagnosis and PHQ-9 > 9, 12 months from the measurement date. Determine from medical records if a patient had a PHQ-9 done at follow-up contact at 12 months, +/- 30 days.

Time Frame Pertaining to Data Collection

Monthly.

Notes

This is a process measure, and improvement is noted as an increase in the rate.

Return to Table of Contents

Implementation Recommendations

Prior to implementation, it is important to consider current organizational infrastructure that address the following:

- System and process design;
- Training and education; and
- Culture and the need to shift values, beliefs and behaviors of the organization.

The following system changes were identified by the guideline work group as key strategies for health care systems to incorporate in support of the implementation of this guideline. The following points have not been updated during this revision.

See Annotation #6, "Comprehensive Treatment Plan with Shared Decision-Making," for definitions of the collaborative care model.

See below for health care cost analysis of a collaborative care model compared with outpatient primary care depression care as usual and review of the cost analysis for enhanced collaborative care and the impact on the workplace, e.g., absenteeism.

- Detection and diagnosis
  - Systems in place to reliably determine if a patient is depressed
  - Use of DSM-5 criteria and structured questionnaires (such as PHQ-9)
- Patient-centered care, education and self-management programs
  - Structured attention to patient preferences
  - Patient and family education materials/protocols
  - Patient self-management skills such as journal writing or self-monitoring

    When appropriate, encourage family or loved ones to attend appointments for patient support and advocacy.
  - Involving families, as well, in care management programs
  - Care manager role to coordinate the disease management for patients with depression including such things as patient contacts, education, self-management tools and tips
- Mental health/behavioral medicine specialist involvement
  - Shared care – collaborative care between behavioral health specialists and primary care clinicians in the primary care setting. Care manager and /or primary care clinician consulting with psychiatry on a regular basis regarding the case load of patients with depression managed in the depression care management program.
  - Appointment availability – access to behavioral health in timely manner
- Outcomes measurement
  - Build in plans for outcome measures as well as ongoing process measures
  - Response rate to various treatments
  - Remission rates – improvement in response is stable over time

Return to Table of Contents

- Systems to coordinate care, ensure continuity and keep clinicians informed of status
  - Build automated processes for the first four core elements wherever possible
  - Reduce dependence on human behavior to ensure delivery of patient care processes
  - Use of components of the chronic care model for depression care, e.g., use of registries, community outreach
  - Structured frequent monitoring and follow-up with patient
  - Nurse/care manager phone care and use of other modalities for patient follow-up

A recent study showed a relationship between the severity of depression symptoms and work function. Data was analyzed from 771 depressed patients who were currently employed. The data showed that for every 1-point increase in PHQ-9 score, patients experienced an additional mean productivity loss of 1.65%. And, even minor levels of depression symptoms were associated with decrements in work function *(Beck, 2011)*.

Cost-Effectiveness Impact of Collaborative Care Models

In a collaborative care model, the primary treatment for depression is provided by a multidisciplinary team. Most studies have concluded that creating and implementing a collaborative care model will increase effectiveness – producing significant and sustained gains in "depression-free days" *(Katon, 2005; Simon, 2001a; Simon, 2001b)*. The six-month and one-year studies show increased cost to the outpatient care system. This is balanced by continuous accumulation of clinical and economic benefits over time. One of the factors is the decrease in the utilization of general medical services in patients with chronic medical comorbidities. The two-year studies show mixed results possibly indicating a turning point *(Dickinson, 2005)*, and the only longer-term study conducted was the IMPACT study. This was a well-done study analyzing the costs of performing collaborative care for one year over a four-year period. The study illustrated a cost savings of $3,363 per patient over the four-year period *(Unützer, 2008)*.

Almost all the studies done on this aspect have compared enhanced/collaborative care with care as usual. Typically enhanced care has involved creating a list of depressed patients under treatment, having a care manager provide education, call or meet with patient periodically to ensure compliance with medications and/or psychotherapy, and to reliably ensure follow-up visits and measurement of outcomes. Some have involved varying participation of physicians, behavioral health professionals and/or patients.

Workplace Impact of Collaborative Care Models

These randomized controlled trials looked at cost of doing enhanced care and specifically tallied decreases of "absenteeism" and improved work performance (which means that employees are present and effectively achieving good work results, sometimes referred to as decreasing "presenteeism") *(Wang, 2007; Schoenbaum, 2001)*. Some studies monetized the results and compared them to usual care. The significance of these studies and this analysis is that in the U.S., depression costs employers $24 billion in lost productive work time *(Stewart, 2003)*.

In two randomized controlled trials, employers received significant ROI (return on investment) from collaborative care treatment of depression by increasing productivity/decreasing absenteeism in the workplace. Increased productivity in one study ranged from 2.6 hours to 5.6 hours/week after one year. Studies going out to two years showed continued gains in year two *(Lo Sasso, 2006; Rost, 2004)*.

Several of the articles recommend consideration of coverage of collaborative care to ensure better patient outcomes and the ROI illustrated.

Return to Table of Contents

Implementation Tools and Resources

Criteria for Selecting Resources

The following tools and resources specific to the topic of the guideline were selected by the work group. Each item was reviewed thoroughly by at least one work group member. It is expected that users of these tools will establish the proper copyright prior to their use. The types of criteria the work group used are:

- The content supports the clinical and the implementation recommendations.
- Where possible, the content is supported by evidence-based research.
- The author, source and revision dates for the content is included where possible.
- The content is clear about potential biases and when appropriate conflicts of interests and/or disclaimers are noted where appropriate.

Return to Table of Contents

Implementation Tools and Resources Table

Author/Organization	Title/Description	Audience	Web Sites/Order Information
Comorbidities			
American Cancer Society	Coping with physical and emotional changes.	Patients and Families	http://www.cancer.org/docroot/MBC/content/MBC_4_1X_Cancer_and_Depression.asp?sitearea=MBC
Medication Assisted Treatment (MAT)	Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders.	Health Care Professionals	http://www.samhsa.gov/medication-assisted-treatment
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Provides an integrated, public health approach for early intervention and treatment services for persons with substance use disorders and those at risk.	Health Care Professionals	http://www.samhsa.gov
Substance Abuse and Mental Health Services Administration	Information on programs and publications for improving the quality and availability of substance abuse prevention, alcohol and drug addiction treatment, and mental health services.	Health Care Professionals	http://www.samhsa.gov/
Cultural Considerations			
National Institute of Mental Health	A colored, easy-to-read brochure called "Stories of Depression/Historias personales sobre la depresion," Spanish Version.	Patients and Families	http://www.nimh.nih.gov Publication No. 03-5122 del NIH English version NIH Publication No. 05-5084
National Institute of Mental Health	Spanish resources. "Depression," a 27-page booklet about depression, and treatment.	Patients and Families	http://www.nimh.nih.gov NIH Publication No. NIH-04-3561 (SP)
U.S. Dept of Health & Human Services, Office of Minority Health	Resources and information to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities.	Patients and Families/ Health Care Professionals	http://www.minorityhealth.hhs.gov
Drug Interactions			
Epocrates Online	Interactive tool for common drug interactions. Includes information on severity and dosing recommendations.	Health Care Professionals	https://online.epocrates.com
Medscape	Drug interaction checker	Health Care Professionals	http://www.medscape.com/druginfo/druginterchecker
University of Maryland Medical Center	Interactive drug checker	Health Care Professionals	http://www.umm.edu/adam/drug_checker.htm

Return to Table of Contents

Author/Organization	Title/Description	Audience	Web Sites/Order Information
Electroconvulsive Therapy			
American Academy of Family Physicians	Depression: Electroconvulsive Therapy Handout	Patients and Families/ Health Care Professionals	http://familydoctor.org/familydoctor/en/diseases-conditions/depression/treatment/how-electroconvulsive-therapy-works.html
General			
American Psychiatric Association	Let's Talk about Depression (8-page booklet)	Patients and Families	American Psychiatric Publishers 1-800-368-5777 #2351; $49.00/50
American Psychiatric Association	Provides mental health news, online CME programs and legislation. Links to MEDEM for patient information.	Patients and Families/ Health Care Professionals	http://www.psych.org
Dennis Greenburger and Christine Padesky	Mind over Mood (215-page workbook)	Patients and Families	Bookstores
DVD Resource	Understanding Depression: Hope through Treatment **and** Understanding Depression: The Suicide Connection	Patients and Families	http://www.understandingdepression.org
ICSI	Workplace Impact of Collaborative Care Models for Depression	Health Care Professionals	https://www.icsi.org/_asset/s9p6bx/White-Paper-on-Collaborative-Care-Model-ROI.pdf
National Alliance for the Mentally Ill	Advocacy, links to Minnesota chapter support groups	Patients and Families/ Health Care Professionals	http://www.nami.org
National Institute of Mental Health	This government-sponsored site provides comprehensive information on the following topics: clinical trials, research and funding opportunities, and patient education materials for adults and children. Links to PubMed, MedlinePlus and other relevant sites are available.	Patients and Families/ Health Care Professionals	http://www.nimh.nih.gov
National Library of Medicine MedlinePlus	This government-sponsored comprehensive site provides information on medications, diagnosis, treatments, clinical trials and links to other relevant sites. Spanish versions of some patient education materials are also provided.	Patients and Families/ Health Care Professionals	http://www.nlm.nih.gov/medlineplus Toxicology Data Network can be found at http://toxnet.nlm.nih.gov/

Return to Table of Contents

Author/Organization	Title/Description	Audience	Web Sites/Order Information
General (Continued)			
National Mental Health Association	Provides patient information, depression screening tool, community resources and discussion board.	Patients and Families/ Health Care Professionals	http://www.nmha.org
The National Suicide Lifeline		Patients and Families	1-800-273-TALK 1-800-273-8255
Stratis Health Culture Care Connection	One significant resource is fact sheets on numerous culturally diverse populations living in Minnesota. Includes information on such issues as social structure, diet, religion, health care beliefs and successful ways to communicate with people of the specific culture.	Patients and Families/ Health Care Professionals	http://www.culturecareconnection.org
Texas Department of State Health Services	The Texas Medication Algorithm Project (TMAP)	Health Care Professionals	http://www.dshs.state.tx.us/mhsa
Perinatal			
The Marcé Society for Perinatal Mental Health	An international society for the understanding, prevention and treatment of mental illness related to childbearing. Dedicated to supporting research and assistance surrounding prenatal and postpartum mental health for mothers, fathers and their babies.	Patients and Families/ Health Care Professionals	http://www.marcesociety.com
Massachusetts General Hospital Center for Women's Mental Health	Resources and information on reproductive psychiatry	Health Care Professionals	http://www.womensmentalhealth.org
Med Ed PPD	Online education about perinatal mental health and treatment options.	Patients and Families/ Health Care Professionals	http://mededppd.org/
Minnesota Department of Health	Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well Child Checks **and** Documenting and Charting for Postpartum Depression in Well Child Checks	Patients and Families	http://www.health.state.mn.us/divs/cfh/topic/pmad/

Return to Table of Contents

Author/Organization	Title/Description	Audience	Web Sites/Order Information
Perinatal (Continued)			
Organization of Teratology Information Specialists	A non-profit organization made up of individual services throughout North America providing evidence-based, clinical information to patients and health care professionals about exposures during pregnancy and lactation. Ongoing research on antidepressant use during pregnancy, autoimmune disorders, vaccines and medication in pregnancy surveillance system.	Patients and Families/ Health Care Professionals	http://mothertobaby.org/
Postpartum Stress Center	Books, articles and information on PPD	Patients and Families/ Health Care Professionals	http://www.postpartumstress.com/
Postpartum Support International	Provides information on postpartum depression for clinicians as well as patients/consumers interested in learning more about postpartum depression. Expanded section for dads.	Patients and Families/ Health Care Professionals	http://www.postpartum.net
Pregnancy and Postpartum Support Minnesota (PPSM)	A group of mental health and perinatal practitioners, service organizations and mother volunteers offering emotional support and treatment to Minnesota families through the perinatal years.	Patients and Families	http://www.ppsupportmn.org
Wisconsin Association for Perinatal Care	Provide resources to improve the health of babies, mothers and families from preconception to early childhood. Site includes algorithms and medication charts for depression in perinatal women.	Patients and Families/ Health Care Professionals	http://www.perinatalweb.org

Return to Table of Contents

The subdivisions of this section are:

- References
- Appendices

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References

Links are provided for those new references added to this edition (author name is highlighted in blue).

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Return to Table of Contents

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Return to Table of Contents

Appendix A – Patient Health Questionnaire (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING

__0__ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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Return to Table of Contents

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the two right columns (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   - if there are at least 5 ✓s in the two right columns (one of which corresponds to Question #1 or #2).

   Consider Other Depressive Disorder
   - if there are 2 to 4 ✓s in the two right columns (one of which corresponds to Question #1 or #2).

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓:
   "Several days" = 1 "More than half the days" = 2 "Nearly every day" = 3
3. Add together column scores to get a TOTAL score.
4. Refer to accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

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Appendix B – ICSI Shared Decision-Making Model

ICSI Institute for Clinical Systems Improvement

The Collaborative Conversation™
Shared Decision-Making and the Translation of Evidence into Practice

A consistent finding from clinical and health services research is the failure to translate research into practice. The translation of evidence into practice can be advanced through the use of shared decision-making since shared decision-making results in evidence being incorporated into patient and clinician consultations.

Shared decision-making (SDM) is a process in which patient and clinicians collaborate to clarify all acceptable options, ensure that the patient is well-informed, and chose a course of care consistent with patient values and preferences and the best available medical evidence *(Minnesota Shared Decision-Making Collaborative [MSDMC], 2011)*.

Evidence based guidelines may recommend the use of shared decision-making for decisions in instances where the evidence is equivocal, when patient action or inaction (such as medication adherence or lifestyle changes) can impact the potential outcome, or when the evidence does not indicate a single best recommendation.

SDM is a patient-centered approach that involves a conversation between the patient and the clinician. It is ideal to involve caregivers and family members in these conversations as well. Family members and caregivers can participate in discussions, ask questions, hear content the patient may miss, and provide invaluable support in decision follow through. Although only patients and clinicians are specifically mentioned throughout this document for brevity purposes, this does not diminish the importance of caregivers and families in patient-centered care.

Both the patient and the clinician bring expertise to the shared decision-making conversation. Clinicians' expertise includes disease etiology, prognosis, options for treatment including the burden and benefit to the patient, and outcome probabilities. Patients' expertise lies in their knowledge of their risk tolerance, body, priorities, family and financial issues, as well as their daily experience with the condition (adapted from "Making Shared Decision-Making a Reality. No Decision About Me, Without Me." Coulter, A., Collins, A., The King's Fund 2011).

Treatment options vary in their burden on a patient. SDM offers an opportunity to help the patient select a treatment to which he/she can adhere. When conversations discussing options occurs, patients and clinicians are actively engaged while considering the attributes and issues of the available options. This empathic approach results in the clinician and patient co-creating a decision and a plan of care (adapted from Montori, V., the Mayo Clinic KER UNIT, April 2015). Decision aids can be supportive of this conversation when they communicate the best available evidence to inform the patient and clinician discussion.

Without a conversation, clinicians may make assumptions about what the patient prefers. This creates the potential for discrepancies between what clinicians assume and what patients want resulting in a "preference misdiagnosis" (adapted from Health Policy Publishing, LLC, May 2013).

Difficulty in initiating a conversation is cited by patients and clinicians as one of the barriers to shared decision-making. To address this impediment, ICSI worked with patients, practicing clinicians, and other stakeholders to develop the Collaborative Conversation™ model for use across the care continuum.

Return to Table of Contents

Collaborative Conversation™

A collaborative approach towards decision-making is a fundamental tenet of Shared Decision-Making (SDM). The Collaborative Conversation™ is an inter-professional approach that nurtures relationships, enhances patients' knowledge, skills and confidence as vital participants in their health, and encourages them to manage their health care. Within a Collaborative Conversation™ , the perspective is that the patient, rather than the clinician, knows which course of action is most consistent with the patient's values and preferences.

Use of Collaborative Conversation™ elements and tools is even more necessary to support patient, care clinician and team relationships when patients and families are dealing with high stakes or highly charged issues. A diagnosis of a life-limiting illness is one example of such a circumstance.

The overall objective for the Collaborative Conversation™ approach is to create an environment in which the patient, family, and care team work collaboratively to reach and carry out a decision that is consistent with the patient's values and preferences along with the best available evidence. A rote script, completed form or checklist does not constitute this approach. Rather it is a set of skills employed appropriately for the specific situation. These skills need to be used artfully to address all aspects of the person involved in making a decision: cognitive, affective, social and spiritual.

Key communication skills help build the collaborative conversation approach. These skills include: (adapted from O'Connor, Jacobsen, "Decisional Conflict: Supporting People Experiencing Uncertainty about Options Affecting their Health" [2007], and Bunn H, O'Connor AM, Jacobsen MJ, "Analyzing Decision Support and Related Communication" [1998, 2003]).

1. **Listening skills:**

   Encourage patient to talk by providing prompts to continue such as ***go on, and then?, uh huh,*** or by repeating the last thing a person said, ***It's confusing***.

   Paraphrase content of messages shared by patient to promote exploration, clarify content and to communicate that the person's unique perspective has been heard. The clinician should use their own words rather than just parroting what they heard.

   Reflection of feelings usually can be done effectively once trust has been established. Until the clinician feels that trust has been established, short reflections at the same level of intensity expressed by the patient without omitting any of the message's meaning is appropriate. Reflection in this manner communicates that the clinician understands the patient's feelings and may work as a catalyst for further problem solving. For example, the clinician identifies what the person is feeling and responds back in his/her own words like this: ***"So, you're unsure which choice is the best for you."***

   Summarize the person's key comments and reflect them back to the patient. The clinician should condense several key comments made by the patient and provide a summary of the situation. This assists the patient in gaining a broader understanding of the situation rather than getting mired down in the details. The most effective times to do this are midway through and at the end of the conversation. An example of this is, ***"You and your family have read the information together, discussed the pros and cons, but are having a hard time making a decision because of the risks."***

   Perception checks ensure that the clinician accurately understands a patient or family member perspective, and may be used as a summary or reflection. They are used to verify that the clinician is interpreting the message correctly. The clinician can say, ***"So you are saying that you're not ready to make a decision at this time. Am I understanding you correctly?"***

Return to Table of Contents

2. **Questioning Skills:**

   Open and Closed questions are both used with the emphasis on open questions. Open questions ask for clarification or elaboration and cannot have a yes or no answer. An example would be, ***"What else would influence you to choose this?"*** Closed questions are appropriate if specific information is required such as, ***"Does your daughter support your decision?"***

   Other skills such as summarizing, paraphrasing, and reflection of feeling can be used in the questioning process so that the patient doesn't feel pressured by questions.

   Verbal tracking, referring back to a topic the patient mentioned earlier, is an important foundational skill (Ivey & Bradford-Ivey). An example of this is the clinician saying, ***"You mentioned earlier…"***

3. **Information-Giving Skills:**

   Providing information and **providing feedback** are two methods of information giving. The distinction between providing information and giving advice is important. Information giving allows a clinician to supplement their knowledge and helps to keep the conversation patient centered. Giving advice, on the other hand, takes the attention away from the patient's unique goals and values, and places it on those of the clinician.

   Providing information can be sharing facts or responding to questions. An example is, ***"If we look at the evidence, the risk is…"*** **Providing feedback** gives the patient the clinician's view of the patient's reaction. For instance, the clinician can say, ***"You seem to understand the facts and value your daughter's advice."***

Return to Table of Contents

When to Initiate a Collaborative Conversation™

Certain seminal events occur along the care continuum creating especially opportune times for collaborative conversations. More than one of these opportunities may present at a time and they will occur in no specific order.

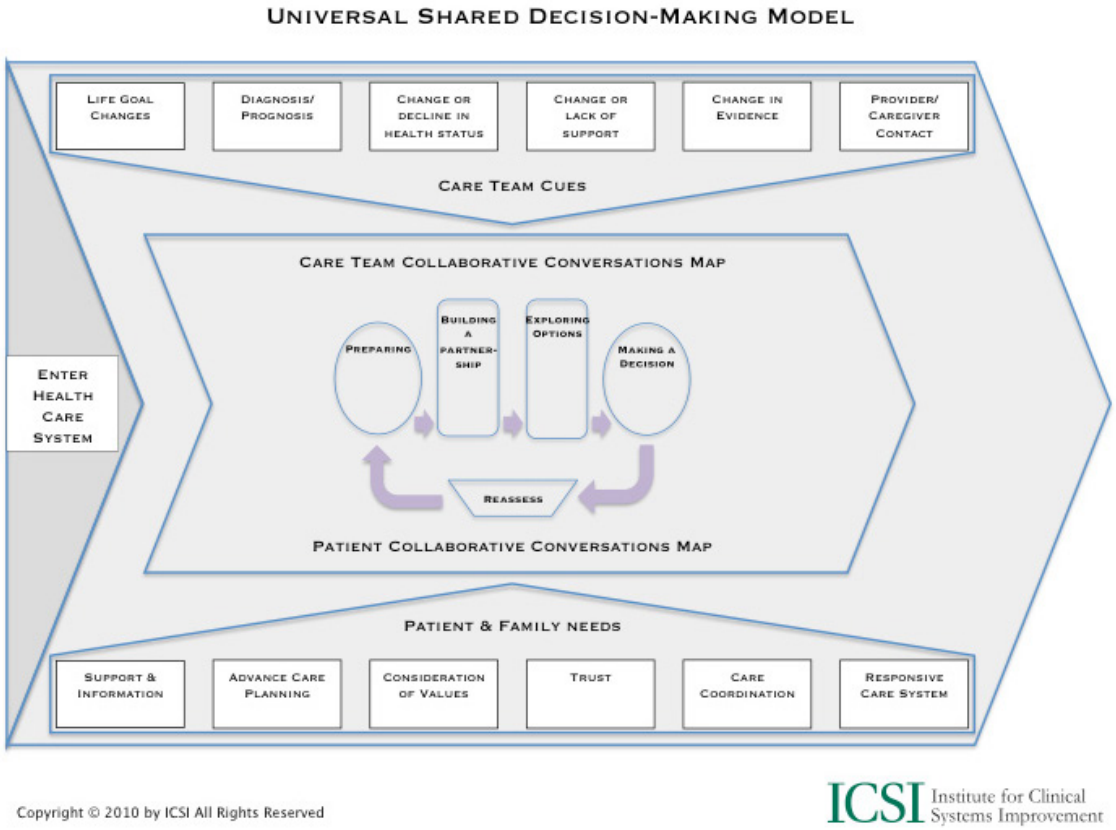

Table 1

Cues for the Care Team to Initiate a Collaborative Conversation™:

- Life goal changes: *Patient's priorities change related to things the patient values such as activities, relationships, possessions, goals and hopes, or things that contribute to the patient's emotional and spiritual well-being.*
- Diagnosis/prognosis changes: *Additional diagnoses, improved or worsening prognosis.*
- Change or decline in health status: *Improving or worsening symptoms, change in performance status or psychological distress.*
- Change or lack of support: *Increase or decrease in caregiver support, change in caregiver, change in caregiver status, change in financial standing, difference between patient and family wishes.*
- Disease progression: *Change in physical or psychological status as a result of the disease progression.*
- Clinician/caregiver contact: *Each contact between the clinician/ caregiver presents an opportunity to reaffirm with the patient that their care plan and the care they are receiving is consistent with their values.*

Patient and Family Needs within a Collaborative Conversation™

- Request for support and information: *Decisional conflict is indicated by, among other things, the patient verbalizing uncertainty or concern about undesired outcomes, expressing concern about choice consistency with personal values, exhibiting behavior such as wavering, delay, preoccupation, distress or tension. Support resources may include healthcare professionals, family, friends, support groups, clergy and social workers. When patient expresses need for information regarding options and their potential outcomes, the patient should understand the key facts about their options, risks and benefits, and have realistic expectations. The method and pace with which this information is provided to the patient should be appropriate for the patient's capacity at that moment.*
- Advance Care Planning: *With the diagnosis of a life-limiting illness, conversations around advance care planning open up. This is an opportune time to expand the scope of the conversation to other types of decisions that will need to be made as a consequence of the diagnosis of a life-limiting illness.*
- Consideration of Values: *The personal importance a patient assigns potential outcomes must be respected. If the patient is unclear how to prioritize his/her preferences, value clarification can be achieved through the use of decision aids. Detailing the benefits and harms of potential outcomes in terms of how they will directly affect the patient, and through collaborative conversations with the clinician.*
- Trust: *The patient must feel confident that his/her preferences will be communicated to and respected by all caregivers.*
- Care Coordination: *Should the patient require care coordination; this is an opportune time to discuss the other types of care related decisions that need to be made. These decisions will most likely need to be revisited often. Further, the care delivery system must be capable of delivering coordinated care throughout the continuum of care.*
- Responsive Care System: *The care system needs to support the components of patient and family centered care so the patient's values and preferences are incorporated into the care they receive throughout the care continuum.*

Return to Table of Contents

The Collaborative Conversation™ Map is the heart of this process. The Collaborative Conversation Map™ can be used as a stand-alone tool that is equally applicable to clinicians and patients as shown in Table 2. Clinicians use the map as a clinical workflow. It helps get the shared decision-making process initiated and provides navigation for the process. Care teams can use the Collaborative Conversation™ to document team best practices and to formalize a common lexicon. Organizations can build fields from the Collaborative Conversation™ Map in electronic medical records to encourage process normalization. Patients use the map to prepare for decision-making, to help guide them through the process and to share critical information with their loved ones.

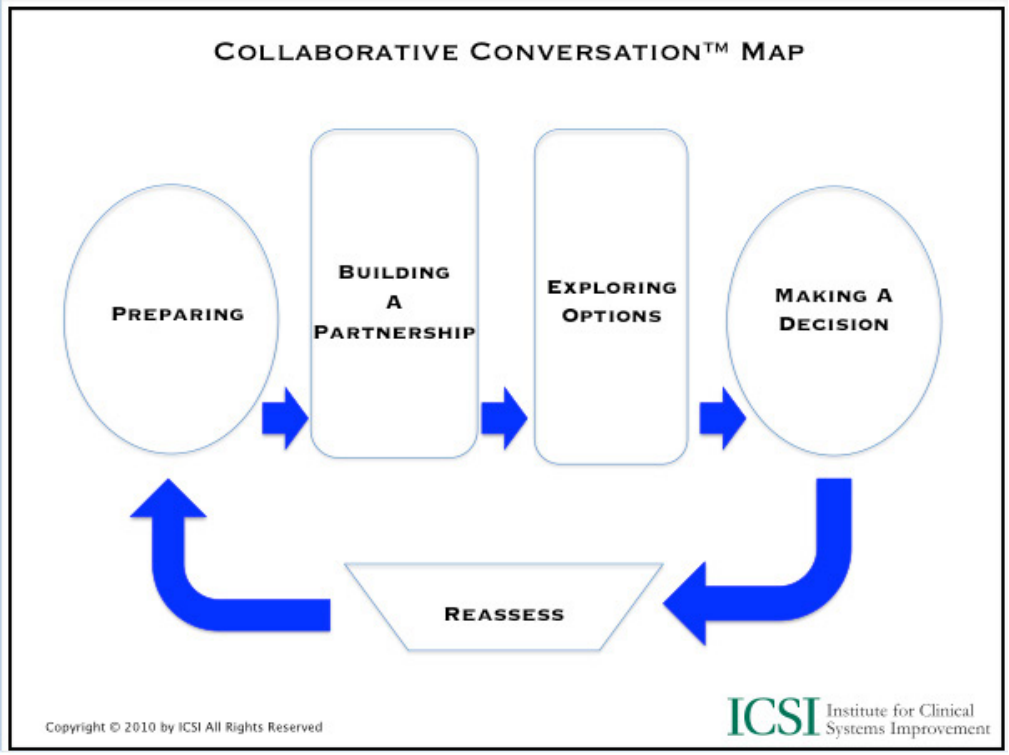

Table 2

Return to Table of Contents

Evaluating Shared Decision-Making

It has proven challenging to assess shared decision-making. Measuring shared decision-making remains important for continued adoption of shared Decision-Making as a mechanism for translating evidence into practice, promoting patient centered care, and to understand the impact of shared decision-making on patient experience, outcomes and revenues. Many assessments exist, but they are often proxy measures.

Two suggested methods for measuring shared Decision-Making are the CollaboRATE tool and the SURE Test. These two tools measure different aspects of shared Decision-Making, as described below.

The CollaboRATE tool measures the level of shared Decision-Making in the clinical encounter from the patient's perspective. It is a brief patient reported measure of shared decision-making. The tools and guidance on their use can be found at http://www.collaboratescore.org/.

The SURE Test is a brief screening questionnaire the patient uses to access their readiness and capacity to make a decision or to determine whether they are comfortable with the choice that was made. In other words, it provides information on how likely a patient may be experiencing decisional conflict. If the SURE screening test indicates decisional conflict may exist, the Decisional Conflict Scale should be completed in order to assess clinically significant decisional conflict.

Shared decision-making is a useful mechanism for translating evidence into practice. While research on the impacts of shared decision-making continues to grow, there is mounting evidence that both patients and clinicians benefit from SDM. Shared decision-making offers the opportunity to bring evidence and the patient's values into the patient/clinician discussion of health choices.

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Return to Table of Contents

Appendix C – Specialized Therapies

The following are descriptions of emerging treatments for depression. Refer to psychiatry for further consideration.

Ketamine infusion therapy

There has been significant interest in using IV ketamine for patients suffering from treatment resistant depression (TRD). Ketamine is an antagonist at the N-methyl-D-aspartate (NMDA) receptor, which modulates the excitatory neurotransmitter, glutamate *(Preskorn, 2012)*. Ketamine has generally been studied via IV administration, because the oral and IM formulations also do not provide the rapid response seen with IV administration *(Aan Het Rot, 2012)*.

In some reports, significant patient response has been observed within 2 to 24 hours of ketamine administration *(Murrough, 2013)*. Two systemic reviews of published literature on the antidepressant effects of ketamine found it to have a rapid antidepressant effect in data on 163 patients in one study and 310 in another, which included treatment-resistant patients, as well as 118 patients undergoing concurrent ECT *(Fond, 2014; Aan Het Rot, 2012)*.

Despite the promise of a robust and rapid response, few studies have followed patients longer than 72 hours after their IV infusion of ketamine. One study followed 73 patients who were randomized to IV ketamine or IV midazolam and found a higher response rate at 24 hours for the IV ketamine vs. the IV midazolam group (64% vs. 28%). They also found that over seven days, the IV ketamine group had a lower and longer time to relapse *(Murrough, 2013)*. It is also unclear why patients who have demonstrated treatment response at 24 hours post-ketamine infusion relapse less than 48 hours later *(Aan Het Rot, 2012)*. One study found two of three subjects did not demonstrate significant responses to ketamine until after they received multiple infusions *(Szymkowicz, 2013)*.

Future studies of ketamine for the treatment of depression are needed prior to recommendations of its use in typical clinical practice settings. These future studies should also evaluate a way to sustain symptom remission following IV ketamine and evaluate larger groups of patients *(Szymkowicz, 2013)*.

Vagus nerve stimulation (VNS)

Vagus nerve stimulation is approved by the FDA for treatment-resistant depression on the basis of its potential benefit with long-term use. The evidence primarily stems from open labeled uncontrolled trials. It is not indicated for use in the acute treatment phase, and it has been studied only in treatment-resistant depression.

Vagus nerve stimulation involves the use of an implantable device, which provides intermittent stimulation to the left vagus nerve (80% afferent to the central nervous system). It is used as an adjunctive treatment along with other modalities such as psychotropic medications *(George, 2005; Kraft, 2005; Nahas, 2005; Sackeim, 2001b; Sackeim, 2001c; Rush, 2005)*.

Side effects include voice alterations (generally just while one is receiving the 30 seconds of stimulation each 5 minutes), increased rate of neck pain, cough, dyspnea and dysphagia *(Schlaepfer, 2008; Sackeim, 2001c)*.

Sackeim, 2007 combined available efficacy studies to assess the durability of VNS benefit. Of those who responded by three months of VNS, 66.7% and 64.5% maintained benefit at one and two years, respectively. By comparison, for those who responded by 12 months of VNS, 68.5% maintained benefit at two years *(Sackeim, 2007)*. More recent studies *(Cristancho, 2011; Bajbouj, 2010)* have focused on long-term outcomes, which show six-month response rates at 21.4%, six-month remission rates at 14.3%, one-year response rates at 28.6-43%, one-year remission rates at 14.3-36.8%, two-year response rates at 53.1%, and two-year remission rates at 38.9%.

Return to Table of Contents

Repetitive transcranial magnetic stimulation (rTMS)

Repetitive TMS is a treatment for non-psychotic major depressive disorder approved in 2008 by the FDA for treatment-refractory major depressive disorder.

Repetitive transcranial magnetic stimulation (rTMS) is a non-invasive brain stimulation technique that utilizes briefly pulsed electromagnetic fields to induce electrical currents in the cerebral cortex *(Allan, 2011; Janicak, 2010)*. Repetitive TMS is generally well tolerated. Transient scalp discomfort and headache are the most common side effects, seizures are very uncommon, and in contrast to ECT, cognitive impairment is not observed *(Allan, 2011; George, 2010)*.

Several studies have shown efficacy of an acute course of rTMS. In an intention-to-treat sample of 190 patients treated with left prefrontal cortex rTMS versus active sham treatment, active rTMS patients had 4.2 times greater odds of remission than sham patients, which was statistically significant *(George, 2010)*.

O'Reardon, 2007 reported on a large 301-patient multicentered, acute, randomized controlled trial of rTMS showing remission rates almost double for active treatment versus sham (MADRS = 14.2% vs. 5.2%, HAMD-17 = 15.5% vs. 7.1%. HAMD-24 = 17.4% vs. 8.2%) at six weeks *(O'Reardon, 2007)*.

Ray, 2011 showed a 75% remission rate for rTMS vs. 10% in the control group in a small 41-patient prospective randomized hospital-based study. This study included patients with psychotic depression *(Ray, 2011)*.

In a recent meta-analysis including 29 randomized, controlled trials, rTMS was found to have response and remission rates comparable to antidepressants with numbers needed to treat for response of 6 and for remission of 8 *(Berlim, 2014)*.

TMS has also shown some evidence in sustaining the durability of efficacy. In a multisite, naturalistic, observational study, it was shown that of the 120 patients with a history of pharmaco-resistant major depressive disorder who met criteria for response or remission after an acute course of treatment, 62.5% continued to meet response criteria through one year. Of note, these patients had access to TMS during the study, and 36.2% of the study patients received reintroduction of TMS.

Magnetic seizure therapy (MST)

Magnetic seizure therapy uses focused stimulation (generally of the right frontal area) to induce a focal seizure. This is designed to obtain efficacy of ECT without the cognitive side effects (which generally occur when seizures spread to the hippocampus). One open label trial *(Sackeim, 1994)* showed less amnesia and faster reorientation than ECT and some improvement in depression scores.

Deep brain stimulation (DBS)

Deep brain stimulation is the process of implanting electrodes to continuously stimulate various brain regions with high-frequency impulses to diminish major depressive symptoms among treatment refractory individuals. To date, five neuroanatomical targets have been studied with favorable effects and minor adverse effects: nucleus accumbens, subcallosal cingulate gyrus, inferior thalamic peduncle, ventral internal capsule/ventral striatum, and the lateral habenula *(Blomstedt, 2011)*. So far, evidence involves small non-blinded trials.

One open label trial *(Mayberg, 2005)* showed four out of six patients achieved remission after surgery (and those with sham sessions did not). At two months, five out of six patients were in remission, and four out of six were in remission at six months. A follow-up study of these patients plus 14 additional patients *(Lozano, 2008)* showed response/remission rates of 60% versus 35% at six months and 55% versus 35% (or were within one point of remission) at 12 months. At two years and three years, the response rates were 46.2% and 75%, respectively, and remission rates were 15-20% and 40-50%, respectively *(Kennedy, 2011)*. Malone, 2009 showed that 40% of treatment refractory depressed patients responded and 20% reached remission at six months of continuous DBS. The rates went up to 53.3% response and 40% remission at last follow-up, up to four years later *(Malone, 2009)*.

Eye movement desensitization and reprocessing (EMDR)

The EMDR Institute's official position is that EMDR is only empirically validated for treatment of trauma-related disorders. At this time, there is no evidence to recommend EMDR as a treatment for depression.

Return to Table of Contents

Appendix D – Special Populations

Overview

This section summarizes evidence related to the prevalence, assessment and treatment of depression in patients with:

- Cardiovascular disease and cerebrovascular disease
- Diabetes
- Chronic pain
- Geriatric and cognitively impaired patients
- Pregnant and postpartum women

Medical Comorbidity

The importance of the interplay between depression and many medical comorbidities cannot be overstated. **Depressed patients often have comorbid conditions.**

In the STAR*D trial, study entry subjects had an average of 3.3 general medical conditions *(Trivedi, 2006b)*.

A study utilizing the second cohort of STAR*D patients reported a prevalence of significant general medical conditions of 50% in the study population *(Yates, 2007)*.

A long list of medical conditions has been associated with increased risk for depression; these include chronic pain, diabetes, cancer, HIV, Parkinson's disease, cardiovascular and cerebrovascular disease, and multiple sclerosis *(Kozhimnanil, 2009; Egede, 2005; Katon, 2004b)*.

Undiagnosed or undertreated depression has been associated with worsened outcomes in cancer, cardiovascular disease and other conditions *(Hedeyati, 2010; Lichtman, 2008)*.

Conversely, one would expect that effective identification and treatment of comorbid depression would be associated with improved medical outcomes. Studies have demonstrated an association between effective treatment of depression and improved adherence to medical treatment for conditions such as cardiovascular disease *(Ciechanowski, 2000)*. However, other suspected benefits of antidepressant therapy, such as decreased mortality after MI or CABG, have been more difficult to prove. See the "Implementation Tools and Resources Table" for more information.

The following conditions are particularly important for screening, given the findings.

Cardiovascular and Cerebrovascular Disease

Interplay of risks

Some studies have shown that major depression is associated with an increased risk of developing coronary artery disease (*Wulsin, 2003; Rugulies, 2002)*.

Studies have shown an increased risk of mortality in patients after myocardial infarction by as much as fourfold *(Lichtman, 2008; Frasure-Smith, 1995)*, while other analyses have disputed this *(Jiang, 2005; Nicholson, 2006)*.

Moderate to severe depression before CABG surgery and/or persistent depression after surgery increases the risk of death after CABG more than twofold higher than non-depressed patients *(Blumenthal, 2003)*.

Depression is three times more common in patients after acute myocardial infarction than in the general population and, notably, young women are at particularly high risk for depression after myocardial infarction *(Lichtman, 2008)*.

A meta-analysis in regards to the relationship between stroke and depression found a pooled hazard ratio of 1.45, on par with the association smoking and obesity have with stroke *(Pan, 2011)*.

Potential explanations

Several possible mechanisms are proposed to explain why depression increases the risk of developing cardiovascular disease. These include behavioral issues such as increased smoking, obesity, sedentary lifestyle, and lack of adherence to medication.

A prospective study found that the association between depression and cardiovascular events disappeared after controlling for physical activity and other health behaviors *(Whooley, 2008)*, suggesting depression's negative impact on activity and behavior may account for its contribution to cardiac risk.

Biologic phenomena associated with depression such as increased inflammatory processes (elevated C-reactive protein or cytokine levels), increased platelet dysfunction (heightened platelet aggregation or adhesiveness), and abnormalities in endothelial function may also explain possible mechanisms for an increased risk *(Katon, 2004b)*.

A cross-sectional study of depressed patients also found that, of their depressive symptomatology, specifically increased sympathetic arousal and insomnia were significantly associated with cardiac disease *(Fraguas, 2007)*.

It has been suggested that the potential causative mechanisms for the association between stroke and depression are similar to those discussed above for cardiovascular disease *(Pan, 2011)*.

Treating depression in this population

A recent meta-analysis suggested that SSRI treatment of depression may improve coronary heart disease prognosis *(Pizzi, 2011)*. In addition, consensus opinion is to treat depressed cardiac patients with a safe drug rather than watchful waiting since they would not only benefit from symptomatic relief of their depressive symptoms but also have a potential improvement in their cardiovascular risk profile *(Ballenger, 2001)*.

Although tricyclic antidepressants are effective against depression, they are associated with cardiovascular side effects including orthostatic hypotension, slowed cardiac conduction, proarrhythmic activity and increased heart rate. SSRIs, by contrast, are well tolerated and have a more benign cardiovascular profile; they would be preferred initial agents for treatment of depression in individuals with cardiovascular disease *(Jiang, 2005)*. SSRI treatment also has been shown to significantly decrease depressive symptoms in coronary heart disease patients *(Pizzi, 2011)*.

The American Heart Association science advisory *(Lichtman, 2008)* suggests **sertraline and citalopram** as first-line drugs for patients with coronary heart disease. See "SSRIs and Other Antidepressants" and "Citalopram Warning" in the Pharmacotherapy section.

A recent meta-analysis showed that treatment with SSRIs after stroke in non-depressed patients significantly reduced the risk of development of a depressive episode after stroke (odds ratio [OR] of 0.34). In addition to this, it has been shown that an ongoing exercise program after stroke also significantly reduces depressive symptoms post-stroke *(Eng, 2014)*.

For more information, see also the ICSI Heart Failure in Adults guideline and Stable Coronary Artery Disease guideline.

Diabetes

Major depression is associated with an increased number of known cardiac risk factors in patients with diabetes and a higher incidence of coronary heart disease; therefore, screening and treatment of depression in this patient group should be emphasized *(Petrak, 2013; Katon, 2004b)*.

Return to Table of Contents

Individuals with diabetes have two to threefold higher odds of depression than those without diabetes *(Jeeva, 2013)*. Additionally, depression earlier in life increases the risk of developing diabetes *(Katon, 2004a)*. Depressive symptom severity is associated with poor self care and medication compliance in addition to higher health care-related costs *(van Dijik, 2013)*. Patient physical and mental quality of life is also decreased *(Petrak, 2013)*.

High levels of symptoms associated with diabetes that do not correlate with physical or laboratory assessments should prompt the physician to assess for depression *(Ludman, 2004)*.

Treatment goals should focus on improvement of glycemic control and improvement or remission of depression via pharmacologic therapy, psychological therapy or combination of both *(Petrak, 2013)*.

For more information, see the ICSI Diagnosis and Management of Type 2 Diabetes Mellitus in Adults guideline.

Chronic Pain

Depression and pain symptoms commonly coexist, exacerbate or attenuate one another, and appear to share biological pathways and neurotransmitters.

Patients with chronic pain are more likely to have coexisting depression. In 2004, data were examined from primary care centers worldwide by the World Health Organization. They found that 22% of all primary care patients suffer from chronic debilitating pain. Further, chronic pain patients were four times more likely to have comorbid depressive disorder than pain-free primary care patients *(Lépine, 2004)*. The findings also showed that the more diffuse the pain complaints, the greater the risk of depression and the bigger impact on the quality of life.

For more information, see the ICSI Assessment and Management of Chronic Pain guideline.

Geriatrics

Depression in the elderly is widespread, often undiagnosed and usually untreated. It is a common misperception that depression is a part of normal aging. Losses, social isolation and chronic medical problems that older patients experience can all contribute to depression.

Rates and presentation

Out of 31 million elderly Americans (65 years and older), nearly 5 million have clinical depression and 1 million have major depression *(Birrer, 2004)*. The rate of depression in adults older than 65 years of age treated in primary care settings ranges from 17 to 37% *(Birrer, 2004)* and is between 14 to 42% in patients who live in long-term care facilities *(Robinson, 2014)*. Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30 to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), Alzheimer's disease (20 to 40%) and dementia (17 to 31%) *(Birrer, 2004)*. The recurrence rate is also extremely high at 40% *(Birrer, 2004)*.

Similar to other groups, the elderly with depression are more likely than younger patients to underreport depressive symptoms. Major depression in the elderly can present with combined clinical symptoms including depressed mood, somatic complaints and sleep disorders *(Chen, 2011)*. This incudes symptoms such as insomnia, headache, dizziness, appetite disturbances, lack of energy, fatigue, chronic pain, constipation and musculoskeletal disorders.

Treatments and outcomes

The outlook for recovery for the elderly is similar to that for the young when appropriately treated. However, treatment usually has to be continued for longer periods than for the young, since it may take longer to reach remission.

Return to Table of Contents

Collaborative care. The IMPACT (Improving Mood: Promoting Access to Collaborative Treatment) study showed improvement in treating the depressed elderly over several measures. Patients were randomized to usual care or collaborative care. The latter involved a team composed of a depression care manager, primary care physician and psychiatrist. The team offered education, behavioral activation, antidepressants, brief behavior-based psychotherapy (problem-solving treatment), and relapse prevention geared to each patient's needs and preferences *(Unützer, 2002)*.

Outcomes from IMPACT included demonstration that collaborative care was more effective than usual care for the elderly, regardless of the elderly patients' ethnicity *(Areán, 2005)*. The intervention group also showed improved physical functioning, less suicidal ideation, improved continuation of antidepressant treatment, fewer depressive symptoms, remission of depression, plus increased quality of life, self-efficacy and satisfaction with care. The intervention lasted for one year. One year later the outcomes for the intervention group were still significantly better than for those who received usual care *(Hunkeler, 2006)*.

Pharmacotherapy and psychotherapy. Pharmacotherapy and psychotherapy are appropriate modalities to treat depression in the elderly *(Birrer, 2004)*. When using pharmacotherapy, the physician must carefully consider how the metabolism of the drug may be affected by physiologic changes in the elderly, their comorbid illnesses and the medications used for them *(Ganzini, 1997; Reynolds, 1992)*. Selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) do not have significant differences in efficacy; however, in the elderly, the better option for treatment may be SSRIs due to potential side effects of TCAs *(Kok, 2012)*. In those individuals who do not respond to the different antidepressants alone, augmentation therapies may be appropriate *(Nierenberg, 1996)*. This would include psychostimulants, such as cytomel or methylphenidate, or the addition of lithium *(Lavretsky, 2015; Cooper, 2011)*. Psychotherapy is also appropriate, limited only by cognitive impairments *(Cuijpers, 2008)*. Cognitive and/or behavioral therapy in particular can have a significant impact on major depression compared with other forms of non-pharmacological interventions such as interpersonal psychotherapy, psychodynamic therapy and physical exercise *(Pinquart, 2007)*.

Behavioral strategies. Behavioral activation strategies such as increasing daily involvement in pleasant activities are safe, simple and beneficial in treating depression in this population *(Cuijpers, 2007)*.

Maintenance therapy. With a recurrence risk of 50, 70 and 90% after the first three episodes respectively, once a patient reaches remission, data supports that continuing with antidepressants is effective regardless of patient age *(Kok, 2011; Birrer, 2004)*. After the first episode of major depression, therapy should be continued for at least one year after remission. The second and third episodes should be treated for at least two and three years after remission *(Birrer, 2004)*. Another study showed that maintenance therapy with an SSRI (paroxetine) for two years was shown to be effective in preventing recurrent depression after a first-time major depression in the elderly over 70 years of age *(Reynolds, 2006)*. See also Annotation #7d, "If Patient is Not Improving on Initial Treatment, Utilize Stepped Care Approach," "Consider Other Strategies," for electroconvulsive treatment.

Dementia/cognitive impairment

Assessment. Patients with more severe cognitive impairments cannot reliably answer the PHQ-9 questions. The 19-item Cornell Scale for Depression in Dementia (CSDD) has the best sensitivity (93%) and specificity (97%). A cutoff of greater than or equal to six identifies depression in a demented population *(Alexopolous, 1988)*. This is a clinician-administered tool to help diagnose depression in patients with dementia. It has been used in a variety of settings ranging from outpatient to assisted living to nursing homes. Its accuracy decreased when it was modified to be used by less-trained staff. Its usefulness for ongoing tracking purposes has not been studied *(Barca, 2010; Watson, 2009)*.

Interplay of risks. There is reasonably good evidence that having a major depressive episode increases the risk of developing Alzheimer's dementia (odds ratio of 2.03 with 95% confidence, with a range of odds ratio of 4.55 with 95% confidence ratio when depression occurred less than one year before diagnosis of

Alzheimer's dementia to odds ratio of 1.71 when depression occurred more than 25 years earlier) *(Ownby, 2006; Green, 2003)*.

Pregnant and Postpartum Women

Recommendation	Quality of Evidence and Strength of Recommendation
Clinicians should screen and monitor depression in pregnant and post-partum women.	Quality of Evidence: Low Strength of Recommendation: Strong
Benefit: Untreated prenatal depression has been associated with negative pregnancy outcomes such as poor maternal self-care, poor nutrition, preterm labor and low birth weight, as well as negative effects on children such as developmental delay and cognitive impairment. There is low to moderate evidence that screening pregnant and post-partum women improves outcomes even in the absence of treatment protocols, care managers and specialty trained providers. The benefit is that by screening patients, one would be finding and treating many more patients with depression. **Harm:** The only harm identified is the cost of screening patients who are not depressed. **Benefit-Harms Assessment:** Although direct evidence of the isolated health benefit of depression screening in primary care is weak, the totality of the evidence supports the benefits of screening in pregnant and post-partum women, particularly in the presence of additional treatment supports such as treatment protocols, care management, and availability of specially trained depression care providers.	
Relevant Resources: *O'Connor, 2016; Yonkers, 2009; Vesga-López, 2008; Gjerdingen, 2007; Gaynes, 2005*	

Prevalence of depression during pregnancy can vary depending on how depression in pregnancy is defined. DSM-5 acknowledges depression during pregnancy (peripartum onset), which is consistent with recent publications that identify perinatal depression beginning at pregnancy onset or the first 12 months after birth. These periods previously referred to as antenatal depression and postpartum depression. A systematic review by Gaynes, 2005 suggests that between 14 and 23% of pregnant women and 10-15% of postpartum women will experience a depressive disorder *(Gaynes, 2005)*. A review by Milgrom, 2014 cites a point prevalence of 13% at three months after delivery and an average of 9% during each trimester of pregnancy *(Milgrom, 2014)*. According to a large-scale epidemiological study by Vesga-López, 2008, depression during the postpartum period may be more common than at other times in a woman's life *(Vesga-López, 2008)*.

With growing understanding of the systemic impact of perinatal stressors, there is a new body of research examining paternal depression. A recent meta-analysis shows a 10-14% incidence of paternal depression during the perinatal period, with a moderate positive correlation with maternal depression *(Paulson, 2010)*.

Untreated prenatal depression has been associated with negative pregnancy outcomes such as low birth weight and preterm labor, as well as negative effects on children such as developmental delay and cognitive impairment *(Milgrom, 2014; Davalos, 2012; Li, 2009)*. A study of pregnancy-associated suicide in women demonstrates pregnant women with mental health problems are at an increased risk of substance abuse and intimate partner problems *(Gold, 2012)*. Studies are demonstrating that untreated paternal depression has an impact on infant and child development similar to untreated maternal depression *(Paulson, 2010)*.

Screening

Two key strategies facilitate early intervention: routine screening and monitoring of known risk factors *(O'Hara, 2014)*. Increased acceptability is found when patients are educated regarding routine screening *(Milgrom, 2014)*. A large scale study by Kaiser Permanente *(Dietz, 2007)* found that of those women identified and treated for depression, more than half had recurring indicators for depression. Key risk factors include:

- Previous history of a mood disorder
- Depression or anxiety during pregnancy
- Poor social support

Return to Table of Contents

- Stressful life events
- Fragmented or poor sleep
- Substance use
- Past or current abuse
- Premorbid or gestational diabetes
- Difficulty breastfeeding in the first two months postpartum

(Watkins, 2011; Coelho, 2011; Lancaster, 2010; Dørheim, 2009; Goyal, 2009; Pearlstein, 2008)

The United States Preventive Services Task Force 2016 recommendations for depression screening recommend that pregnant and postpartum women be screened for depression even in the absence of treatment protocols, care managers and specialty trained providers *(Siu, 2016)*.

Routine use of a self-report screening instrument that has been validated among pregnant women does not supplant clinical diagnosis *(Yonkers, 2009)*. However, it significantly increases the incidence of systematic case finding over spontaneous detection during routine clinical evaluation *(Gjerdingen, 2007)*. Routine maternal screening is highly recommended, followed by a clinical interview of those scoring above threshold *(Yonkers, 2009)*.

Validated tools for screening pregnant and postpartum women. "Edinburgh Postnatal Depression Scale (EPDS)" and Patient Health Questionnaire (PHQ-2 or PHQ-9).

A 1987 validation study by Cox et al. that included 84 mothers showed that EPDS had satisfactory sensitivity and specificity, and was also sensitive to change in the severity of depression over time. The scale can be completed in about 5 minutes and has a simple method of scoring *(Cox, 1987)*.

PHQ-2 or PHQ-9 questionnaire can also be used to screen pregnant and postpartum women for depression. An observational study by Gjerdingen, 2009 that included 506 women to determine the validity of PHQ-2 and PHQ-9 for identifying postpartum depression during well child visits found that the two-question screen was highly sensitive and the PHQ-9 was highly specific for identifying postpartum depression. Both screens can be easily administered in primary care clinics *(Gjerdingen, 2009)*.

A study of 81 pregnant and 104 postpartum patients by Flynn et al. 2010 on comparative performance of EPDS and PHQ-9 in pregnant and postpartum women seeking psychiatric services for depression found few significant differences in the performance of the PHQ-9 and EPDS in detecting clinician-diagnosed MDD in a psychiatry outpatient sample of pregnant and postpartum women *(Flynn, 2011)*.

Treatment

Psychotherapies

Psychotherapeutic treatment recommendations for mild to moderate perinatal depression are interpersonal therapy (IPT) and cognitive behavioral therapy (CBT) *(Cuijpers, 2011a; Cuijpers, 2011b; O'Hara, 2000)*. Successful IPT treatment of antenatal depression has also improved functioning for six months postpartum. Existing literature clearly suggests that IPT and CBT are more efficacious than routine care for postpartum depression *(Cuijpers, 2011a; Cuijpers, 2011b; O'Hara, 2009)*.

Pharmacotherapy

The recommendation for moderate to severe perinatal depression is antidepressant medication in combination with supportive interventions or psychotherapy *(Stewart, 2011)*. Since partial SSRI treatment during pregnancy does not successfully treat the depression, it is not a recommended option *(Wisner, 2009)*. Clinicians

should be cautious in disrupting maintenance antidepressants during pregnancy. In a study of antidepressant discontinuation for pregnant women with a history of recurrent major depression, 68% relapsed, compared with 26% who maintained antidepressant treatment *(Cohen, 2006)*.

Light therapy and integrative medicine

There is promising preliminary evidence for bright light therapy, acupuncture, progressive relaxation, music therapy, reduced sleep deprivation, and exercise *(Pearlstein, 2008)*. Evidence for omega-3 fatty acids is still insufficient; however, they pose little to no risk *(Freeman, 2008)*.

Other

Hormonal treatments such as estrogen or progesterone have not shown clear evidence for efficacy for post-partum depression, and in some cases may worsen symptoms *(Pearlstein, 2008)*.

See the "Implementation Tools and Resources Table" for perinatal decision-making tools and clinical algorithms.

Safety assessment of psychotropic medication during pregnancy and lactation

Treatment of a psychiatric illness during pregnancy involves weighing potential risk of fetal exposure to psychotropic medication against potential adverse effects of an untreated disorder on mother and fetus. In conclusion, there is no zero-risk option. Clinicians must help patients assess these negative effects of depression on mothers and families against the risks and benefits of psychotropic medication and other treatment options *(Mian, 2005)*.

The process of making decisions about the use of any medicine, particularly psychotropics, during pregnancy should be made on a case-by-case basis, weighing the varying amounts of information about the medicine and the patient's underlying disease state.

The available evidence about psychotropic medication in pregnancy is substantial but limited by ethical considerations that preclude prospective controlled trials of pregnant women. Most studies retrospective or reliant on databases that do not allow for accuracy in the determination of fetal exposure or other confounders. We will provide a more global risk assessment across pregnancy, including the perinatal period and lactation. Medications taken during pregnancy are considered teratogenic if they increase the risk of congenital malformations above the baseline risk of 3 to 4%. The most reproductive safety information is available for the tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs) *(Ferreira, 2007; Mian, 2005; Sivojelezova, 2005)*.

Among the available pregnancy data, TCAs and SSRIs have not shown any evidence of increased risk of major congenital malformations, with the possible exception of paroxetine. In 2006 the FDA issued a warning that first-trimester paroxetine was associated with an increased risk of major malformations (4% vs. 3%), particularly cardiac malformations (2% versus 1%). The FDA changed the pregnancy labeling from category C to D, indicating that controlled or observational studies in pregnant women have demonstrated a risk to the fetus. Studies have suggested that first-trimester exposure to paroxetine at doses greater than 25 mg a day are associated with a greater risk of cardiac malformations *(Bérard, 2007; Thormahlen, 2006)*.

Based on these findings, paroxetine should not be considered a first-line choice for initiating an antidepressant in pregnancy. For women who are already on paroxetine and planning pregnancy, the risks of paroxetine should be weighed against the risks of discontinuing it. For some high-risk women, severe depression or anxiety could also adversely affect the pregnancy.

Factors to consider when choosing an antidepressant *(Ray, 2014)*.

- If there is a history of positive response to medication prior to pregnancy it is recommended to continue with the same medication. This includes effective antidepressants with unplanned pregnancies.

Return to Table of Contents

- Data is limited regarding new or improved medications in the peripartum period. Consider starting older medications if there is not a history of prior antidepressant use as more data is available for safety assessment and education.

Impact of antidepressants on neonates

Prenatal exposure to antidepressants has been associated with transient symptoms of possible medication withdrawal or toxicity in neonates *(Austin, 2006)*. These neonatal syndromes have been described with most TCAs, SSRIs and non-SSRIs and can include jitteriness, irritability, breathing difficulties, bowel obstruction and urinary retention. These symptoms are transient and possibly confounded by physiologic effects from maternal depression and anxiety or other medications administered during delivery *(Ferreira, 2007; Austin, 2006; Oberlander, 2006; Sivojelezova, 2005)*.

Potential persistent pulmonary hypertension of the newborn (PPHN)

While studies have evaluated a possible association between SSRI exposure after 20 weeks' gestation and persistent pulmonary hypertension of the newborn (PPHN), in 2011, the U.S. Food and Drug Administration issued a notification that "given the conflicting results from different studies, it is premature to reach any conclusion about a possible link between SSRI use in pregnancy and PPHN." The FDA advisory committee suggested that health care professionals should "weigh the small potential risk of PPHN that may be associated with SSRI use in pregnancy against the substantial risks associated with undertreatment or no treatment of depression during pregnancy." (http://www.fda.gov/Drugs/DrugSafety/ucm283375.htm) *(Kieler, 2011; Austin, 2006; Bérard, 2007; Chambers, 2006)*.

Breastfeeding while taking antidepressants

For women with depression who require antidepressants, breastfeeding and remaining on medication can be highly compatible ways of caring for themselves and their infants. Clinicians can support nursing mothers with depression by helping them weigh the risks and benefits of different treatment options including supportive interventions and medication if indicated *(Davanzo, 2011)*. If choosing to use antidepressant during breastfeeding, the same antidepressant during pregnancy should be maintained because evidence regarding risk with breastfeeding, excludes use of a different antidepressant during pregnancy *(Ray, 2014)*.

Clinicians should advise nursing women on psychotropic medications to monitor infants for behavioral changes such as excessive sedation, jitteriness or inconsolable crying. Infants who develop these symptoms should be evaluated by their clinician for possible drug toxicity.

For infants who are premature or have any medical problems, mothers on psychotropic medication who choose to breastfeed could consider pumping and storing/discarding breast milk until the infant is healthy and can metabolize medication more efficiently.

Consultation with a pediatrician or neonatologist may be warranted.

SSRIs and Autism

A recently published observational study of 145,456 infants suggested the maternal use of SSRIs during the second and third trimester may increase the risk of autism spectrum disorders of their infants. The women using antidepressants were older and were more likely to have had a previous child with autism spectrum disorder. Women who used SSRIs during the first trimester or during the year prior to their pregnancy did not have an increased risk of ASD *(Boukhris, 2016)*. Additional research and evaluation of this risk is needed before definitive correlations can be made.

Return to Table of Contents

ICSI has long had a policy of transparency in declaring potential conflicting and competing interests of all individuals who participate in the development, revision and approval of ICSI guidelines and protocols.

In 2010, the ICSI Conflict of Interest Review Committee was established by the Board of Directors to review all disclosures and make recommendations to the board when steps should be taken to mitigate potential conflicts of interest, including recommendations regarding removal of work group members. This committee has adopted the Institute of Medicine Conflict of Interest standards as outlined in the report, Clinical Practice Guidelines We Can Trust (2011).

Where there are work group members with identified potential conflicts, these are disclosed and discussed at the initial work group meeting. These members are expected to recuse themselves from related discussions or authorship of related recommendations, as directed by the Conflict of Interest committee or requested by the work group.

The complete ICSI Policy regarding Conflicts of Interest is available at http://bit.ly/ICSICOI.

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ICSI facilitates and coordinates the guideline development and revision process. ICSI, member medical groups and sponsoring health plans review and provide feedback, but do not have editorial control over the work group. All recommendations are based on the work group's independent evaluation of the evidence.

Return to Table of Contents

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Disclosure of Potential Conflicts of Interest

Jeffrey Gursky, MD (Work Group Member)
Department Chair of Psychiatry and Psychology, Olmsted Medical Center
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Robert Haight, Pharm D, BCPP (Work Group Member)
Clinical Pharmacy Specialist, Psychiatry, Fairview Health Services
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: Paid expert testimony for the State of Minnesota. On request case, consulting for specific patient cases involving psychiatric medications to be reviewed by various departments.

Jeffrey Hardwig, MD (Work Group Member)
Psychiatrist, Essentia Health
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Todd Hinnenkamp, RN, NC (Work Group Member)
Nurse Clinician, Internal Medicine, Essentia Health
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Daniel Kessler, LP (Work Group Member)
Lead Psychologist, Allina Medical Clinic – Part of Allina Health
National, Regional, Local Committee Affiliations: Minnesota Psychological Association
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Nicki Mack, RN (Work Group Member)
Care Navigator, North Memorial Health Care
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Return to Table of Contents

Mioki Myszkowski, MD (Work Group Member)
Mayo Clinic
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Michael Trangle, MD (Work Group Leader)
Senior Medical Director for Behavioral Health Services, Psychiatry, HealthPartners Medical Group and Regions Hospital
National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
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Return to Table of Contents

External Review and Acknowledgements:
Adult Depression in Primary Care

ICSI seeks review from members and the public during the revision process.

Member Review

All ICSI documents are available for member review at two points in the ICSI revision process. The ICSI Response Report is sent to members at the beginning of a document revision. The goal of this report is to solicit feedback about the guideline, including but not limited to the algorithm, content, recommendations and implementation. Members are also welcome to participate in the public comment period (see below).

The work group would like to thank the following organizations for participating in the Adult Depression in Primary Care pre-revision review:

- *Fairview Health Services*
- *HealthPartners Health Plan*
- *Mayo Clinic*

Public Comment

ICSI makes a draft of the guideline available to the public on the ICSI website. The public is invited to comment in an effort to get feedback prior to its finalization. All comments will be reviewed by the ICSI facilitator and work group members when needed. ICSI work group may or may not make changes to the guideline based on public comment responses.

The work group would like to thank all those who took time to thoughtfully and thoroughly review our draft and submitted comments for the Adult Depression in Primary Care guideline.

Invited Reviews

For some guidelines, ICSI will invite experts in the community to comment on a guideline draft prior to finalization. This is done during the public comment period.

No invited review was done for the depression guideline.

ICSI Patient Advisory Council (PAC)

The ICSI Patient Advisory Council responds to any guideline review requests put forth by ICSI facilitators and work groups. The PAC members may be involved at the beginning, middle, and/or end of the revision process. Patient advisors who serve on the council consistently share their experiences and perspectives in either a comprehensive or partial review of a document.

The ICSI Patient Advisory Council did not review the Adult Depression in Primary Care guideline.

Return to Table of Contents

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Original Work Group Members

David J. Abelson, MD
Work Group Leader
Park Nicollet Clinic

Richard Anderson, MD
Mental Health
HealthPartners

Larry Berger, MD
Mental Health
Park Nicollet Clinic

Nancy Bologna, PhD, MS, LP
Mental Health
Park Nicollet Clinic

Nancy R. Cohen, MD
Mental Health
Group Health, Inc.

Barry Cosens, MD
Mental Health
Park Nicollet Clinic

Susan Czapiewski, MD
Mental Health
Park Nicollet Clinic

Sandy Dahl
Business Health Care Action Group
Honeywell, Inc.

Laura Ellis, RN
Health Education
HealthPartners

Susan E. Erikson, LPN
Internal Medicine
Park Nicollet Clinic

Gary Goldetsky, PsyD
Health Psychology
HealthPartners

Ed Gould, MD
Family Practice
Maple Grove Medical Center

Mary Pat Hanauska, RN
Internal Medicine
Park Nicollet Clinic

Kate Harri
Business Health Care Action Group
Norwest

Lakhbir Kang, MD
Family Practice
HealthPartners

Jeanette Kiefert, MD
Family Practice
North Suburban Family Physicians

Dave Knutson
Measurement Advisor
Park Nicollet Medical Foundation

Eric W. Larson, MD
Mental Health
Mayo Clinic/Park Nicollet Clinic

Steve Lucas, MD
Family Practice
HealthPartners

Mark Mellstrom, MD
Family Practice
Family Physicians of Northfield

Robert Nesse, MD
Family Practice
Mayo Clinic

Teresa Rummans, MD
Mental Health
Mayo Clinic

Catherine Spurr, RN
Facilitator
Park Nicollet Clinic

Kathy Van Guilder
Health Education
Park Nicollet Medical Foundation

David von Weiss, MD
Family Practice
Park Nicollet Clinic

Steve Wetzell
Business Health Care Action Group
BHCAG

Thomas E. Will, PsyD, MPH, LP
Health Psychology
Group Health, Inc.

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This guideline is a primary resource for Minnesota's statewide DIAMOND Depression Initiative. Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) is a primary care-based program modeled after and adapted from Project IMPACT. The DIAMOND model has demonstrated results for redesigning both health care and payment systems.

The next revision will be no later than March 2021.

This document is celebrating its 20th anniversary of the first edition.

Return to Table of Contents

Contact ICSI at:
8009 34th Avenue South, Suite 1200; Bloomington, MN 55425; (952) 814-7060; (952) 858-9675 (fax)
Online at http://www.ICSI.org

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ICSI Document Development and Revision Process

Overview

Since 1993, the Institute for Clinical Systems Improvement (ICSI) has developed more than 60 evidence-based health care documents that support best practices for the prevention, diagnosis, treatment or management of a given symptom, disease or condition for patients.

Audience and Intended Use

The information contained in this ICSI Health Care Guideline is intended primarily for health professionals and other expert audiences.

This ICSI Health Care Guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients and families are urged to consult a health care professional regarding their own situation and any specific medical questions they may have. In addition, they should seek assistance from a health care professional in interpreting this ICSI Health Care Guideline and applying it in their individual case.

This ICSI Health Care Guideline is designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition.

Document Development and Revision Process

The development process is based on a number of long-proven approaches and is continually being revised based on changing community standards. The ICSI staff, in consultation with the work group and a medical librarian, conduct a literature search to identify systematic reviews, randomized clinical trials, meta-analysis, other guidelines, regulatory statements and other pertinent literature. This literature is evaluated based on the GRADE methodology by work group members. When needed, an outside methodologist is consulted.

The work group uses this information to develop or revise clinical flows and algorithms, write recommendations, and identify gaps in the literature. The work group gives consideration to the importance of many issues as they develop the guideline. These considerations include the systems of care in our community and how resources vary, the balance between benefits and harms of interventions, patient and community values, the autonomy of clinicians and patients and more. All decisions made by the work group are done using a consensus process.

ICSI's medical group members and sponsors review each guideline as part of the revision process. They provide comment on the scientific content, recommendations and implementation strategies. This feedback is used by and responded to by the work group as part of their revision work. Final review and approval of the guideline is done by ICSI's Committee on Evidence-Based Practice. This committee is made up of practicing clinicians and nurses, drawn from ICSI member medical groups.

Implementation Recommendations and Measures

These are provided to assist medical groups and others to implement the recommendations in the guidelines. Where possible, implementation strategies are included that have been formally evaluated and tested. Measures are included that may be used for quality improvement as well as for outcome reporting. When available, regulatory or publicly reported measures are included.

Document Revision Cycle

Scientific documents are revised as indicated by changes in clinical practice and literature. ICSI staff monitors major peer-reviewed journals for any pertinent evidence that would affect a particular guideline and recommendation.

Return to Table of Contents

Catholic Medical Center

HCH Manchester

Policy and Procedure Manual

TITLE: Referral Tracking

PURPOSE: To provide standardized workflow for tracking of referrals to specialists and to provide standard guidelines for the status of orders.

Status Order Guidelines:

Admin Hold: This is to be used when a specialist office will call the patient to schedule an appointment (NHGI, DH, NEHI, etc), if the patient will call to schedule their own appointment or when the office is waiting for a call back from the patient. Document all pertinent information on the status of the referral in the "Administrative Comments".

In Process: Appointments scheduled for future dates of service. Always document date and time on order in the "Administrative Comments".

Complete orders only when both of the following have been done:

- It's confirmed that the patient was actually seen by the office by calling them directly and then documenting in the "Administrative Comments" that the patient was seen and when they were seen.
- The consult notes are imported into the EMR and signed off by the ordering provider.

Removed/Cancel orders only when all three of the following have occurred:

- The specialty office confirmed the patient was NOT seen.
- There have been three separate attempts to contact the patient to reschedule.
- The provider has been notified and approves removing the order.

This information is then documented in the "Administrative Comments" on the referral order. Document in the removal popup box that the patient canceled or no showed the specialist appointment and that the provider is aware. Sign the popup by ending the statement with your initials.

Steps to run referral tracking report:

The referral report is run daily and weekly for "Admin Hold" status and monthly for the "In Process" status. Once a quarter, the referral report is run for all "Admin Hold" and "In Process" status referrals for review.

From your desktop in EMR:

1. Select "Reports" located in the menu bar at the top of your desktop.

2. Click on the “Reports” tab.
3. Select the folder titled “HCH”.
4. Select “Referral Report – In Process” or “Referral Report-Admin Hold”.
5. Select “Preview” located at the bottom of the screen.
6. Enter the date range you wish to run the report and select “OK”.
7. A “Preview Print Item” popup box should come up.
8. Select “Format” “Microsoft Excel 97-2000 (XLS)”.
9. Select “Destination” “Application”. This will automatically open “Excel”.
10. Review or print lists for phone call follow up.

APPROVED: _____

[redacted], RN, Director HCH of Manchester

_____

[redacted], MD, Medical Director HCH of Manchester

Prepared By: [redacted], Transitions of Care Coordinator

Referral Tracking Workflow

Provider Creates Referral
Provider:

1. Makes referral
2. Identifies reason for referral and referral source
3. Referral is generated
4. Provider signs visit

Discharge Nurse Attends Referral
Discharge Nurse:

1. Patient has insurance?
    a. No: Leave referral on "Admin Hold". If applicable have patient complete DH application or CMC Free Care Application. Document in "Administrative Comments" that patient has no insurance and if applicable what the status of the application is. ".sign".
    b. Yes: Proceed to next step.
2. Referral can be schedule prior to sending OV notes?
    a. No:
        i. Client has a phone: Fax referral, office notes, chart summary, pertinent diagnostic testing to referral source with a note requesting that referral source call the client directly with an appointment.
            1. Document status in "Administrative Comments". ".sign". Leave on "Admin Hold".
        ii. Client does <u>NOT</u> have a phone: Ask client to return to the clinic in 5 business days. Fax referral, office notes, chart summary, pertinent diagnostic testing to referral source with a note stating patient will call for appointment. Document status in "Administrative Comments". ".sign". Leave on "Admin Hold".
            1. Call referral source and schedule appointment when client returns.
            2. Once scheduled, document appointment date and time in the "Administrative Comments". Change status of referral to "In Process".
    b. YES:
        i. Call referral source and schedule appointment.
        ii. Fax referral, office notes, chart summary, pertinent diagnostic testing to referral source.
        iii. Document appointment date and time in the "Administrative Comments". Change status of referral to "In Process".

Transitions of Care Coordinator Tracks Referral
Transitions of Care Coordinator:

1. Run daily "Admin Hold" Referral Report of the previous date of business.
    a. Review "Administrative Comments"

i. The administrative comments are blank or do not state the information has been faxed to the referral source.
    1. Follow previously listed workflow “Discharge Nurse Attends Referral”.
ii. The administrative comments list that the information has been sent to the referral source but no appointment details are listed.
    1. Leave referral on “Admin Hold” for review on weekly report.
iii. The administrative comments list that the patient does not have insurance.
    1. Leave referral on “Admin Hold” for review on weekly report.

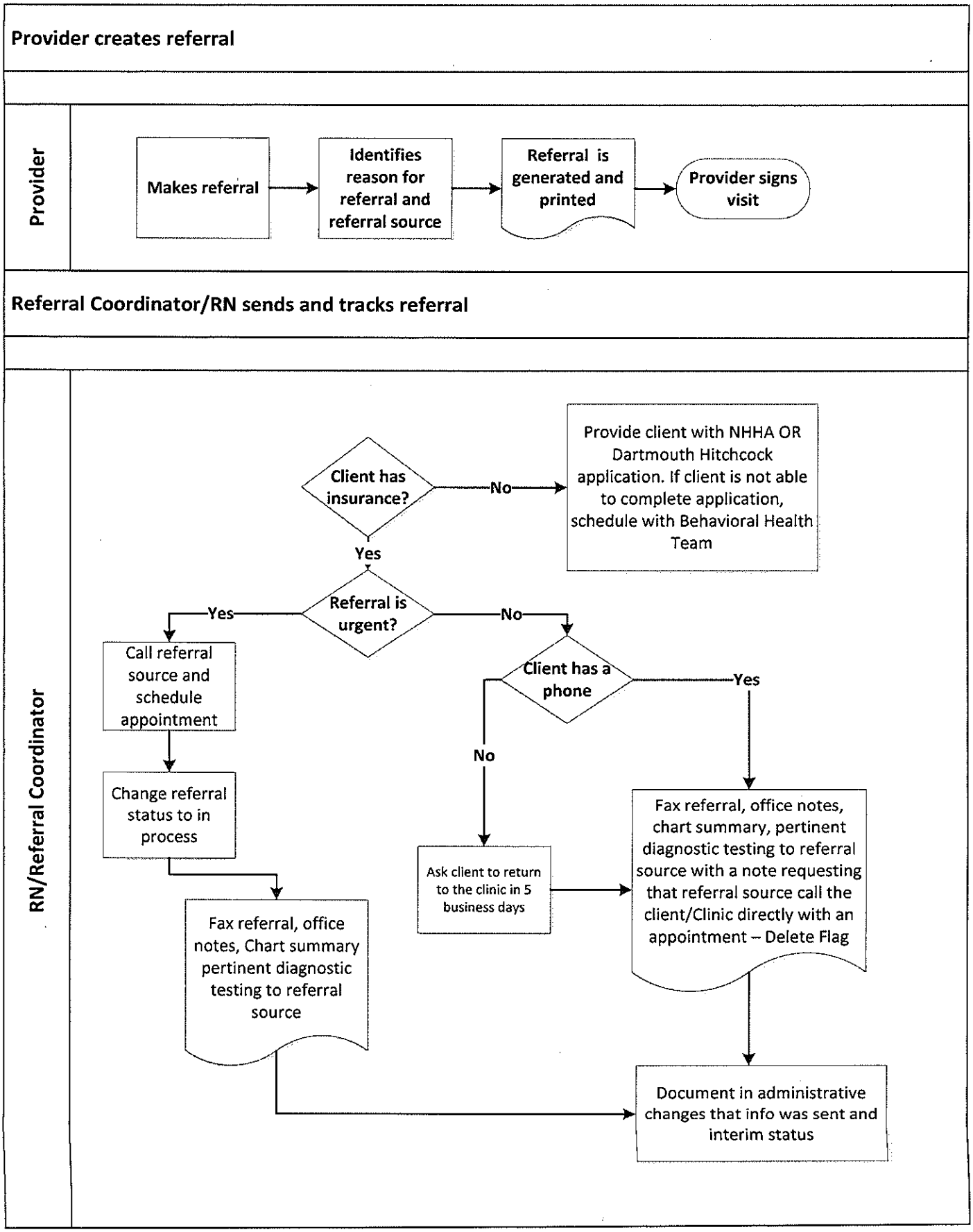
2. Run weekly “Admin Hold” Referral Report of the previous week of business.
    a. Review “Administrative Comments”
        i. The administrative comments are blank or do not state the information has been faxed to the referral source.
            1. Follow previously listed workflow “Discharge Nurse Attends Referral”.
        ii. The administrative comments list that the information has been sent to the referral source but no appointment details are listed.
            1. Call referral source to follow up on appointment status and confirm they have received the listed information.
            2. If appointment has been booked, update “Administrative Comments” with date and time of appointment. “.sign”. Update referral status to “In Process”.
        iii. The administrative comments list that the patient does not have insurance.
            1. Follow up on application or insurance status.
            2. Document status update in “Administrative Comments”. “.sign”
            3. If the patient has an active insurance status, follow the “Discharge Nurse Attends Referral” workflow.
                a. If appointment has been booked, update “Administrative Comments” with date and time of appointment. “.sign”. Update referral status to “In Process”.

3. Run monthly “In Process” Referral Report of the previous month of business.
    a. Review “Administrative Comments”
        i. The date of listed appointment has passed:
            1. Check EMR for consult notes.
                a. Notes are in the chart and signed by Provider.
                    i. Document this in “Administrative Comments” and “Complete” referral.
                b. Notes are NOT in the chart.
                    i. Call referral source to check status.
                        1. Patient cancelled or no showed appointment.
                            a. No appointment rescheduled. Call patient or send letter. Update “Administrative Comments”. Update status back to “Admin Hold”.

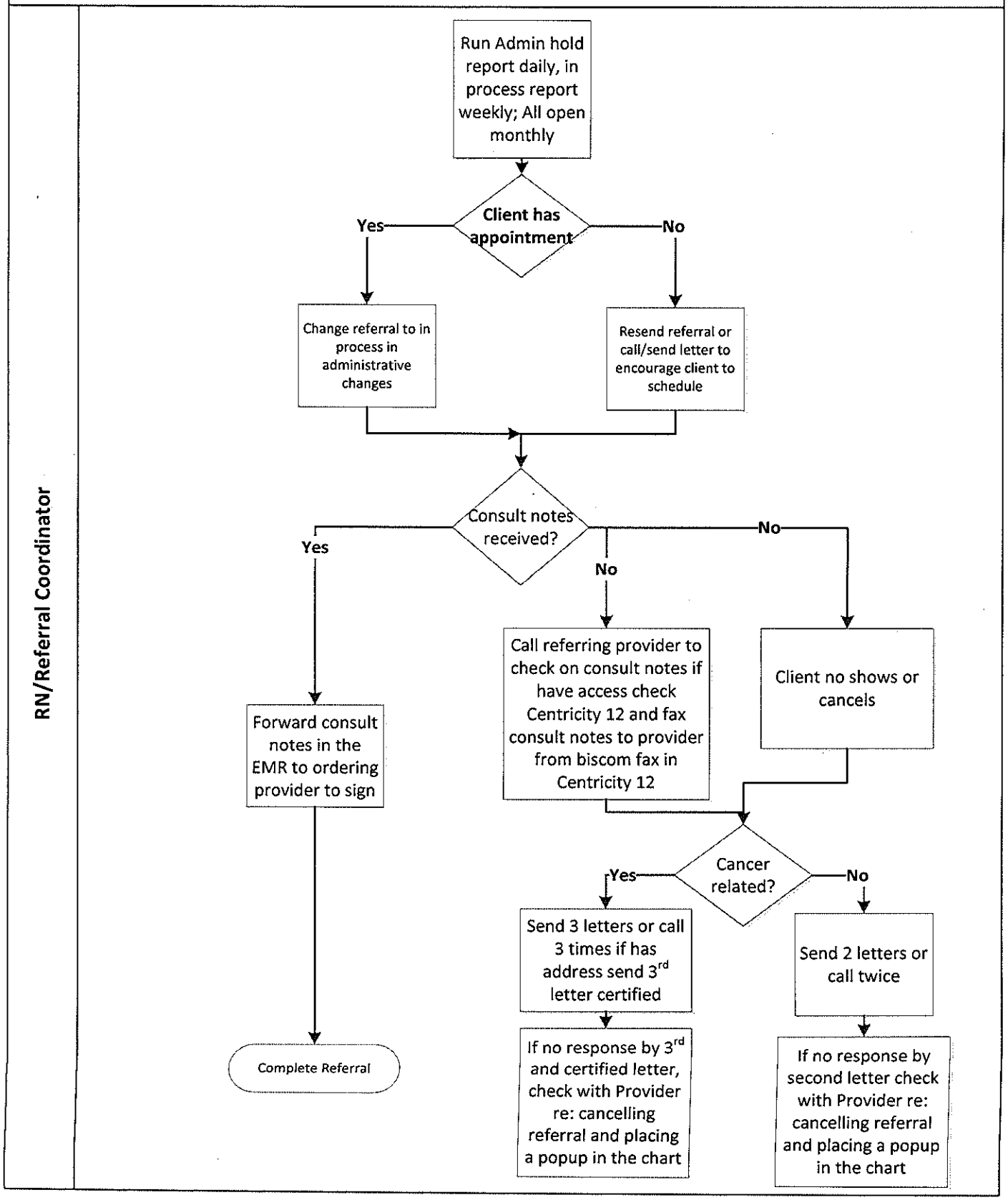
b. Appointment was rescheduled. Update "Administrative Comments" with appointment date and time. ".sign".

4. Run quarterly "Admin Hold" and "In Process" Referral Report.
    a. Review the "Date" of the order.
    b. Past one year: Flag provider. Relay "Administrative Comments" and ask them to advise on next steps.
    c. Within one year: Follow the same review process as the monthly "In Process" and weekly "Admin Hold".

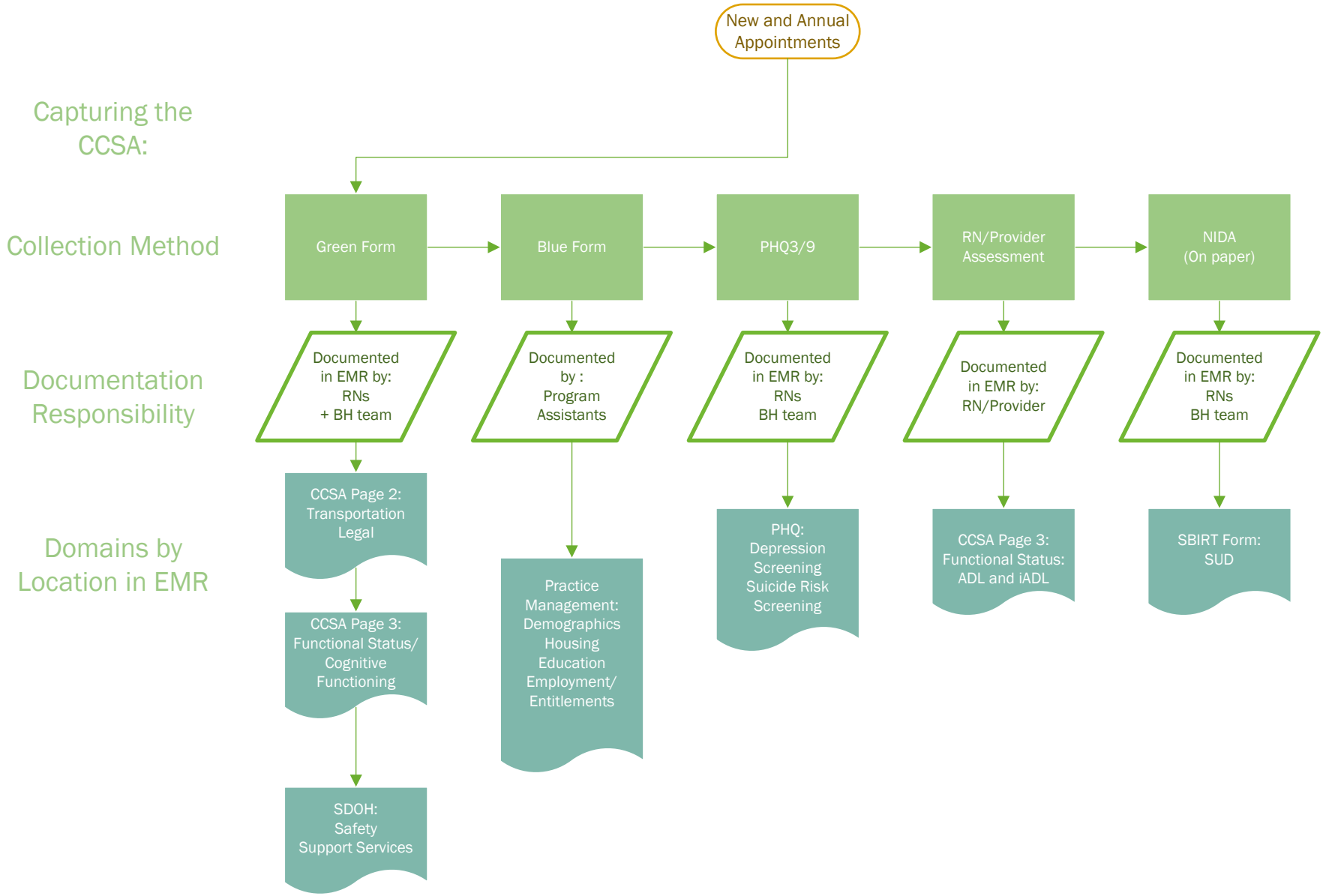
HCH Manchester
Process for Tracking Referrals



RN/Referral Coordinator tracks receipt of consult notes

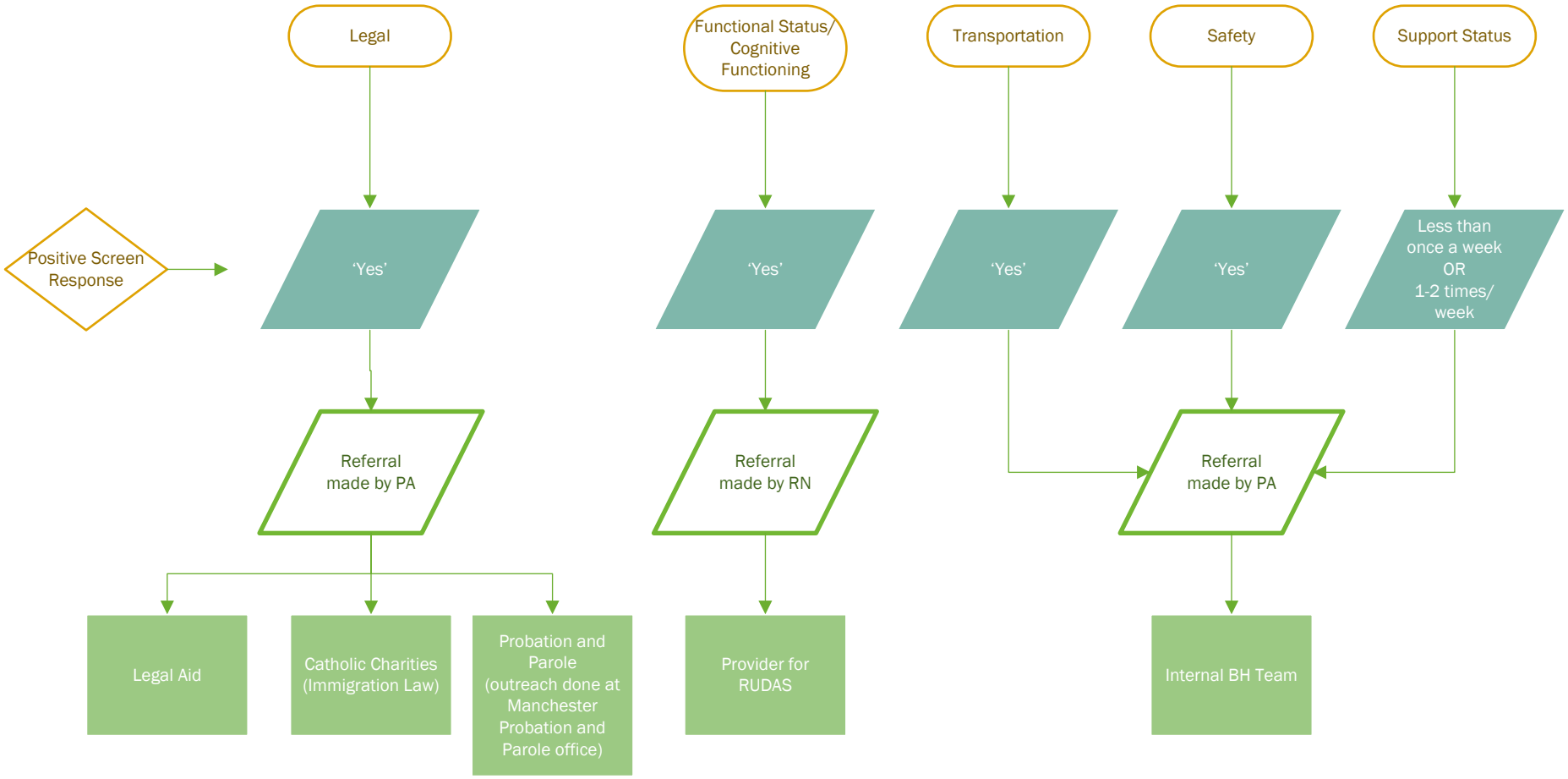


CCSA


New and Annual Appointments
Capturing the CCSA:
Collection Method
Green Form
Blue Form
PHQ3/9
RN/Provider Assessment
NIDA (On paper)
Documentation Responsibility
Documented in EMR by: RNs + BH team
Documented by : Program Assistants
Documented in EMR by: RNs BH team
Documented in EMR by: RN/Provider
Documented in EMR by: RNs BH team
Domains by Location in EMR
CCSA Page 2: Transportation Legal
CCSA Page 3: Functional Status/ Cognitive Functioning
SDOH: Safety Support Services
Practice Management: Demographics Housing Education Employment/ Entitlements
PHQ: Depression Screening Suicide Risk Screening
CCSA Page 3: Functional Status: ADL and iADL
SBIRT Form: SUD

CCSA

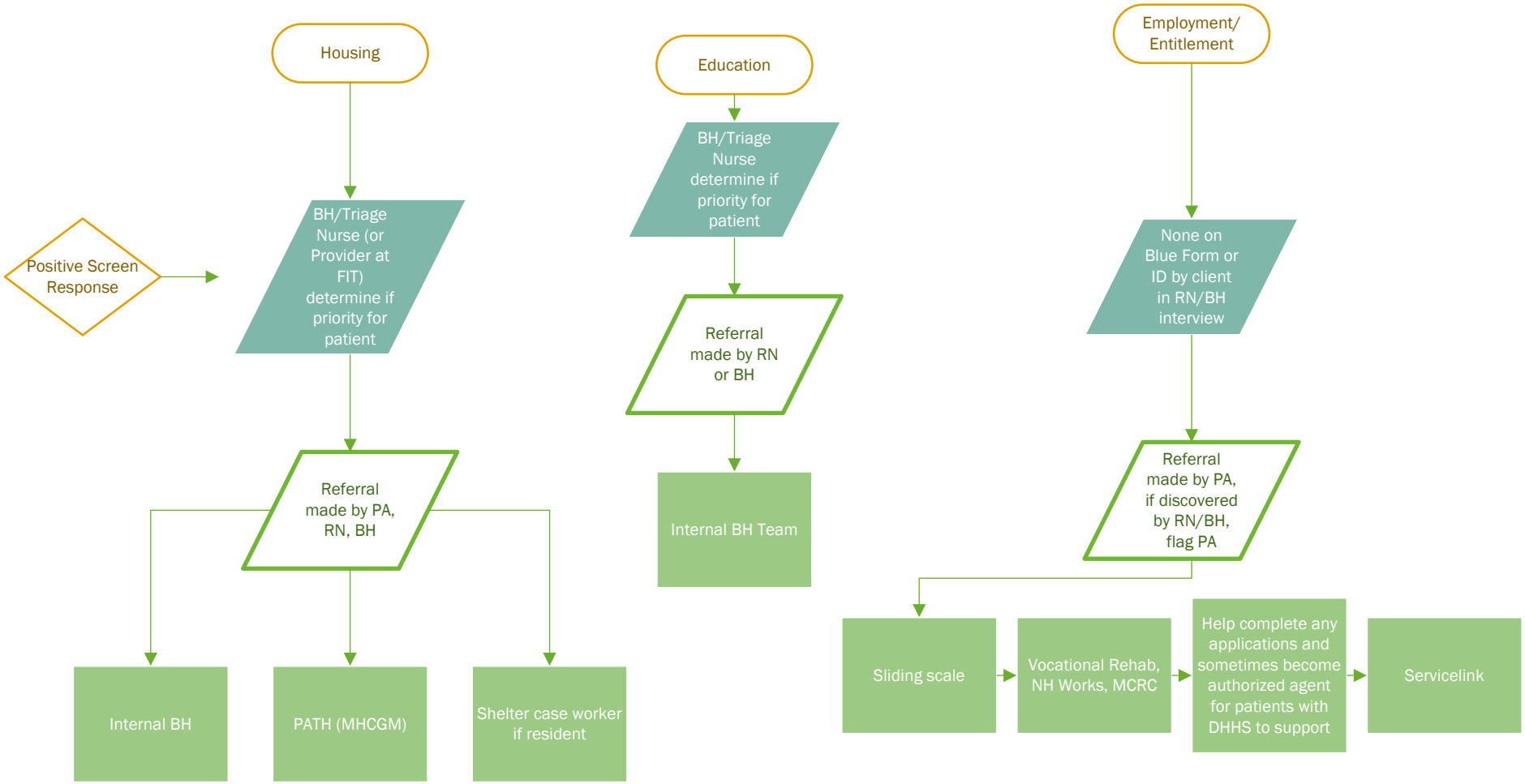
Green Form Positive Screen Workflow



Implementation Date: 12/19/2018 FB Revision Date:

CCSA

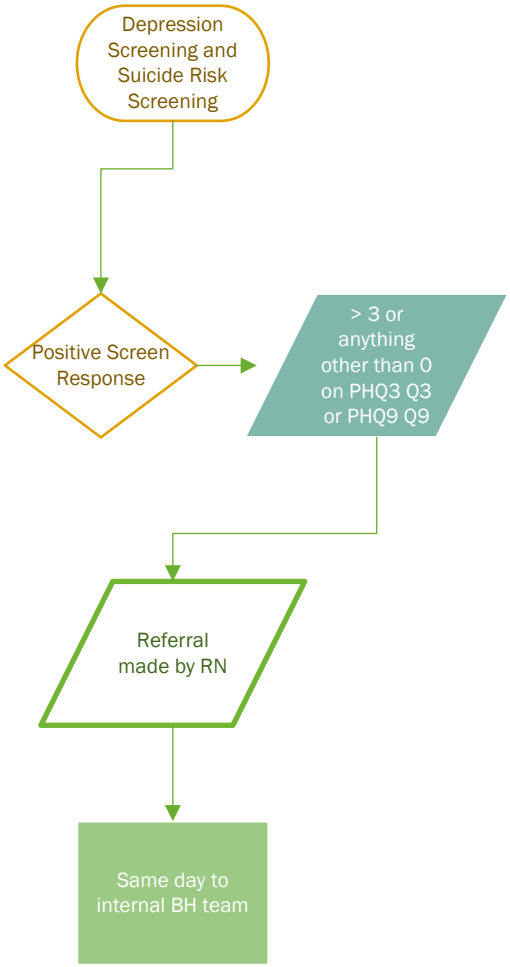
Blue Form Positive Screen Workflow



Implementation Date: 12/19/2018 FB Revision Date:

CCSA

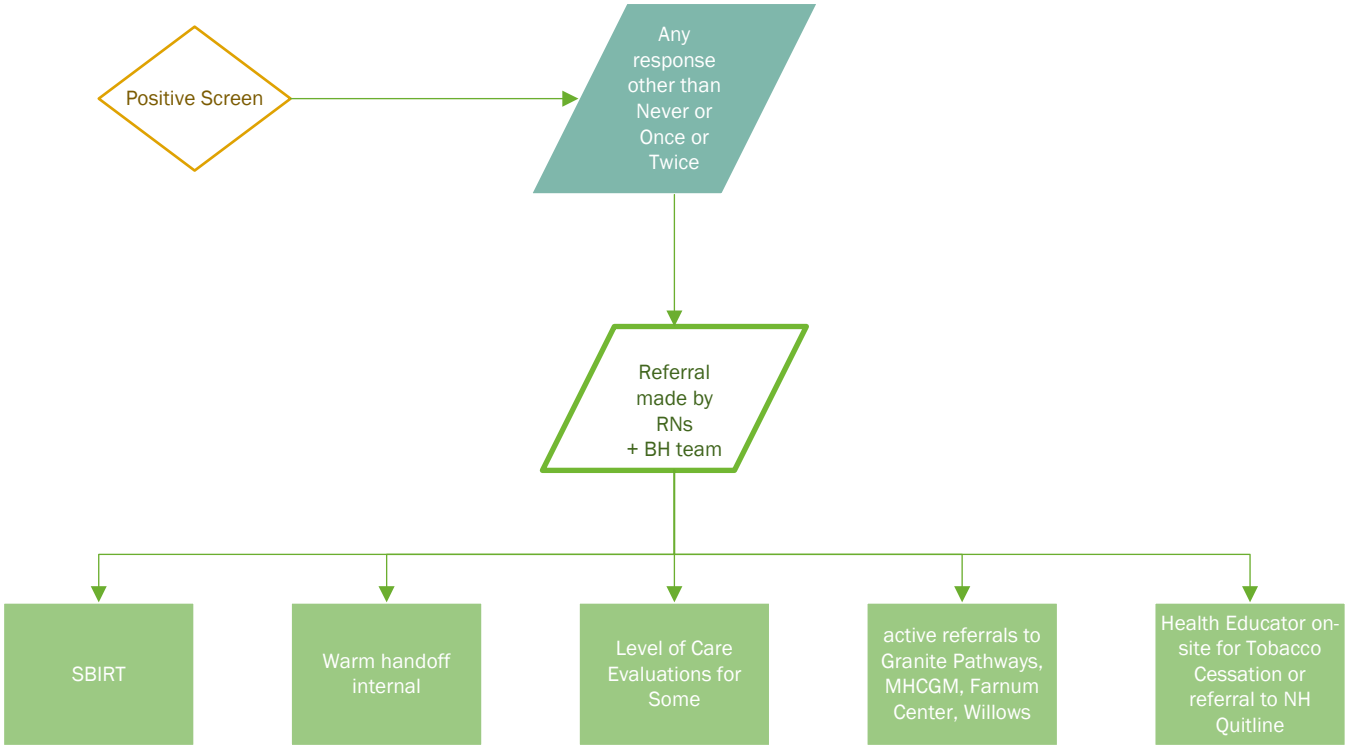
PHQ 3/9 Positive Response Workflow



RN/ Provider Assessment

CCSA

SUD


Positive Screen
Any response other than Never or Once or Twice
Referral made by RNs + BH team
SBIRT
Warm handoff internal
Level of Care Evaluations for Some
active referrals to Granite Pathways, MHCGM, Farnum Center, Willows
Health Educator on-site for Tobacco Cessation or referral to NH Quitline

Title:	**Workflow for the Completion of CCSA (Comprehensive Core Screening Assessments)**
Original Date of Implementation:	07/01/18
Reviewed By Group/Committee:	Dr. [redacted], CMO, [redacted], COO, [redacted], CEO
Review Date(s):	
Revision Date(s):	New
File in the Following Manual:	Patient Care

Objective:
To provide a guideline and procedure for the screening of patients for social determinants of health and other core measures.

Standard:
All CHW's (Community Health Workers) and CM's (Case Managers) who are designated in the workflow to complete CCSA's on patients will utilized the approved questions and the following workflows to assure standardization across the organization.

Approved Questions: Please see below a summary of the core screening questions to be utilized in combination with other age appropriate screens.

1) <u>What are we completing for screens?</u>

Social determinant	**Question**	**Target Age Range**
2) Demographics	Are you Hispanic, Latino/a, or Spanish origin	All Ages
3) Demographics	What is your race?	All Ages
4) Housing & 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?	All Ages
5) Education & Health Literacy	What is the highest level of school you have finished?	All Ages
6) Education & Health Literacy	How confident are you filling out forms by yourself?	All Ages
7) Language Preference	What Language are you most comfortable speaking?	All Ages
8) Employment & Entitlement	What is your current work situation?	12+ up
9) 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?	All Ages (children asked in Family Risk Screen)
10) Housing & Transportation	What is your housing situation today?	All Ages (children asked in Family Risk Screen)
11) Family & Support Services	How often do you see or talk to people that you care about and feel close to?	All Ages (children asked in Family Risk Screen)
12) Family and Social Isolation	How often do you feel isolated from others?	All Ages (children asked in Family Risk Screen)
13) Legal	Have you or do you have any legal issue that are getting in the way of your health or wellbeing?	All Ages (children asked in Family Risk Screen)
14) Substance Use including tobacco and SBIRT	NIDA Screening: (See Sheet 2)	12+ up

Screening		
15) Depression Screening	PHQ-2 (see Sheet 2) (and Edinburgh for Postpartum patients)	12+ up
16) Suicide Risk	PHQ 2 Question 9 Only (see Sheet 2)	12+ up
17) Functional Status (ADL, Cognitive)	Do you need assistance to complete any of the following?	Screening completed as clinically appropriate
18) Functional Status (ADL, Cognitive)	Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?	Screening completed as clinically appropriate
19) Functional Status (ADL, Cognitive)	Have you fallen in the last year?	Screening completed as clinically appropriate
20) Functional Status (ADL, Cognitive)	Do you ever feel unsteady when standing or walking?	Screening completed as clinically appropriate
21) Developmental Screening & MCHAT	SWYC Tool	Age appropriate

2) How are we completing the screens?
   a. All of the screens are now available both on paper and in the EMR. For individuals that may not have a high level of English comprehension or reading/writing skills, it may be more appropriate to verbally ask the questions. For patients who have a high level of skills with English and reading/writing skills, they may be asked to complete them on their own on paper and then the staff member responsible will enter them into the system. In the future, we hope to expand our utilization of tablets to be used in lieu of paper for these patients, which will allow the results to flow directly into the EMR.

3) Who is completing the screens?
   a. Sections 1)- 8) are completed by the Intake and Enrollment staff.
   b. Sections 9)-16) are completed by the CHW or CM.
   c. Sections 17)-20) are completed by the provider seeing the patient
   d. Section 21) is completed by the provider and parts may be completed by the CHW/CM or MA, as deemed appropriate

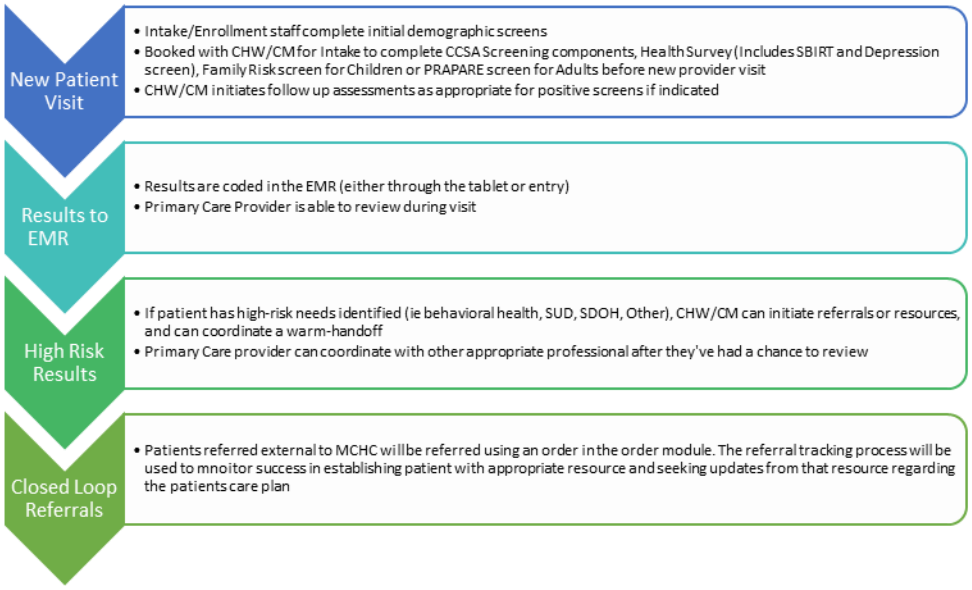
4) When are the screens being completed?
   a. Sections 1)- 8) are completed during the intake/registration process on an annual basis.
   b. Sections 9)-16) are completed during a new patient visit (for new patients) or preferably during a wellness exam or chronic disease visit (for established patients).
   c. Sections 17)-20) are completed during a wellness exam or other visit as deemed clinically appropriate by the provider staff
   d. Section 21) is completed during a well-child exam

5) What happens if a screen is positive?
   a. If a screen is positive, the individual completing the screen may be asked to do a more comprehensive screen (for example, a positive PHQ2 will necessitate a PHQ9, a positive GAD-4 will necessitate a GAD-7, etc)
   b. If the subsequent screen is positive, the patient will be referred internally or externally as appropriate to the necessary resources. Internal referrals may include warm-handoffs to case managers or BHC's (Behavioral Health Consultants), and external referrals may include referrals to residential programs, partial hospitalization programs, the mental health center, or others as appropriate.

6) What are the expectations for referrals (interactions and timeframes)?
   a. Staff will utilize partner organizations (either through Network4Health or existing MOA's and collaboratives) to refer patients to community organizations and specialty providers as appropriate.

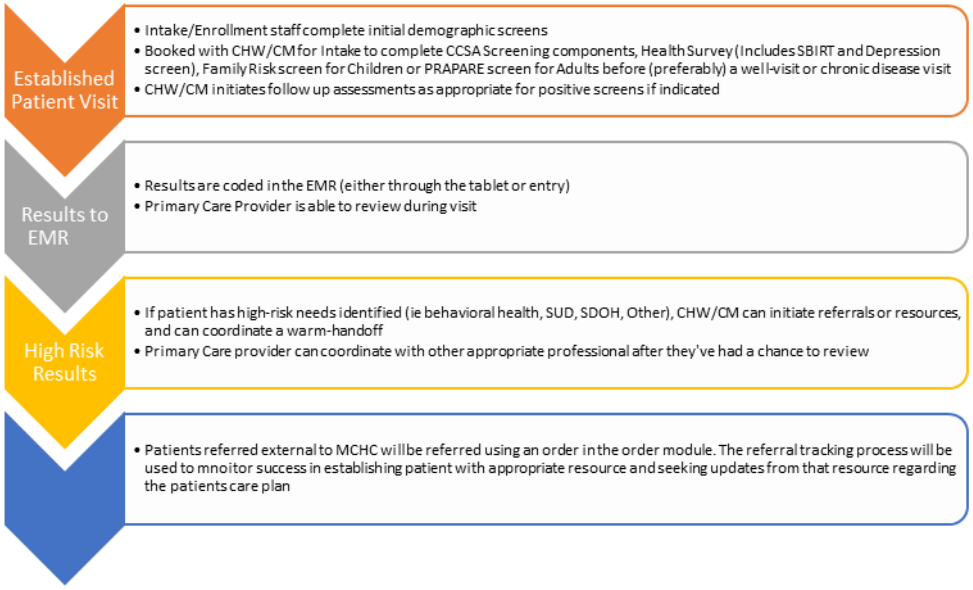
b. Referrals will be made as soon as reasonably possible (within 5 business days for non-urgent issues, and within 1-2 business days for urgent issues. MCHC tracking protocols for referrals will be utilized for communication timeframe expectations.

Please see below a summary of the workflows and the process for closed loop referrals for both new and established patients.



New Patients

Established Patients



Attachment_B1.10

Attachment_B1.10		COORDINATED CARE DESIGNATION											Integrated Care (Additional Requirements)			
		CCSA and PedS Screenings		Depression/Suicide Screening		SBIRT	Care Plan	MDCT	Training				MAT	Depression Treatment	Technology Use	Joint Workflows
Primary Care & Behavioral Health Organizations	**Network/Health Ex Project Cohort**	**Comprehensive Core Standardized Assessment (CCSA), as adc Screenings and as needed assessments/interventions implemented for Medicaid clients/patients across the following domains:** Demographic Information Physical Health Review Substance Use Depression Screening (PHQ-2 & 9) Functional Status (ADL, IADL, cognitive functioning) Suicide Risk Assessment Housing Assessment Family and Support Services Educational Attainment Access to legal services	**CCSA Primary Care Pediatric Practices:** **All children receive standardized, validated developmental screening,** such as the ASQ-3 and/or ASQ:SE, at 9, 18 and 24/30 month pediatric visits AND use Bright Futures or other American Academy of Pediatrics recognized developmental and behavioral screening system.	**PHQ-2**	**PHQ-9**	**Implementation of Screening Brief Intervention and Referral to Treatment (SBIRT) process**	**Use of a Care Plan**	**Practice has implemented a multi-disciplinary care team with the following roles, at minimum:** - PCPs - Behavioral health providers (including a psychiatrist) - Assigned care managers or community health worker	**ALL multi-disciplinary care team Behavioral Health Providers (including psychiatrist) have been trained on:** **-Diabetes hyperglycemia** **-Dyslipidemia** **-Hypertension**	**ALL multi-disciplinary care team Primary Care Providers have been trained in mental health and SUD topics.**	**Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management**	**Multi-disciplinary care team holds monthly (or more frequent) case conferences on behalf of patients with significant behavioral health conditions or chronic conditions**	**Practice offers Mediication Assisted Treatment (MAT) intervention**	**Practice offers Mild to Moderate Depression Treatment intervention utilizing an evidence based model (AIMS, ICSI, etc.)**	**Practice uses technology to identify, at minimum:** • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	**Practice has documented work flows with community based social support service providers including, at minimum:** • Joint service protocols • Communication channels
Catholic Medical Center - Amoskeag Family Practice	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met				
Catholic Medical Center - CMC Behavioral Health	1	Met	N/A - Not Applicable to Practice	Met	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met				
Catholic Medical Center - Willowbend Family Practice	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met				
Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met				
Healthcare for the Homeless	2	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Center for Life Management	2	Met	N/A - Not Applicable to Practice	Met	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met				
Dartmouth-Hitchcock Bedford/Manchester Adult	1	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met	Met	Met	Met				
Dartmouth-Hitchcock Bedford/Manchester Pediatric	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met				
Easterseals NH/ Farnum Center	3	Met	N/A - Not Applicable to Practice	Met	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met				
Elliot Health System - Doctors Park Pediatrics, Manchester	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met				
Elliot Health System - Partial Hospitalization Program	3	Met	N/A - Not Applicable to Practice	Met	Met	N/A - Not Applicable to Practice	Met-Attestation Received	Met	Met	Met	Met	Met				
Families in Transition / Family Willows Treatment Center	2	Met	N/A - Not Applicable to Practice	Met	Met	N/A - Not Applicable to Practice	Met-Attestation Received	Met	Met	Met	Met	Met				
Fusion Health Services	2	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met			
Manchester Community Health Center - Hoffis Street	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Manchester Community Health Center - Terrytown	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Manchester Community Health Center - West Side Neighborhood Health	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Manchester Community Health Center - Child Health Services	1	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Mental Health Center of Greater Manchester	1	Met	N/A - Not Applicable to Practice	Met	Met	N/A - Not Applicable to Practice	Met	Met	Met	Met	Met	Met				
Practice Count	18															

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

Network4Health's Critical Time Intervention (CTI) program is fully implemented. As of December 2018, we are serving 47 clients out of 163 referrals (56 total served during this reporting period). Since our last reporting period we have had 12 participants graduate from the program. Participants are still moving through the phases of CTI in accordance with fidelity standards of the CTI model. All participants have phase plans in place and Transition Coaches continue to complete phase plan reviews at the 90, 180, and 270 day marking period. All participants enrolled in CTI complete the Illness Management & Recovery scale (IMR) upon admission. CTI's 12 graduates have also completed the IMR scale upon exiting the program.

Through CTI, Network4Health continues to provide barrier reduction funds to support participants in obtaining proofs such as: photo ID, birth certificate, social security cards etc. These have been instrumental in ongoing cases with assisting clients applying for benefits as part of their transition plan.

Network4Health and its partners have held several trainings for the CTI project during this reporting period. The Care Transitions Clinical Director, Administrative Assistant and the 5 CTI Coaches all attended trainings, including:

- In August 2018, 2 Coaches attended CALM training on 8/8, the CTI clinical Director completed Train the Trainer event held 8/23 & 8/24, 2 Coaches attended Domestic Violence training 8/17, and 2 Coaches attended Co-Occurring Disorder training on 8/21. All Coaches and CTI Clinical

Director attended the In-Person Community of Practice on 8/22 with the other IDNs, 3 Coaches attended Foundations of Suicide training held on 8/24 and 8/31.

- In September 2018: on 9/7/18 2 Coaches attended Zero Suicide training, 2 others attended the LEAP training on 9/11 and all coaches and the CTI Director attended the in-person Community of Practice on 9/12. Our 2 newest Coaches were able to attend the Stages of Change training held on 9/27/18
- In October 2018, 2 Coaches attended the Dialectical Behavioral Therapy (DBT) skills for non-DBT practitioners training on 10/1 & 10/2, 2 Coaches attended the Over Coming Stigma training on 10/12, 2 also attended Intro to Cross Cultural Effectiveness training on 10/17 as well as Cognitive Behavioral Therapy training on 10/18. All Coaches, the Clinical Director and the Administrative Assistant participated in the Community of Practice Phone call on 10/24 with the other IDNs.
- In November 2018, 1 Coach was able to attend a CTI training on 11/1/18 and 4 coaches attended the Illness Management Recovery training held on 11/7 & 11/8. All 5 Coaches also attended training with the NH Dept. Of Corrections in Concord NH on 11/19. 4 Coaches then attended an in house training around Trial Competency on 11/28.
- In December 2018, 1 CTI Coach completed the first overview for the WRAP Training held in Concord, NH on 12/6 & 12/7. 4 Coaches were able to attend Integrated Treatment of Co-Occurring Disorders training on 12/6. On 12/12 1 Coach completed another Stages of Change training and on 12/20 1 Coach attend an LGBTQ Seminar in Concord, NH.

The 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.*

Network4Health has updated additional performance measures for the number of clients served at any time in the program, referrals received to reflect community engagement, and number of individuals completed to reflect cumulative numbers to date, not just this reporting period. Referrals are reviewed as a team and are assessed by a coach to determine eligibility. During assessment, clients are provided materials detailing CTI program specifics and phases and are given the opportunity to consent or decline. Some clients require multiple visits prior to making a decision about their willingness to participate in the CTI program.

The focus for this reporting period was to finalize reports on targeted performance measures. We have continued to work with the MHCGM's EMR team to finalize reports. At this time, we can accurately report on Performance Measure "average number of days from transition to first outpatient behavioral health visit". We can report on "average number of MH and SUD visits" per phase. Lastly, we continue to work with MHCGM's EMR team to complete a report to accurately reflect the number of community resources individuals are connected to during their participation in CTI. We anticipate this report will be finalized by July 2019.

With regards to Performance Measure "Average number of MH and SUD appointments", this data is preliminary and only reflective of individuals who have completed that phase. We are unable to reflect

data on all individuals currently being served in the program as individuals are at different points within each phase. You will note that each performance measure has been updated to reflect the sum total of individuals that this data reflects.

This reporting period, despite our best efforts to outreach all participants, it was found that the average number or Mental Health and Substance use visits have decreased per phase rather than increase as originally projected. We hypothesize that the decreased visits are due to factors such as:

- Social determinants causing disengagement from CTI and MH/SUD services; homelessness, transportation, and/or relapse.
- Improvement in symptom management, resulting in a decrease need in frequent services

Note: These numbers are reflective of all clients served during this reporting period. This includes clients that have consented and disengaged from CTI services. CTI fidelity requires that any participant consented shall remain open and eligible to the CTI program for the full 9 months, despite level of participation. Due to this, we hypothesize that the number of disengaged clients may be distorting these numbers and does not accurately reflect the number of services by engaged participants in the CTI program.

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 (cumulative)	Up to 333	1	33	60
Number of individuals referred to program (cumulative)	Up to 333	1	66	163
Number of individuals completed program (cumulative)	Up to 333	0	0	12
# of days from transition to first BH outpatient visit (n=60)	Up to 20 days	NA	NA	12.08
Average # of Mental health & substance abuse visits at end of Phase 1 (n=41)	Up to 4	NA	NA	6.41
Average # of Mental health & substance abuse visits at end of Phase 2 (n=27)	Up to 6	NA	NA	6.25
Average # of Mental health & substance abuse visits at end of Phase 3 (n=12)	Up to 8	NA	NA	4.75
Increase average # of community resource contacts from program enrollment to program completion	Up to 5	NA	NA	NA

C-3. IDN Community Project: Workforce Staffing

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

Care Transitions experienced turnover of one CTI Coach during this reporting period and also hired 1 additional coach. We are still actively recruiting for a sixth CTI coach.

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

C-4. IDN Community Project: Budget

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

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

Revenue- All project budgets have been adjusted to reflect the actual receipt of funding. During the reporting period, anticipated funding was not received due to ongoing negotiations between NH DHHS and NH counties. The anticipated, but not yet received, 2018 funding for the Care Transitions budget totals $285,315. These expected funds have been added to revenue in 2019. If expected revenue is reduced as a result of State negotiations, Network4Health will revise budgets and project plan deliverables, subject to Steering Committee and NH DHHS approval.

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

Reported actual expenses continue to be significantly below budget due in part to expense reporting limited to invoiced and paid. Another significant factor has been related to workforce challenges and our ability to achieve full staffing. During the reporting period, one coach left employment and was replaced late in the reporting period. Barrier Reduction funds have not been utilized at rates originally projected. Some of this is due to the ramping up of the coach caseloads. In addition, coaches have worked diligently to utilize other funding resources existing within the community for this purpose.

TRANSFOR MATON FUNDS	CY 2017 (Yr2) Actual	CY 2018 (Yr3) January to June Actual	CY 2018 (Yr3) July to December Actual	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected
C1: Care Transitions	$ 230,012	$ 128,807	$ 46,002	$ 745,239	$ 468,542	$ 238,530

Revenue (New)						
C1: Care Transitions Revenue (Rollover)		$ 218,891	$ 264,562	$ 143,449	$ 205,738	$ (369)
Total Revenue	$ 230,012	$ 347,698	$ 310,564	$ 888,688	$ 674,280	$ 238,161
Salary and benefits- Transitions Coaches (6.0 FTE) and Admin Assistant (1.0 FTE)		$ 70,066	$ 149,498	$ 599,000	$ 590,000	$ 200,000
Technology (Laptops, phones, software)	$ 8,955	$ 7,374	$ 9,266	$ 28,515	$ 28,515	$ 10,000
Barrier Reduction Funds (Client Emergency funds and Interpretati on Services)		$ 281	$ 606	$ 40,000	$ 40,000	$ 20,000
Occupancy	$ 2,166	$ 5,415	$ 7,745	$ 15,435	$ 16,134	$ 8,067
Subtotal	$ 11,121	$ 83,136	$ 167,115	$ 682,950	$ 674,649	$ 238,067
Variation to Budget (Transfer Funds to Subsequent Year)	$ 218,891	$ 264,562	$ 143,449	$ 205,738	$ (369)	$ 94

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

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

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

C-6. IDN Community Project: Standard Assessment Tools

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

There have been no changes to this chart since the last submission.

Standard Assessment Tool Name	Brief Description
Intake Assessment	The Self-Reporting Assessment is provided by the Critical Time Intervention Coach or Director upon consent to participate in the CTI program and will assess, at a minimum, the number of hospitalizations, number of contacts with community organizations, number of emergency room visits, number of homeless days, number of incarcerations and interactions with law enforcement within the previous 12 months. The Intake Assessment is 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 decided to utilize the "Illness Management and Recovery Scale" This instrument is in the public domain, can be self-administered, takes 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. -Clients complete the tool upon entrance to and at exit from the CTI program.
Client Satisfaction Tool	We are utilizing a self-administered participant satisfaction tool when the individual exits the CTI program. 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.

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.

There have been no changes since the last submission.

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

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, NAMI Deputy Director
[redacted]	Team Co-lead, President & CEO for Center for Life Management
[redacted]	Executive Director of Network4Health
[redacted]	Care Transitions Director
[redacted]	Team Member, VP of Operations, Ascentria Care Alliance
[redacted]	Team Member, Easter Seals, Chief Operating Officer
[redacted]	Team Member, VP of Research & training, Families in Transition
[redacted]	Team Member, Hillsborough County Department of Corrections
[redacted]	Team Member, Special Project Director, Life Coping Inc.
[redacted]	Team Member, Crotched Mountain Telehealth & IDN Specialist
[redacted]	Team Member. Program Director, Rockingham Service Link Resource Ctr
[redacted]	Team Member, Executive Director, Building Community in NH
[redacted]	Team Member, Executive Director, NH Legal Assistance
[redacted]	Team Member, RCDOC Director of adult diversion program
[redacted]	Team Member, Director or Quality Improvement & MU
[redacted]	Team Member, Granite State Independent Living

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)

- 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. There were 10 attendees from Netwok4Health.

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 the Network4Health Executive Director, Care Transitions Director, Care Transitions Consultant and the project Director of Integrated Treatment of Co-occurring Disorders (ITCOD). These four individuals are providing oversite and guidance to the CTI Coaches until they are able to attend the next coach training provided by CACTI.

Supervisor Training (Completed - 12/18/17)

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

Implementation Self-Assessment measure was provided as part of this training. Network4Health's CTI Director participated in this this training as well as the Network4Health Executive Director, Care Transitions Consultant and ITCOD Director.

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

- CACTI delivered training on the CTI model which Network4Health's CTI coaches ~~will~~ attended. 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)** (Monthly beginning 12/20/17)
    - CoP meetings began in December 2017 and occur monthly. These meetings of transitions coaches and/or supervisors allow providers to receive technical support during the implementation phase. A locally-based CACTI consultant facilitates these meetings, with the goal of reducing their role as they help local trainers assume primary leadership responsibilities. Meetings 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) (Monthly beginning 1/31/18)**
    - As individuals are enrolled in the CTI program, CACTI continues to provide monthly telephone consultation to case managers and supervisors at individual provider organizations. This ensures program staff are given ample opportunity to receive and offer feedback, and provides assistance in identifying and overcoming challenges specific to their organization. Feedback may be provided on data collected via self-assessment tools that organizations can use to monitor fidelity to the CTI model.

Phase 4 **Train-the-Trainer (Completed on 8/23/18 & 8/24/18)**

A combined CACTI team provided a two 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 completed basic training in the CTI model and have prior training experience. Both the Care Transitions Clinical Director and another Network4Health Director were Train the Trainer trained.

Phase 5 **Coach, Supervisor, Coaching/Implementation Support and Fidelity Training**

Network4Health is currently planning for continued training in conjunction with the four other NH Integrated Delivery Networks offering Critical Time Intervention. Negotiations are ongoing with CACTI to provide an additional supervisor training, continued Coaching/Implementation Support and Fidelity Training. Coach Training is planned and will be provided by NH trainers approved by CACTI.

Project Scoring: IDN Community Project Process Milestones

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

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

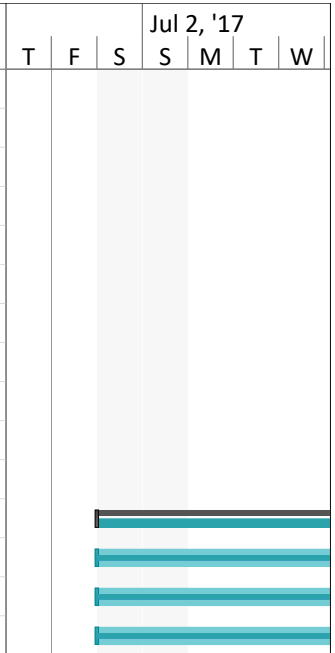
Attachment_C1.1

ID		Task Mode	Task Name	Duration	Start	Finish
1			**Care Transitions**	**916 days**	**Sat 7/1/17**	**Thu 12/31/20**
2			**Recruitment**	**916 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 12/31/1**	**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

Project: CAre TransitionsPP
Date: Mon 1/28/19

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

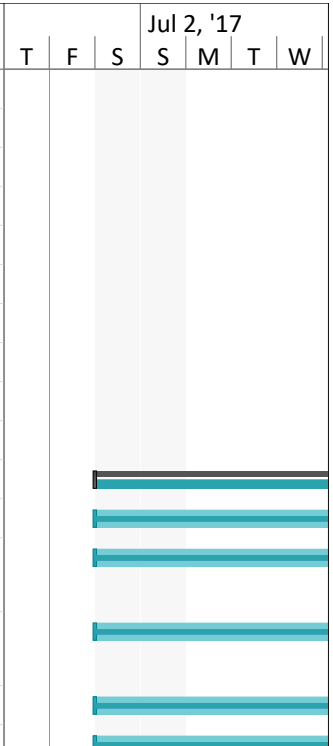
ID		Task Mode	Task Name	Duration	Start	Finish
24			Confirm need to recruit for open positions	132 days	Mon 7/1/19	Tue 12/31/19
25			Recruit for open positions as needed	132 days	Mon 7/1/19	Tue 12/31/19
26			**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
27			Evaluate open 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**	**916 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



Project: CAre TransitionsPP
Date: Mon 1/28/19

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

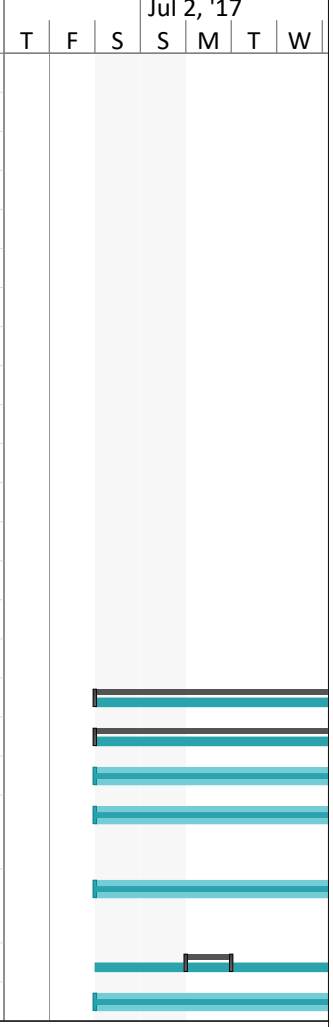
ID		Task Mode	Task Name	Duration	Start	Finish
48			**Milestone reporting period**	**0 days**	**Mon 12/31/1**	**Mon 12/31/18**
49			Multi regional Community of Practice meetings monthly	130 days	Tue 1/1/19	Sun 6/30/19
50			N4H Coaching from CACTI monthly via phone	130 days	Tue 1/1/19	Sun 6/30/19
51			**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**
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**	**916 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	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



Project: CAre TransitionsPP
Date: Mon 1/28/19

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

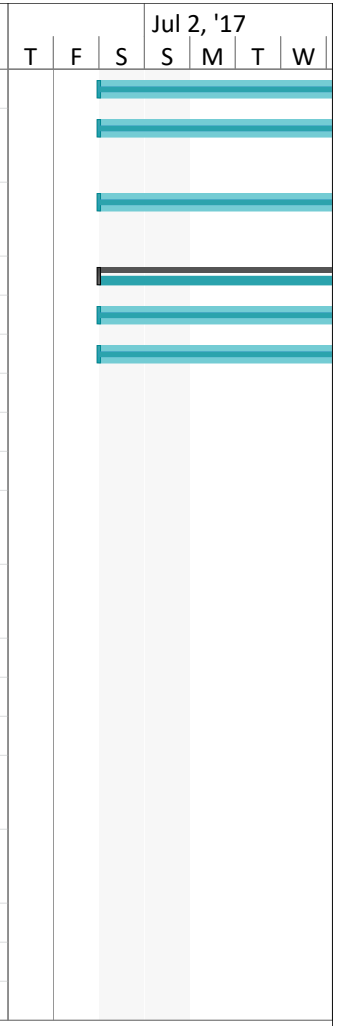
ID		Task Mode	Task Name	Duration	Start	Finish
71	✓		Perform data collection for reporting period	132 days	Sun 7/1/18	Mon 12/31/18
72			**Milestone reporting period**	**0 days**	**Mon 12/31/1**	**Mon 12/31/18**
73			Accept client referrals from N4H partners	130 days	Tue 1/1/19	Sun 6/30/19
74			Perform 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**
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**	**916 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



Project: CAre TransitionsPP
Date: Mon 1/28/19

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

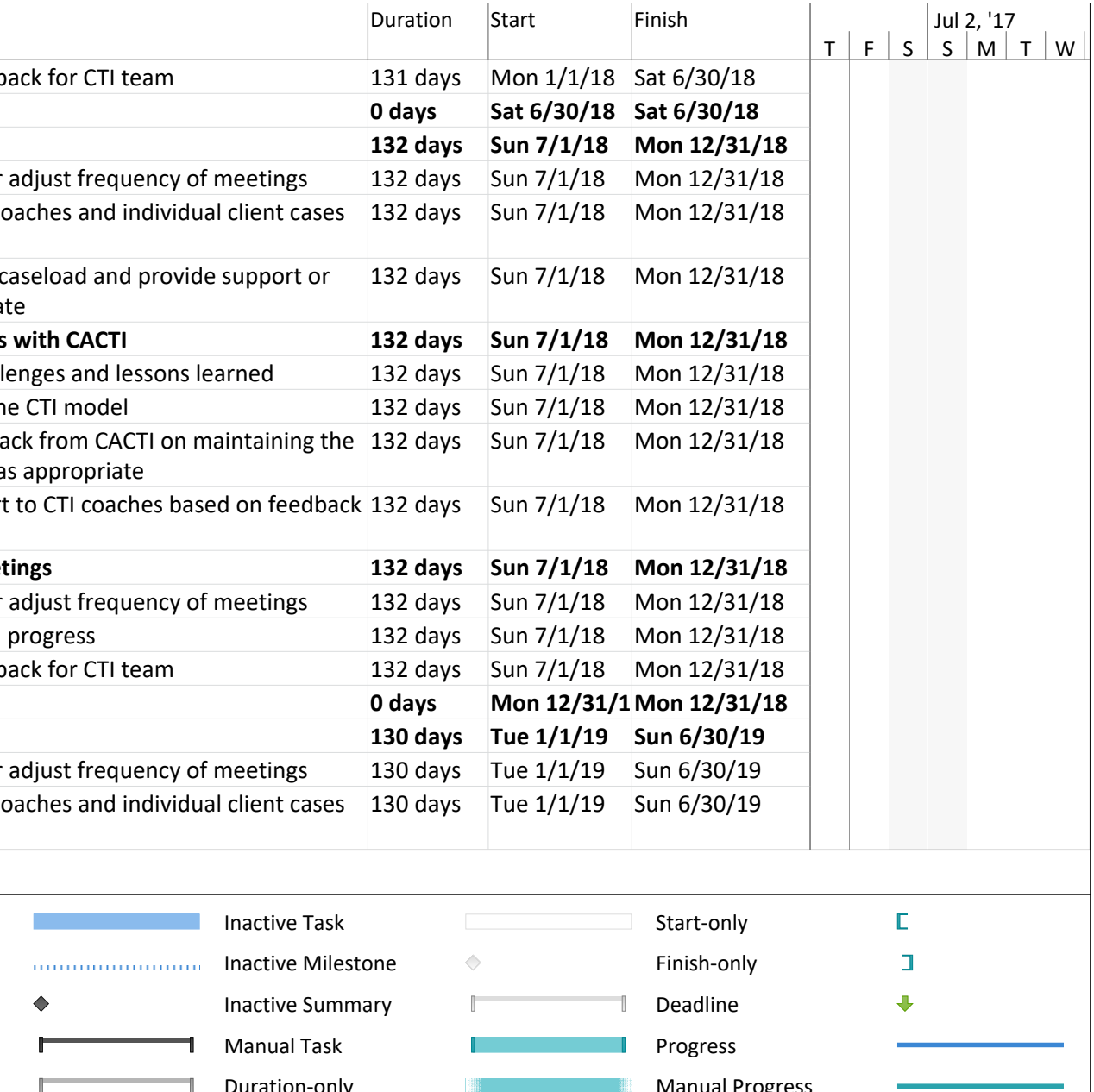
ID		Task Mode	Task Name	Duration	Start	Finish
94	✓		Evaluate the fidelity of the CTI model	132 days	Sat 7/1/17	Sun 12/31/17
95	✓		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
96	✓		Provide coaching support to CTI coaches 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**
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



Project: CAre TransitionsPP
Date: Mon 1/28/19

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

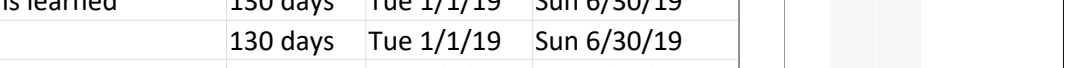
ID		Task Mode	Task Name	Duration	Start	Finish
113	✓		Provide directional feedback for CTI team	131 days	Mon 1/1/18	Sat 6/30/18
114			**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
115	✓		**CTI team meetings**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**
116	✓		Evaluate need 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
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 12/31/1**	**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



Project: CAre TransitionsPP
Date: Mon 1/28/19

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

ID		Task Mode	Task Name	Duration	Start	Finish
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
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



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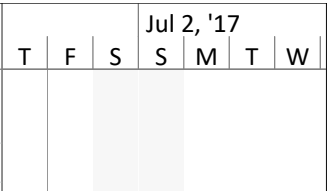
Task		Inactive Task		Start-only	
Split		Inactive Milestone		Finish-only	
Milestone		Inactive Summary		Deadline	
Summary		Manual Task		Progress	
Project Summary		Duration-only		Manual Progress	
External Tasks		Manual Summary Rollup			
External Milestone		Manual Summary			

ID		Task Mode	Task Name	Duration	Start	Finish
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**
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**



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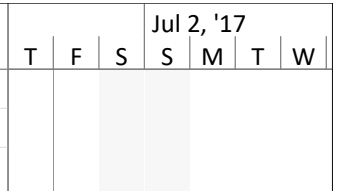
Task		Inactive Task		Start-only	
Split		Inactive Milestone		Finish-only	
Milestone		Inactive Summary		Deadline	
Summary		Manual Task		Progress	
Project Summary		Duration-only		Manual Progress	
External Tasks		Manual Summary Rollup			
External Milestone		Manual Summary			

ID		Task Mode	Task Name	Duration	Start	Finish
171			**CTI team meetings**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**
172			Evaluate need and set or adjust frequency of meetin	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
178			Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as	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 meetin	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 12/31/2(**	**Thu 12/31/20**



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Task		Inactive Task		Start-only	
Split		Inactive Milestone		Finish-only	
Milestone		Inactive Summary		Deadline	
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Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

The Elliot Hospital Partial Hospitalization Program (PHP) developed by the Network4Health project team to serve the community with co-occurring diagnosis successfully opened on October 1, 2018. Between July through September, the project team executed on several key activities to ensure the timely opening of the PHP. A detailed project plan is available in Attachment D3.1. The high-level activities included the following:

1. **EHR build, test and training:** Due to a major, system-wide EHR refuel project at Elliot Hospital, we were aware that the Elliot's IT resources would not be available. To address this significant issue, an outside consulting agency was hired to perform the department build, testing and training. The team began on July 9th, finished the build and testing on September 28th , and provided troubleshooting and training through October 19th. This build included addressing HIPAA Part 2 regulations.
2. **Space and Equipment:** Although the space was confirmed in June, multiple activities had to come together in order for the space to be ready for the PHP. The space was occupied by another department and several other system-wide moves (due to another major initiative) had to take place before the space could be vacated. On September 10th, the space was vacated. On September 14th the renovations, IT infrastructure and security were completed. On

September 17th all furniture and equipment were delivered and set up and on the 18th all computers, printers and other hardware were installed. The PHP staff moved into their space on September 19th.

3. **Billing and Contracting:** Documentation and staff requirements were finalized during this time. The Medicaid application was approved with an effective date of March 1, 2018. As clinicians were on-boarded, provider enrollment began.
4. **Compliance:** After a complete risk analysis, the Elliot's compliance department worked closely with the IT consultants to make sure the appropriate level of security was built into the system. All paper documents (consents, fax covers, etc.) were reviewed and updated to be in compliance with HIPAA Part 2.
5. **Human Resources:** During the last two quarters of 2018, 8.6 FTE's were hired to support the program. Due to the behavioral health staffing issue across the state, we were unable to on-board a LICSW by October 1. In December, unfortunately we lost our MLADC, however, by mid-December a new MLADC and LICSW were on-boarded at which point the program was fully staffed with a cohesive team.

From October through December, we had nearly 50 referrals to the program. The great majority of those referrals have been from Elliot's Drug Court Program and self-referrals – individuals who have heard about the program from other clients and marketing. We continue to meet with many community collaboratives and other agencies in the community in order to increase our referral base. There have been some concerns about the current hours offered for group sessions (8:30am-1pm), but it was determined that as the demand increases, we will add an early evening component tentatively 4pm-8pm, Monday through Friday.

In our last semi-annual report, we discussed the topic of changing the culture around substance use disorders at the Elliot. Laying the groundwork for the PHP and other substance use disorder (SUD) programs over the last twelve months created quite a buzz around the health system. Through an additional grant from the Foundation for Healthy Communities, the Elliot's emergency department (ED) began exploring ways to better identify, evaluate and provide a smooth transition to SUD treatment for all patients (age 12 and up) presenting to the ED. After significant planning and education efforts, we are planning to go live with our implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT), including SUD evaluation by a Master Level Alcohol and Drug Counselor (MLADC) on January 23, 2019. Through this planning process we tackled the subject of stigma, the challenges of treating those with a SUD and addiction as a chronic disease. Over one hundred providers, clinical and administrative staff attended education and training sessions led by our Director to have open and honest communication about the disease of addiction the various SUD programs that we now (or will be) offering. In March 2019, our Director will be leading additional education and training sessions for several of our primary care offices. In addition to promoting the PHP and other programs, this type of education has and will continue to give people accurate information about the disease of addiction and, at a bare minimum, get people talking about substance use disorders; a significant step towards decreasing the stigma surrounding this disease.

Since Elliot Hospital took over the Hillsborough County North Drug Court program last March, there have been 55-70 participants at any given time. The Elliot Hospital Intensive Outpatient Program (IOP), designed to treat the participants of Drug Court who meet this level of care, averages 8-10 participants at a time. The IOP provides, among other group therapies, relapse prevention, anger management and

moral reconation therapy. Since inception, we have proudly witnessed 12 clients graduate from the Drug Court program.

Over the past six months, Elliot Hospital has made great strides in their development of a comprehensive Medication Assisted Treatment (MAT) program with supplemental funds from an additional grant through the Foundation for Healthy Communities. A core MAT team was established consisting of three waivered primary care providers, a MAT Nurse Care Coordinator and Master Licensed Alcohol and Drug Counselor (MLADC) whom are integrated into two primary care practices. We are now able to provide a chronic disease model of care to our primary care patients who present with a substance use disorder appropriate for MAT services. Evaluation, stabilization, connection to treatment and services and monitoring are the key components of our MAT program.

Partial Hospitalization Program Statistics

By looking at PHP program data and patient demographics, we can ascertain information about the population that we are serving to inform business decisions and how we may want to tailor the program to best support our clients' needs. To date, the following information is what were able to capture during the first three months of the program. Reporting enhancement initiatives taking place this year will make reporting more automated and should offer further insight to our program and population served.

Program Data

Since the opening of the PHP through December, we have received 46 referrals. The majority of the referrals are coming from Elliot's Drug Court Program (40%) followed by self-referrals (24%). See figure 1.1 below to understand referral patterns. The Drug Court works closely with the PHP in terms of treatment and case management. In the future, to get a better picture of referral tracking, we will work towards further understanding of the self-referred population by asking more pointed questions like "how did you hear about us"?

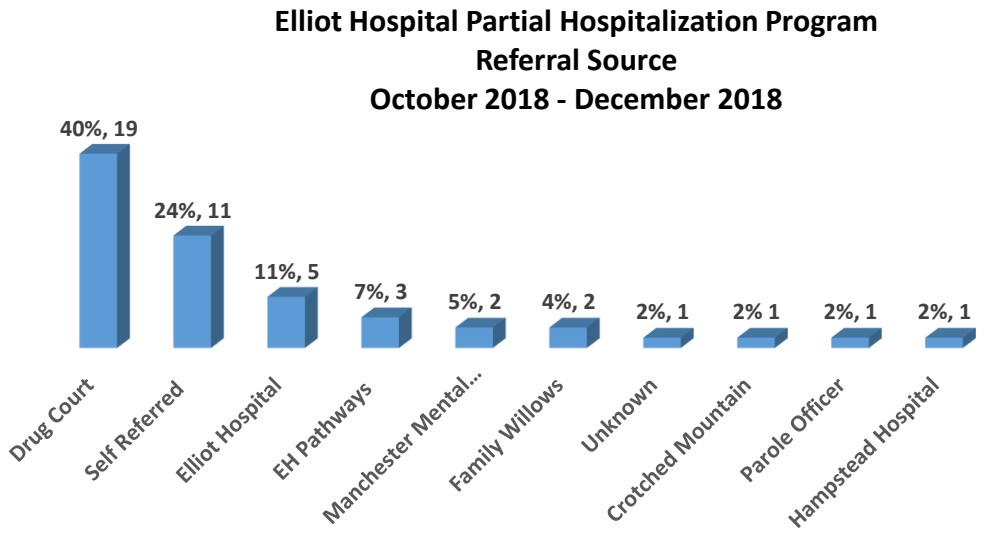


Figure 1.1

The Director of the program has made significant efforts to get the word out to the community about the program. She has attended community Safe Stations meetings, the Governor's Task Force on Opioid Use, the BHI Learning Collaborative, the Manchester Substance Abuse Collaborative, the Network4Health All Partners Meeting, the state MAT Community of Practice in addition to meeting with staff from a variety of community agencies such as Farnum and Families in Transition. With the recent announcement of the hub at Granite State Pathways, we anticipate that we will see a marked increase in referrals coming from this source.

Of the 46 referrals, 39 were evaluated for the program. Seven clients did not make it to their scheduled evaluation. Our staff attempts to contact each client or potential client who misses an appointment for follow-up connections or referrals. Eighty-five percent (33) of those evaluated were found to be appropriate for PHP level of care. Ninety-four percent (31) actually entered the program (2 were no-shows) and 6 clients (19%) successfully completed the program. Twenty patients were discharged from the program prior to completion for a variety of reasons, however, attendance issues were the primary reason (42%). Figure 1.2 below shows the reasons for discharge. Although we had a high rate of discharges, the average length of stay in the program was three weeks.

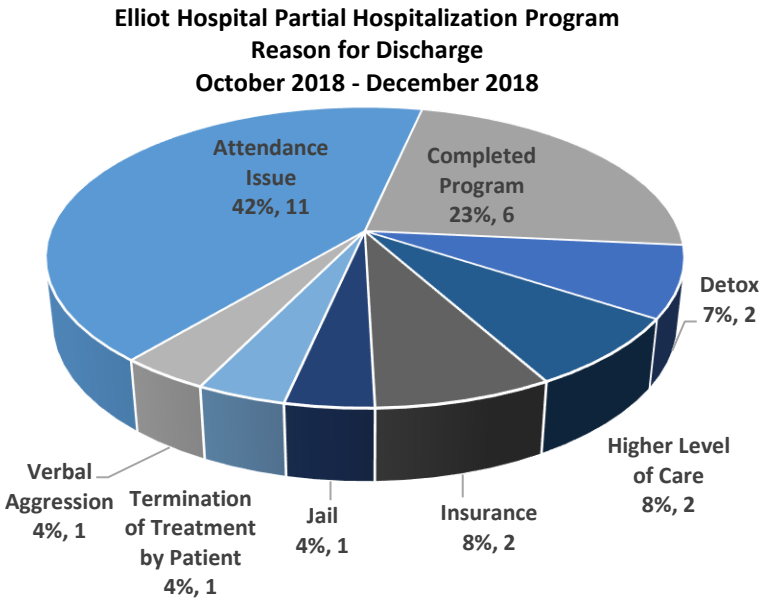


Figure 1.2

Patient Demographics

As expected, the majority of the patients that entered the PHP program came from Hillsborough County (91%), with the majority coming from the city of Manchester (79%). However, we did have two patients from Rockingham County and one from Grafton County who joined our program. Please see Figure 1.3 below to see the client origin mix by city.

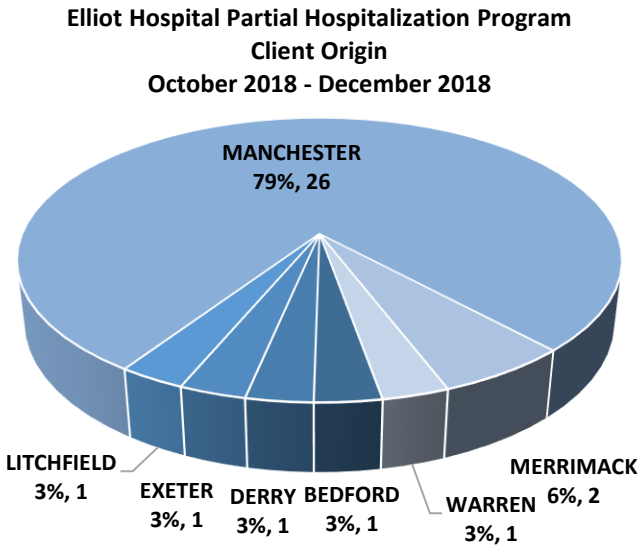


Figure 1.3

As shows in Figure 1.4 below, the age distribution of our clients revealed that the majority of clients fell into the age range of 30-39 years old.

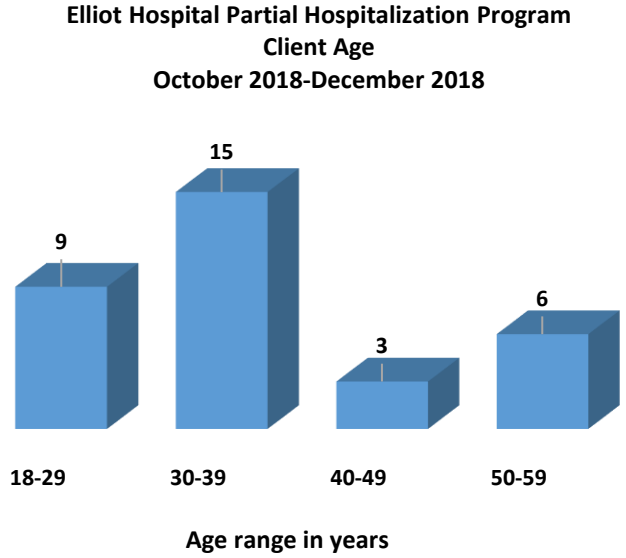


Figure 1.4

As shown in Figure 1.5, over half of the participants in the PHP had Medicaid, a Medicaid MCO or were self-pay.

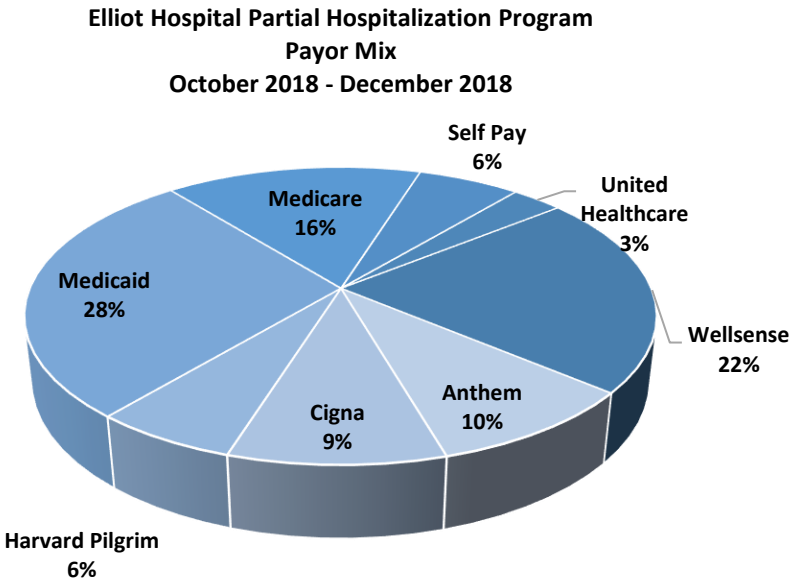


Figure 1.5

Lastly, 67% (22) of PHP participants were male.

An updated project plan is included as Attachment_D3.1.)

D-2. IDN Community Project: Evaluation Project Targets

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

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

The chart below provides details on our progress towards the performance measures we identified. Our admissions volume of 31 was well over our target of 19. Although program completions were lower than expected, based on the data presented above (Figure 1.2), we can attribute a portion of this to attendance issues which may stem from inadequate transportation and/or the patient's readiness for change. A deeper dive into the data and identification of trends as the program continues will provide insight into helping our clients successfully complete the program. It is Elliot's normal procedure to do a 100% billing and coding audit on all new departments, PHP included. At this point, 100% of October and November encounters have been audited with no critical issues reported. December encounters are currently in the auditing process, again, with no critical issues reported.

Eighty-eight percent of clients who were discharged from the program were referred to aftercare services. In cases where the patient stopped attending PHP and the case manager was unable to make contact again, the opportunity to connect the patient to aftercare services was lost.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of admissions	Up to 19 by 12/31/18	0	0	31

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of program completions	Up to 80% by 12/31/18	0	0	19%
# of chart reviews per quarter	Up to 50% by 12/31/18	0	0	50% documentation review & 100% billing and coding review
# of patients successfully referred to aftercare programs in the community	Up to 80% by 12/31/18	0	0	88%

D-3. IDN Community Project: Workforce Staffing

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

The chart below shows that we have met all staffing requirements in our project plan. Plans to hire an outreach worker were slated for year two after opening the PHP. We have postponed the hiring of an Outreach staff until we are able to stabilize the program. It is likely that we will pursue this position in the next quarter.

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

D-4. IDN Community Project: Budget

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

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

Revenue- All project budgets have been adjusted to reflect the actual receipt of funding. During the reporting period, anticipated funding was not received due to ongoing negotiations between NH DHHS and NH counties. The anticipated, but not yet received, 2018 waiver funding for the Expansion of Substance Use Disorder Treatment Options budget totals $285,315. These expected funds have been added to revenue in 2019. If expected revenue is reduced as a result of State negotiations, Network4Health will revise budgets and project plan deliverables, subject to Steering Committee and NH DHHS approval. Generated patient, revenue anticipated for the period, has not been recorded and will be included in future budget updates.

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

Reported actual expenses continue to be below budget due in part to expense reporting limited to invoiced and paid. Another significant factor has been the delay in finalizing the services agreement and other legal documentation needed for funds disbursements. The program opened on October 1, 2018.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 Jan-Jun	ACTUAL 2018 Jul-Dec	PROJECTED CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
Expected Patient Volume with Ramp Up			19	137	137	69
D3 Revenue (New)	$230,012	$128,807	$46,002	$745,239	$468,542	$238,530
D3 Revenue (Rollover)		$230,012	$358,819	$404,821	($76,752)	$8,922
Generated Revenue from Billing				$933,904	$820,013	$413,603
Total Revenue	**$230,012**	**$358,819**	**$404,821**	**$2,083,964**	**$1,211,803**	**$661,055**
Salaries and Benefits				$1,033,415	$790,561	$395,281
Rent, Utilities & Housekeeping				$40,000	$30,000	$15,000
Cell Phones				$1,440	$1,080	$540
Lab				$23,370	$20,520	$10,260
Food/Snacks				$23,370	$20,520	$10,260

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 Jan-Jun	ACTUAL 2018 Jul-Dec	PROJECTED CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
Travel/Training				$17,200	$8,600	$4,300
Marketing				$6,000	$3,000	$1,500
Miscellaneous Supplies				$4,800	$3,600	$1,800
Start Up Costs						
EMR build and implementation				$875,000	$325,000	$200,000
FF&E				$27,811		
Security				$6,000		
IT Hardware/Infrastructure				$40,000		
Facility/Construction				$50,000		
Signage (internal and external)				$1,000		
Miscellaneous/Contingency				$4,000		
On-boarding				$7,310		
Total Expenses				**$2,160,716**	**$1,202,881**	**$638,941**
Variation to Budget (Transfer Funds to Proceeding Year)	$230,012	$358,819	$404,821	($76,752)	$8,922	$22,114

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

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

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

D-6. IDN Community Project: Standard Assessment Tools

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

During program planning, the Director made the decision to implement a comprehensive Biopsychosocial Assessment, PHQ-9 and URICA to take the place of the Modified Mini Screen and Mental Health Screening tool. Together, the Biopsychosocial Assessment and PHQ-9 is comprehensive enough to ascertain the mental health needs of the patient and also assesses the social determinants of health. The URICA was added to assess the stage of change.

Standard Assessment Tool Name	Brief Description
Biopsychosocial Assessment	A comprehensive assessment that evaluates both mental health and substance use needs along with the social determinants of health.

Standard Assessment Tool Name	Brief Description
PHQ-9	The PHQ-9 is an instrument for screening, diagnosing the severity of depression.
URICA	The URICA is a self-report measure that includes 4 subscales measuring the stage of change at entrance to treatment; Pre-contemplation, Contemplation, Action and Maintenance.
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.

No changes have been made to the protocols utilized for the PHP in this reporting period

Protocol Name	Brief Description	Use (Current/Under Development)
Admissions	To establish criteria for appropriate admission to the Partial Hospitalization Program.	Current
Appointments and Rescheduling	This policy is designed to set reasonable and appropriate expectations for setting appointments by clients and staff.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Assessment	Assessment and service planning is an ongoing, collaborative, continuous and person-centered process at the Elliot Hospital Substance Use Disorder Services programs. This process is a mutual exploration of the client's issues and strengths, complemented by the staff's professional perspective and recommendations resulting in a jointly created plan with mutually agreed upon goals	Current
Behavioral Health Emergencies	To identify the necessary processes that need to occur in the event of a behavioral health emergency	Current
Case Management	This policy is designed to identify the activities, roles and responsibilities of a case manager in a substance use disorder program	Current
Clients Rights	This policy is designed to outline the rights of clients within the Department of Substance Use Services.	Current
Clinical Documentation	This policy is designed to ensure that client information is maintained in an organized and secure manner.	Current
Clinical Supervision	This policy is designed to ensure that the highest possible professional standards are adhered to in the provision of behavioural health services	Current
Complaints (Elliot Hospital)	To provide a guideline for appropriate and timely management pf client complaints and grievances while complying with state and federal laws, regulations and guidance	Current
Compliance (Elliot Hospital)	To describe the policy and procedure related to the federal and state False Claims Act, whistleblower protections and the Elliot Health System ("EHS") compliance program in accordance with federal and state regulations.	Current
Confidentiality (Elliot Hospital)	The purpose of this policy is to clearly identify uses and disclosures of PHI that require a valid patient authorization.	Current
Critical Incidents (Elliot Hospital)	To provide a support mechanism for staff who have been involved in a work-related traumatic event or critical incident.	Current
Cultural Competency	To foster greater understanding and compatibility of staff for the diversity of cultural, racial, ethnic, and socioeconomic backgrounds of our clients.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Dangerous Items on Premises	To ensure the safety of all clients, their family members and staff.	Current
Discharges	This policy is designed to affirm a client's right to refuse treatment. The policy also affirms the program's right to end treatment when the client is not deemed to be maintaining minimal standards of commitment to treatment, and this has been communicated to the client.	Current
Discharge Documentation	This policy is designed to ensure that the treatment record will adequately communicate the nature and course of treatment provided, as well as the reasons for the termination of treatment.	Current
Ethical Conduct	To ensure that all actions by staff are performed in an ethical manner.	Current
Medical Clearance	Participants in the Partial Hospitalization Program need to be medically cleared to participate in the group therapy program. The program is not clinically appropriate for participants with compromised medical conditions.	Current
Progress Notes	This policy is designed to ensure that all contact with clients, their families, and other outside agencies is appropriately documented, to ensure the maintenance of a consistent record of treatment, and a means for the provision of continuity of care and the verification of professional conduct.	Current
Psychiatric Prescribing and Documentation	This policy is designed to ensure the following: that all contact of staff prescribers with clients is performed in a professional manner, that the most appropriate treatment is provided to clients, that a consistent and complete medical record of treatment is maintained, and that a means for the provision of continuity of care and the verification of professional conduct is maintained.	Current
Record Maintenance (Elliot Hospital)	This policy is designed to accomplish the goals of maintaining accurate, relevant and useful records for Elliot Health System ("EHS"), and to maintain these records for reasonable, proper retention periods.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Referrals	The Substance Use Disorder Services (SUDS) Department creates and maintains linkages and relationships with other service providers, organizations and professionals in the community in order to ensure clients have the opportunity to access the most effective, coordinated and comprehensive services available. The SUDS Department, with the informed consent and participation of the client, may make referrals to another service within Elliot Hospital or to external resources, at any time in service delivery (i.e., prior to offering service, while service is ongoing or when service is being terminated).	Current
Social Media (Elliot Hospital)	The purpose of this policy is to enable the EHS workforce to embrace social networking and to provide parameters to work within. This policy establishes a set of rules for any activity and participation in "social media".	Current
Subpoenas	This policy is designed to clarify how and when staff should release information of any sort to courts and government investigators	Current
Suicide Assessment	This policy is designed to ensure the safety of all clients by effectively assessing suicidal and homicidal ideation and intent	Current
Tobacco (Elliot Hospital)	Elliot's primary mission is to protect the health of those in our community while promoting and supporting a community culture of healthier living. Elliot Health System has, therefore, set this policy regarding tobacco use on campus.	Current
Witnessing Documents	To clarify the legal limits of staff as signatory witnesses for their clients.	Current

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

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

Project Team Member	Roles and Responsibilities
[redacted] Elliot Health System	Executive Sponsor • Champion the project and the team. • Responsible for the overall success of the project. • Provide high-level oversight, direction, and support. • Empower the project owner/business sponsor and project manager.

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

[redacted] Elliot Health System	Project Manager
	• Responsible for the overall success of the project.
	• Manage and lead the project team.
	• Recruit project staff and consultants, where necessary.
	• Manage coordination of the partners and working groups engaged in project work.
	• Facilitate scope definition as part of the project charter.
	• Facilitate project plan development to set expectations for deliverables and schedule.
	  ○ Develop and maintain a detailed project schedule.
	  ○ Manage project deliverables in line with the project plan.
	  ○ Record and manage project issues and escalate where necessary.
	  ○ Resolve cross-functional issues at project level.
	  ○ Manage project scope and change control and escalate issues where necessary.
	  ○ Monitor project progress and performance.

Project Team Member	Roles and Responsibilities
	○ Provide status reports to the project sponsor and EPMO. • Coordinate with, and update progress to project executive sponsor, co-leads, and project team. • Coordinate phase sign-offs. • Work closely with stakeholders to ensure the project meets business needs. • Manage project close out and evaluation and ensure appropriate transition to operations.
[redacted] Chairman of the Board, Derry Friendship Center [redacted] Derry Friendship Center [redacted] MHCGM [redacted] Director, Office of Catholic Identity, CMC [redacted] Clinical and Supportive Services Manager, Families in Transition [redacted] Farnum Center at Easter Seals	Team Members • Actively support and endorse project. • Ensure quality outcomes. • Participate in project team meetings as needed. • Actively participate in project activities as needed to support the successful delivery of project outcomes. • Ensure cross-team communication and collaboration. • Identify cross-team issues and coordinate issue resolution. • Document operations process flows, gaps and recommended changes. • Work with the co-leads to ensure the needs of the Network can be supported. • Ensure that all team members have the information they need to complete their work successfully. • Provide recommended changes for policies and procedures based on the project outcomes. • Review project deliverables for completeness, quality, and compliance with established project standards. • Problem solve and embrace change. • Step in and help whenever needed.

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

The table below represents the training that has been conducted thus far and those who have attended. As noted below two sessions, Assessment Tools and Family Therapy, which were rescheduled and will take place on February 5, 2019 and February 12, 2019, respectively. Our newly hired MLADC and LICSW will both be attending training on February 21, 2019 for those sessions that were held prior to their arrival. In addition, since mental health first aid is meant for non-clinical staff, you will notice the change

from all providers and staff to just our Patient Service Representative and Billing Coordinator. At this time, we are waiting for this training course to be offered in our area.

Training	Type of Provider	Date of Completion
Orientation	All providers, clinical & support staff	12/17/18
Effective Documentation	LICSW, MLADC, CRSW, ARNP, RN, Case Manager	12/20/18
Policies and Procedures for PHP	PSR, Billing Coordinator, Case Manager, CRSW, RN, APRN	10/04/18
Confidentiality	PSR, Billing Coordinator, CRSW, ARNP, RN, Case Manager	10/25/18
Ethics and Clinical Boundaries	CRSW, ARNP, RN, Case Manager	11/14/18
Assessment Tools	LICSW, MLADC, CRSW, ARNP, RN, Case Manager	02/05/19
Safety in the Workplace	PSR, Billing Coordinator, CRSW, ARNP, RN, Case Manager	12/20/18
Counseling Skills (EBP's)	CRSW, ARNP, RN, Case Manager	10/26/18
Developing Outcomes	CRSW, ARNP, RN, Case Manager	12/19/18
Differential Diagnosis	CRSW, ARNP, RN, Case Manager	11/09/18
Co-occurring Disorder Treatment	CRSW, RN, Case Manager	11/20/18
Suicidality and Crises Interventions	CRSW, ARNP, RN, Case Manager	11/23/18
Family Therapy	LICSW, MLADC, CRSW, ARNP, RN, Case Manager	02/12/19
Motivation Interviewing	CRSW, ARNP, RN, Case Manager	12/07/18
Mental Health First Aid	Patient Service Representative, Billing Coordinator	TBD

Project Scoring: IDN Community Project Process Milestones

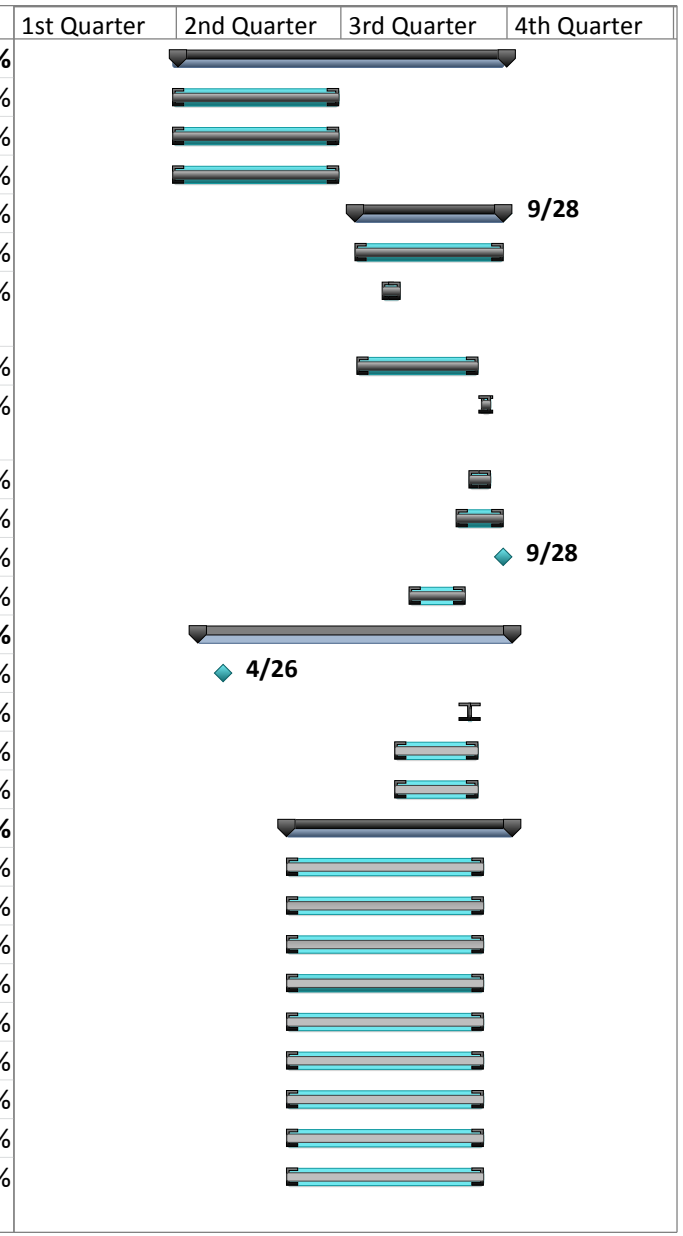
DHHS will use the tool below to assess each IDN's Community Projects activities. Grayed areas indicate that no submission is expected for the time frame. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

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				

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

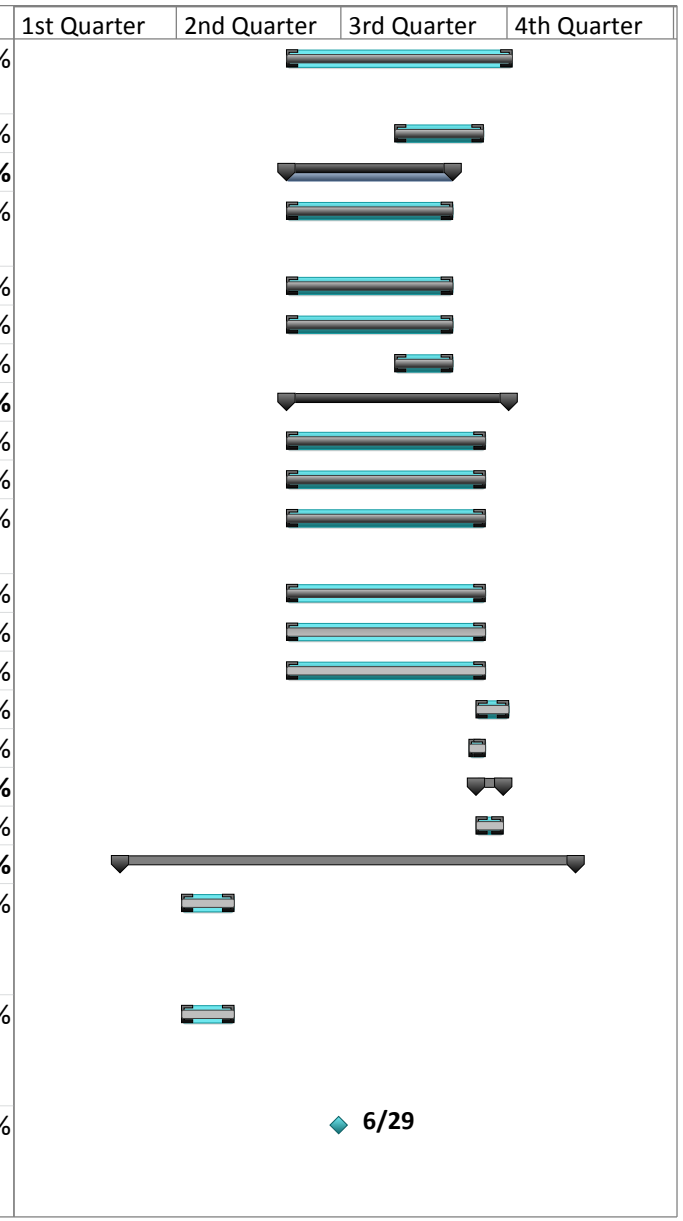
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
1	**1 IT Epic Build**	**131 days**	**Mon 4/2/18**	**Sun 9/30/18**	**No**	**100%**
2	1.1 Scope Project	66 days	Fri 3/30/18	Fri 6/29/18	No	100%
3	1.2 Develop Timeline	66 days	Fri 3/30/18	Fri 6/29/18	No	100%
4	1.3 Develop Cost	66 days	Fri 3/30/18	Fri 6/29/18	No	100%
5	1.4 Epic Build	60 days	Mon 7/9/18	Fri 9/28/18	Yes	100%
6	1.4.1 PHP Practice Me	60 days	Mon 7/9/18	Fri 9/28/18	No	100%
7	1.4.2 PHP Workflow-Build	8 days	Tue 7/24/18	Thu 8/2/18	No	100%
8	1.4.3 Build	49 days	Tue 7/10/18	Fri 9/14/18	No	100%
9	1.4.4 Hardware Dress Rehearsal	5 days	Mon 9/17/18	Fri 9/21/18	No	100%
10	1.4.5 Testing	10 days	Mon 9/10/18	Fri 9/21/18	No	100%
11	1.4.6 Training	20 days	Mon 9/3/18	Fri 9/28/18	No	100%
12	2 Operational Workflows	125 days	Mon 4/9/18	Fri 9/28/18	Yes	100%
13	3 Pre Go Live Workflows	23 days	Wed 8/8/18	Fri 9/7/18	No	100%
14	**4 Space & Equipment**	**124 days**	**Fri 4/13/18**	**Wed 10/3/18**	**No**	**100%**
15	4.1 Determine where	10 days	Fri 4/13/18	Thu 4/26/18	Yes	100%
16	4.2 Move existing tenant	1 day	Mon 9/10/18	Mon 9/10/18	No	100%
17	4.3 Renovations	34 days	Tue 7/31/18	Fri 9/14/18	No	100%
18	4.4 IT Infrastructure	34 days	Tue 7/31/18	Fri 9/14/18	No	100%
19	**4.5 FF&E**	**89 days**	**Fri 6/1/18**	**Wed 10/3/18**	**No**	**100%**
20	4.5.1 Desks	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
21	4.5.2 Desk chairs	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
22	4.5.3 Group room chai	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
23	4.5.4 Lobby furniture	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
24	4.5.5 Shredder bins	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
25	4.5.6 Kitchen equipme	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
26	4.5.7 Artwork	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
27	4.5.8 Water cooler	77 days	Fri 6/1/18	Mon 9/17/18	No	100%
28	4.5.9 Medical Equipment and	77 days	Fri 6/1/18	Mon 9/17/18	No	100%



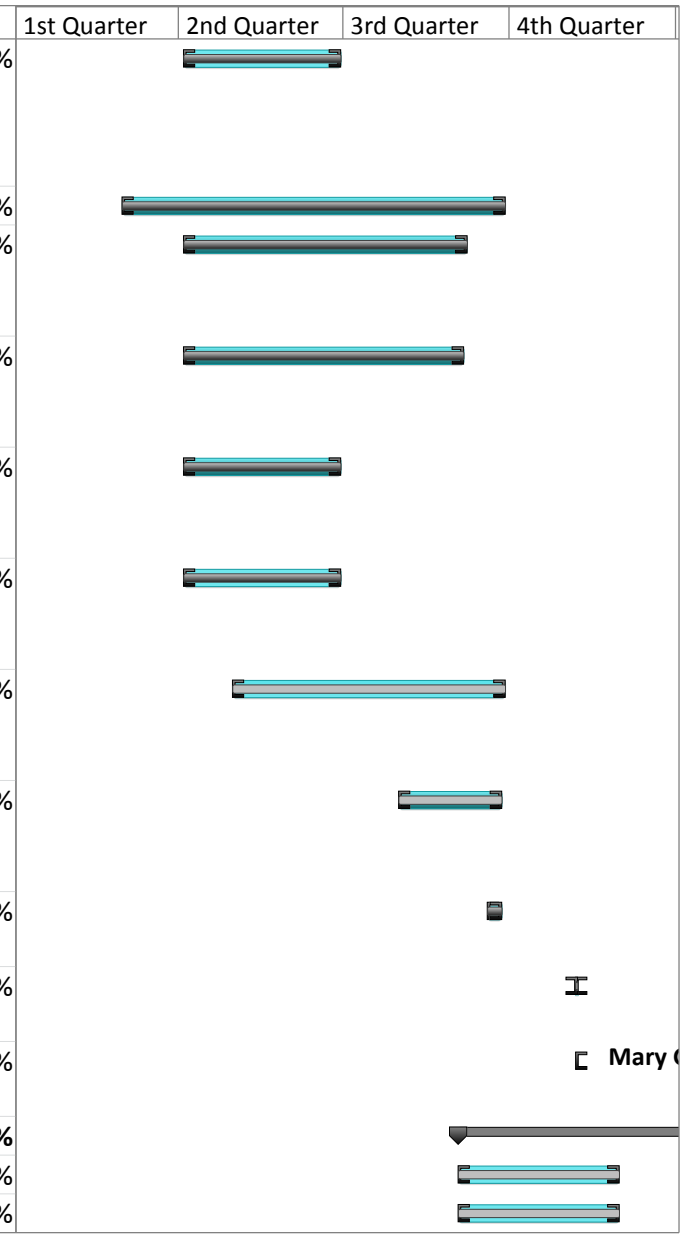
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
29	4.5.10 Internal/External	89 days	Fri 6/1/18	Wed 10/3/18	No	100%
30	4.5.11 Delivery & Set u	35 days	Tue 7/31/18	Mon 9/17/18	No	100%
31	**4.6 Security**	**66 days**	**Fri 6/1/18**	**Fri 8/31/18**	**No**	**100%**
32	4.6.1 Hospital key system locks	66 days	Fri 6/1/18	Fri 8/31/18	No	100%
33	4.6.2 Panic Buttons	66 days	Fri 6/1/18	Fri 8/31/18	No	100%
34	4.6.3 Cameras	66 days	Fri 6/1/18	Fri 8/31/18	No	100%
35	4.6.4 Install	24 days	Tue 7/31/18	Fri 8/31/18	No	100%
36	**4.7 IT Equipment**	**87 days**	**Fri 6/1/18**	**Mon 10/1/18**	**No**	**100%**
37	4.7.1 Computers/Lapto	78 days	Fri 6/1/18	Tue 9/18/18	No	100%
38	4.7.2 Monitors	78 days	Fri 6/1/18	Tue 9/18/18	No	100%
39	4.7.3 Printers - type and location	78 days	Fri 6/1/18	Tue 9/18/18	No	100%
40	4.7.4 Fax	78 days	Fri 6/1/18	Tue 9/18/18	No	100%
41	4.7.5 Phones	78 days	Fri 6/1/18	Tue 9/18/18	No	100%
42	4.7.6 Data Drops	78 days	Fri 6/1/18	Tue 9/18/18	No	100%
43	4.7.7 Cell Phones?	12 days	Fri 9/14/18	Mon 10/1/18	No	100%
44	4.7.8 Delivery & Set Up	7 days	Mon 9/10/18	Tue 9/18/18	No	100%
45	**4.8 Office Supplies**	**11 days**	**Fri 9/14/18**	**Fri 9/28/18**	**No**	**100%**
46	4.8.1 Business Cards	11 days	Fri 9/14/18	Fri 9/28/18	No	100%
47	**5 Billing**	**180 days?**	**Thu 3/1/18**	**Wed 11/7/18**	**No**	**99%**
48	5.1 Determine if it will be hospital based billing or professional only	21 days	Wed 4/4/18	Wed 5/2/18	No	100%
49	5.2 Determine which billing form is required; 1500 or UB	21 days	Wed 4/4/18	Wed 5/2/18	No	100%
50	5.3 Determine enrollment requirements for each	63 days	Wed 4/4/18	Fri 6/29/18	Yes	100%



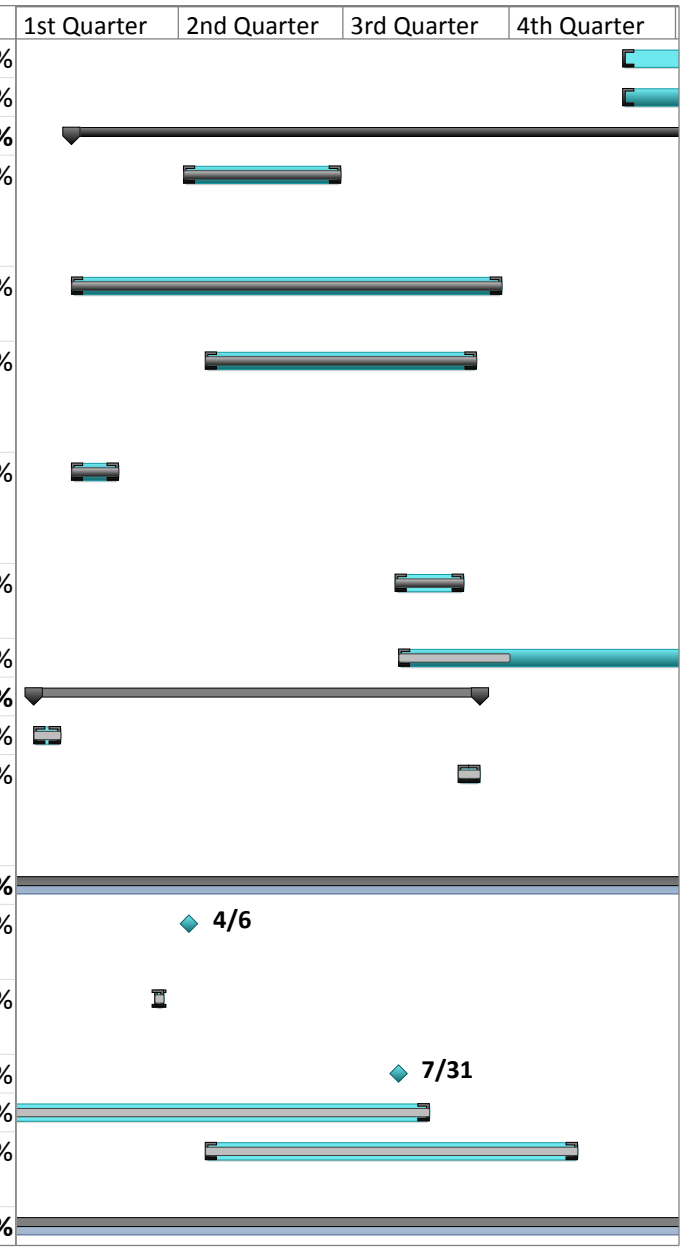
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
51	5.4 Notify insurances of new program; Determine if contracts need to be modified	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
52	5.5 Medicaid Application	152 days	Thu 3/1/18	Fri 9/28/18	No	100%
53	5.6 Determine if site visit is required and by whom	113 days	Wed 4/4/18	Fri 9/7/18	No	100%
54	5.7 Determine the staffing requirements for each insurance	111 days	Wed 4/4/18	Wed 9/5/18	No	100%
55	5.8 Determine the CPT and Dx codes required for each insurance	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
56	5.9 Create encounter form (if not being entered directly into	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
57	5.10 Determine if clinicians need to be enrolled with payers	109 days	Tue 5/1/18	Fri 9/28/18	No	100%
58	5.11 Determine Documentation requirements	41 days	Wed 8/1/18	Wed 9/26/18	No	100%
59	5.12 Request Tempus/Installation	6 days	Wed 9/19/18	Wed 9/26/18	No	100%
60	5.13 Set up clarity report - daily charge review	1 day	Wed 11/7/18	Wed 11/7/18	No	100%
61	5.14 Set up monthly meeting with Mary		Wed 11/7/18		No	0%
62	**6 Provider Enrollment**	**130 days**	**Mon 9/3/18**	**Fri 3/1/19**	**No**	**50%**
63	6.1 ARNP	65 days	Mon 9/3/18	Fri 11/30/18	No	100%
64	6.2 Director	65 days	Mon 9/3/18	Fri 11/30/18	No	100%



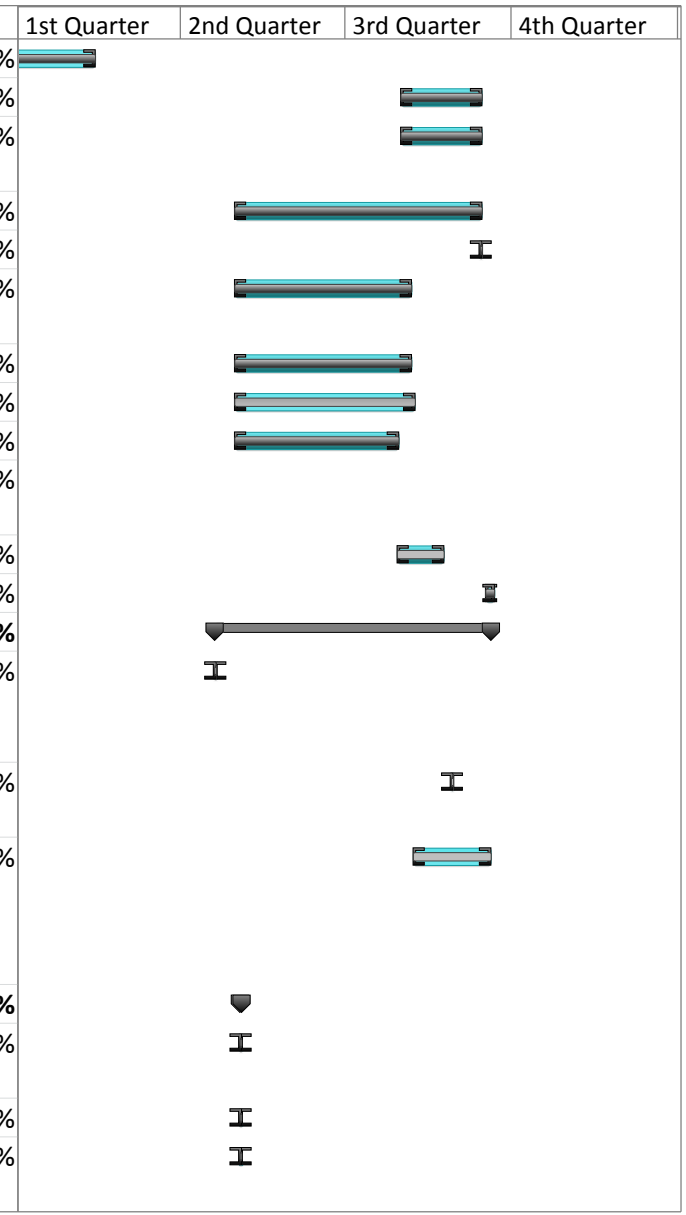
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
65	6.3 MLADC	65 days	Mon 12/3/18	Fri 3/1/19	No	0%
66	6.4 LICSW	65 days	Mon 12/3/18	Fri 3/1/19	No	0%
67	**7 Regulatory/Compliance**	**302 days**	**Thu 2/1/18**	**Fri 3/29/19**	**No**	**77%**
68	7.1 Determine if certification/licensing is required and by whom	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
69	7.2 Creation of appropriate 42 CFR Part	170 days	Thu 2/1/18	Wed 9/26/18	No	100%
70	7.3 Work with IT to incorporate 42 CFR Part 2 into the Epic system	108 days	Mon 4/16/18	Wed 9/12/18	No	100%
71	7.4 Create fax cover letter with 42 CFR Part 2 language	18 days	Thu 2/1/18	Mon 2/26/18	No	100%
72	7.5 Determine level of physician involvement	28 days	Mon 7/30/18	Wed 9/5/18	No	100%
73	7.6 Forms approval	173 days	Wed 8/1/18	Fri 3/29/19	No	25%
74	**8 Finance**	**177 days**	**Thu 1/11/18**	**Fri 9/14/18**	**No**	**100%**
75	8.1 Create PHP Dept	11 days	Thu 1/11/18	Thu 1/25/18	No	100%
76	8.2 Complete General Ledger Maintenance Form	10 days	Mon 9/3/18	Fri 9/14/18	No	100%
77	**9 Human Resources**	**614 days**	**Mon 7/3/17**	**Thu 11/7/19**	**No**	**94%**
78	9.1 Create Job Descriptions	200 days	Mon 7/3/17	Fri 4/6/18	Yes	100%
79	9.2 Send to Position Control	5 days	Mon 3/19/18	Fri 3/23/18	No	100%
80	9.3 Post Positions	77 days	Mon 4/16/18	Tue 7/31/18	Yes	100%
81	9.4 Conduct Interviews	285 days	Mon 7/17/17	Fri 8/17/18	No	100%
82	9.5 Medical Staff - Priviledges	148 days	Mon 4/16/18	Wed 11/7/18	No	100%
83	**9.6 On board**	**487 days**	**Mon 11/20/17**	**Tue 10/1/19**	**No**	**87%**



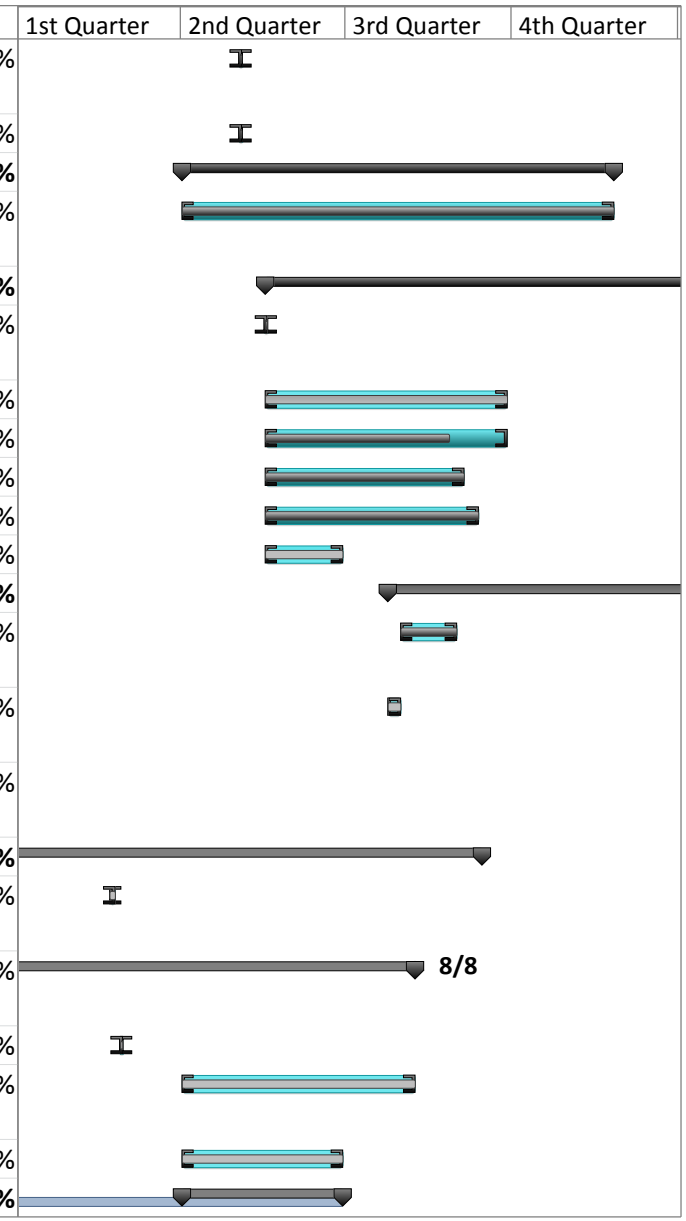
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
84	9.6.1 Hire Director	140 days	Tue 8/1/17	Mon 2/12/18	No	100%
85	9.6.2 Hire PSR	33 days	Wed 8/1/18	Fri 9/14/18	No	100%
86	9.6.3 Hire Billing Coordinator	33 days	Wed 8/1/18	Fri 9/14/18	No	100%
87	9.6.4 Hire LICSW	99 days	Tue 5/1/18	Fri 9/14/18	No	100%
88	9.6.5 Hire MLADC	1 day	Fri 9/14/18	Fri 9/14/18	No	100%
89	9.6.6 Hire Clinical Case Manager	70 days	Tue 5/1/18	Mon 8/6/18	No	100%
90	9.6.7 Hire CRSW	70 days	Tue 5/1/18	Mon 8/6/18	No	100%
91	9.6.8 Hire RN	72 days	Tue 5/1/18	Wed 8/8/18	No	100%
92	9.6.9 Hire Psychiatric N	65 days	Tue 5/1/18	Mon 7/30/18	No	100%
93	9.6.10 Hire Outreach Worker	87 days	Mon 6/3/19	Tue 10/1/19	No	0%
94	9.6.11 Secure Physicia	20 days	Mon 7/30/18	Fri 8/24/18	No	100%
95	9.6.12 Submit SARFs	5 days	Mon 9/17/18	Fri 9/21/18	No	100%
96	**10 HIM**	**109 days**	**Fri 4/20/18**	**Wed 9/19/18**	**No**	**100%**
97	10.1 Schedule meeting to discuss new department	1 day	Fri 4/20/18	Fri 4/20/18	No	100%
98	10.2 Determine pick up schedule	1 day	Wed 8/29/18	Wed 8/29/18	No	100%
99	10.3 Determine process to secure paper consents/outside facility documents	31 days	Wed 8/8/18	Wed 9/19/18	No	100%
100	**11 Lab**	**1 day**	**Fri 5/4/18**	**Fri 5/4/18**	**No**	**100%**
101	11.1 Schedule meeting with Lab	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
102	11.2 In house or outsour	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
103	11.3 Determine panels needed	1 day	Fri 5/4/18	Fri 5/4/18	No	100%



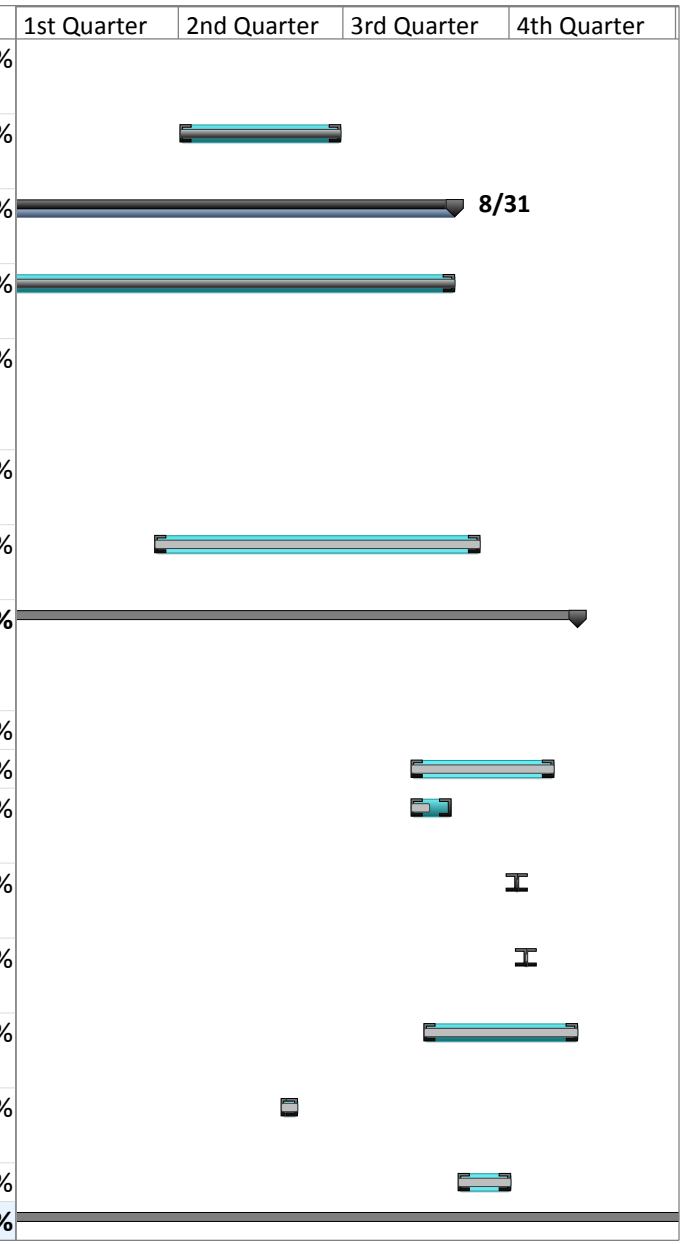
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
104	11.4 Lab courier pick up schedule	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
105	11.5 Lab supplies	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
106	**12 Legal**	**171 days**	**Mon 4/2/18**	**Mon 11/26/18**	**No**	**100%**
107	12.1 Determine if any contracts need review	171 days	Mon 4/2/18	Mon 11/26/18	No	100%
108	**13 Marketing**	**685 days**	**Fri 5/18/18**	**Thu 12/31/20**	**No**	**52%**
109	13.1 Schedule meeting with marketing	1 day	Fri 5/18/18	Fri 5/18/18	No	100%
110	13.2 Internal	96 days	Fri 5/18/18	Fri 9/28/18	No	100%
111	13.3 External	96 days	Fri 5/18/18	Fri 9/28/18	No	75%
112	13.4 Website	78 days	Fri 5/18/18	Tue 9/4/18	No	100%
113	13.5 Pamphlets	84 days	Fri 5/18/18	Wed 9/12/18	No	100%
114	13.6 Timeline & Plan	31 days	Fri 5/18/18	Fri 6/29/18	No	100%
115	**13.7 Outreach**	**637 days**	**Wed 7/25/18**	**Thu 12/31/20**	**No**	**28%**
116	13.7.1 Develop Road Show Presentation	23 days	Wed 8/1/18	Fri 8/31/18	No	100%
117	13.7.2 Determine who to present to	5 days	Wed 7/25/18	Tue 7/31/18	No	100%
118	13.7.3 Schedule presentations	632 days	Wed 8/1/18	Thu 12/31/20	Yes	25%
119	**14 Programming**	**206 days**	**Fri 12/1/17**	**Fri 9/14/18**	**No**	**100%**
120	14.1 General program description	3 days	Wed 2/21/18	Fri 2/23/18	No	100%
121	14.2 Detailed program description	179 days	Fri 12/1/17	Wed 8/8/18	Yes	100%
122	14.2.1 Hours	1 day	Tue 2/27/18	Tue 2/27/18	No	100%
123	14.2.2 Interdisciplinary Team	93 days	Mon 4/2/18	Wed 8/8/18	No	100%
124	14.2.3 Persons served	65 days	Mon 4/2/18	Fri 6/29/18	No	100%
125	**14.2.4 Services Offere**	**65 days**	**Mon 4/2/18**	**Fri 6/29/18**	**No**	**100%**



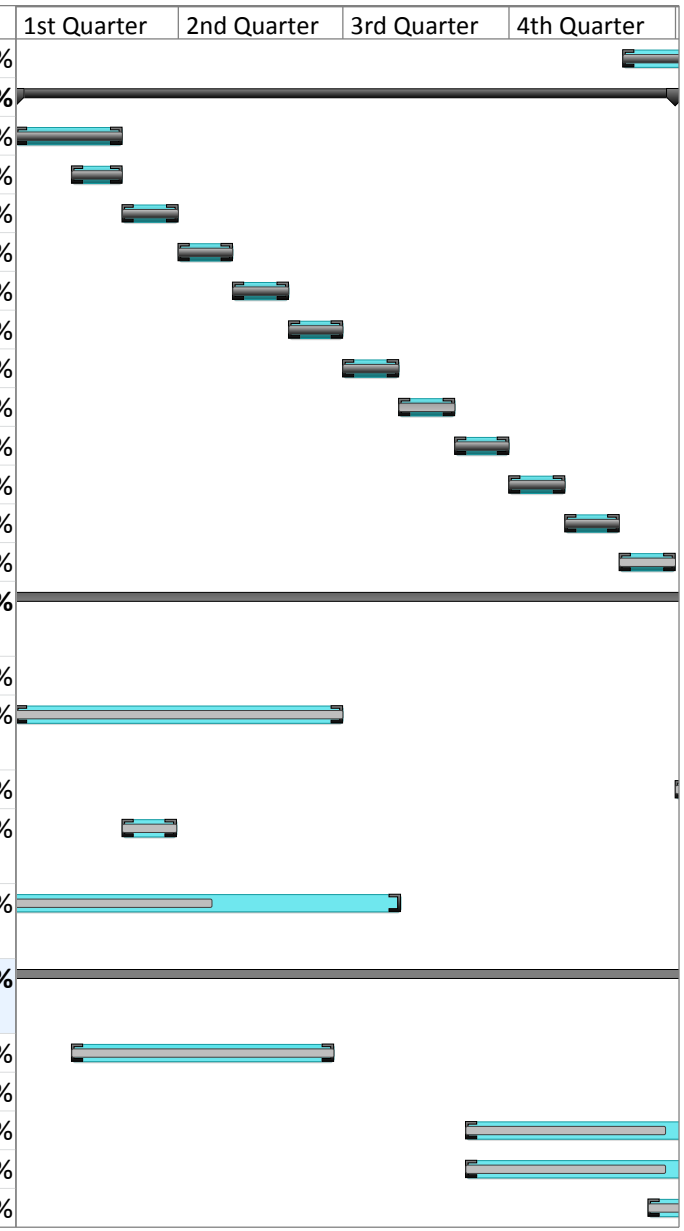
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
126	14.2.4.1 Group Names and Topics	21 days	Fri 12/1/17	Fri 12/29/17	No	100%
127	14.2.4.2 Other services-	65 days	Mon 4/2/18	Fri 6/29/18	No	100%
128	14.3 Policy & Procedure Manual	195 days	Mon 12/4/17	Fri 8/31/18	Yes	100%
129	14.3.1 Develop policies and	196 days	Fri 12/1/17	Fri 8/31/18	No	100%
130	14.3.2 Identify and adapt screening and assessment tools	20 days	Mon 12/4/17	Fri 12/29/17	No	100%
131	14.3.3 Develop Patient Handbook	21 days	Fri 12/1/17	Fri 12/29/17	No	100%
132	14.4 Program Evaluation Metrics	130 days	Mon 3/19/18	Fri 9/14/18	No	100%
133	**15 Develop Program Training Plan and Schedule**	**244 days**	**Fri 12/1/17**	**Wed 11/7/18**	**No**	**95%**
134	15.1 Clinical Training Plar	21 days	Fri 12/1/17	Fri 12/29/17	No	100%
135	15.2 Compliance Training	57 days	Wed 8/8/18	Thu 10/25/18	No	100%
136	15.3 HIM Training Plan/Release of Info	16 days	Wed 8/8/18	Wed 8/29/18	No	50%
137	15.4 Copay Collection Training/Courier pick up	1 day	Fri 10/5/18	Fri 10/5/18	No	100%
138	15.5 Coding/Documentation	1 day	Wed 10/10/18	Wed 10/10/18	No	100%
139	15.6 Registration and Scheduling Training	61 days	Wed 8/15/18	Wed 11/7/18	No	100%
140	16 Notify Safety Department of PHP	7 days	Mon 5/28/18	Tue 6/5/18	No	100%
141	17 Appoint Safety Trainer	21 days	Mon 9/3/18	Mon 10/1/18	No	100%
142	**18 Grant Activity**	**544 days**	**Sun 1/1/17**	**Thu 1/31/19**	**No**	**87%**



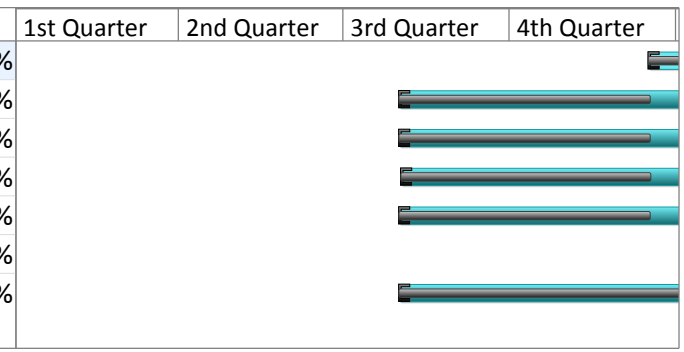
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
143	18.1 Execute new contra	44 days	Mon 12/3/18	Thu 1/31/19	No	75%
144	**18.2 Submit Monthly Re**	**261 days**	**Mon 1/1/18**	**Mon 12/31/18**	**No**	**100%**
145	18.2.1 January Report	43 days	Mon 1/1/18	Wed 2/28/18	No	100%
146	18.2.2 February Repor	20 days	Thu 2/1/18	Wed 2/28/18	No	100%
147	18.2.3 March Report	23 days	Thu 3/1/18	Sat 3/31/18	No	100%
148	18.2.4 April Report	22 days	Sun 4/1/18	Mon 4/30/18	No	100%
149	18.2.5 May Report	23 days	Tue 5/1/18	Thu 5/31/18	No	100%
150	18.2.6 June Report	22 days	Fri 6/1/18	Sat 6/30/18	No	100%
151	18.2.7 July Report	23 days	Sun 7/1/18	Tue 7/31/18	No	100%
152	18.2.8 August Report	23 days	Wed 8/1/18	Fri 8/31/18	No	100%
153	18.2.9 September Rep	22 days	Sat 9/1/18	Sun 9/30/18	No	100%
154	18.2.10 October Repor	23 days	Mon 10/1/18	Wed 10/31/18	No	100%
155	18.2.11 November Rep	22 days	Thu 11/1/18	Fri 11/30/18	No	100%
156	18.2.12 December Rep	22 days	Sat 12/1/18	Mon 12/31/18	No	100%
157	**18.3 Submit Semi-Annual Reports**	**405 days**	**Sat 7/1/17**	**Fri 1/18/19**	**No**	**100%**
158	18.3.1 July-Dec. 2017 F	132 days	Sat 7/1/17	Sun 12/31/17	No	100%
159	18.3.2 Jan. - June 2018 Report	131 days	Mon 1/1/18	Sat 6/30/18	No	100%
160	18.3.3 July-Dec. 2018 F	14 days	Tue 1/1/19	Fri 1/18/19	No	100%
161	18.4 Submit Revised Project Plan	22 days	Thu 3/1/18	Fri 3/30/18	No	100%
162	18.5 Meet with B1 Project Owner re: CCSA	414 days	Sun 1/1/17	Wed 8/1/18	No	82%
163	**18.6 Provide SOW's to N4H Finance**	**544 days**	**Sun 1/1/17**	**Thu 1/31/19**	**No**	**83%**
164	18.6.1 Director	103 days	Thu 2/1/18	Mon 6/25/18	No	100%
165	18.6.2 Project Mgr	122 days	Sun 1/1/17	Mon 6/19/17	No	100%
166	18.6.3 PSR	105 days	Fri 9/7/18	Thu 1/31/19	No	75%
167	18.6.4 Billing Coordina	105 days	Fri 9/7/18	Thu 1/31/19	No	75%
168	18.6.5 LICSW	34 days	Mon 12/17/18	Thu 1/31/19	No	75%



Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Thu 1/24/19

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
169	18.6.6 MLADC	34 days	Mon 12/17/18	Thu 1/31/19	No	100%
170	18.6.7 Clinical Case Ma	132 days	Wed 8/1/18	Thu 1/31/19	No	75%
171	18.6.8 CRSW	132 days	Wed 8/1/18	Thu 1/31/19	No	75%
172	18.6.9 RN	131 days	Thu 8/2/18	Thu 1/31/19	No	75%
173	18.6.10 Psychiatric NP	132 days	Wed 8/1/18	Thu 1/31/19	No	75%
174	18.6.11 Outreach Wor				No	0%
175	18.6.12 Create Budget for Addendum	132 days	Wed 8/1/18	Thu 1/31/19	No	100%



Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

Progress Update

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

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

A DDC assessment report includes scores on 35 benchmarks across 7 domains within the Dual Diagnosis Capability Index on how capable a program is to work with individuals with co-occurring disorders. As shown in the table below, the scoring range includes: Addiction (AOS) or Mental Health Only Services (MHOS): includes treatment programs that cannot accommodate patients with co-occurring mental health disorders that require ongoing treatment, no matter how stable or functional the patient (assessment score range: 1.0-1.99); Dual Diagnosis Capable (DDC) Programs: treatment programs that

have a primary focus on treating substance use or mental health disorders, however are capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring disorders (assessment score range: 2.0-3.49); and Dual Diagnosis Enhanced (DDE) Programs: Programs at the this level are designed to treat patients who have unstable or disabling co-occurring mental health disorders or substance use disorders (assessment score range: 3.5-5.0). Thus far, the average scoring of the five agency programs that have been assessed with the DDC is 2.56, which falls on the lower end of "Dual Diagnosis Capable". It is our hope that through the use of ITCOD quality improvement plans (QIPs) and support, the agencies will be able to increase scoring to the middle/high range of "Dual Diagnosis Capable". In delivery of the final report, a rationale narrative and recommendations are provided to organizations within each of the 7 domains.

DUAL DIAGNOSIS CAPABILITY INDEX DESIGNATIONS:	DDC Assessment Score Range
Addiction (AOS) or Mental Health Only Services (MHOS)	1.00 – 1.99
Dual Diagnosis Capable)	2.00 - 3.49
Dual Diagnosis Capable/ Dual Diagnosis Enhanced (DDC/DDE)	3.50 – 4.49
Dual Diagnosis Enhanced (DDE)	4.50 – 5.00

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

New Dual Diagnosis Capability Assessments

- One new Dual Diagnosis Capability in Mental Health Treatment assessment was completed in December 2018 for Network4Health partner organization Parkland Medical Center at their Partial Hospitalization Program, as well as their Acute Behavioral Health Unit, both located in Derry. Parkland Medical Center's mission is "commitment to excellence defines Parkland Medical Center, your community partner delivering innovative, compassionate care to you and your family".
- The ITCOD DDC Assessment team utilized CEBP, for consultation on final scoring as well as for report recommendations. 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 Parkland in their final report. For each dimension, an organization is provided with detailed reasoning for the scores, as well as recommended areas of improvement. This information will be used in the creation of Parkland's Dual Diagnosis Capability Quality Improvement Plan for funding.

DDC Assessment Report Delivery and Presentation

- A DDC assessment report was delivered to Parkland Medical Center on December 28, 2018 as a result of their December 5, 2018 program assessment.
- The report meeting reviewed scores and findings of the DDC assessment as documented in the DDC assessment report and began conversations around recommended areas for quality improvement to be further refined in the quality improvement plan (QIP) development process.

DDC Quality Improvement Plans (QIP)

- A draft QIP has been developed for the most recent DDC assessment at Parkland Medical Center. Network4Health will work with representatives of Parkland Medical Center to complete of the QIP no later than the first quarter of 2019.
- Partners who developed the original 4 Dual Diagnosis Capability Quality Improvement Plans (DDC QIPs) made continued progress during the reporting period:
    - **Center for Life Management (CLM)**
        - QIP Timeline: June 2018 to May 2019
        - Program Re-assessment Scheduled: February 2019
        - QIP Goals:

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

          In addition, CLM will provide basic Stage of Change (SOC) training, and Core Competencies of Substance Use Disorder (SUD) Treatment for up to 75% of their clinical staff. To help support learning and application, CLM will develop a standardized format and log for Supervisors to use during clinical supervisions that includes the review of Mental Illness (MI), Stages Of Change (SOC) and Core Competency skills and application of skills in their daily work. Changes within the EMR will be amended to include Stage of Change Assessments in treatment notes, and will also include the ability to collect data from client charts that monitors patient's responses to the DAST and AUDIT screening tools to help assure that patients are receiving stage appropriate treatments and interventions.

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

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

          Completed QIP Activities:

          CLM has made steady progress toward increasing staff competencies in the knowledge base of co-occurring disorders and in responding more effectively to the needs of this population. CLM has completed approximately 35% of all deliverables in their Quality Improvement Plan and made progress in the below Dual Diagnosis Capability domain areas. They are on track to complete all deliverables for the end of their current QIP timeline through May 14, 2019.
            - Specialized interventions with substance use content,
            - Stage Wise assessment capabilities
            - Display and distribution of literature and patient educational materials

- All staff members have basic (or advanced) training in COD and integrated treatment.

CLM reports an increased quality of care for individuals with COD who receive services through CLM.

From September to December 2018, CLM experienced significant workforce challenges inclusive of two clinical supervisors leaving CLM for other professional opportunities. Therefore, the creation of group MLADC supervision, which was to begin meeting twice weekly as of September, was placed on hold in November, as well as individual MLADC supervisions for two clinicians. A decision has now been made to hire a very seasoned per diem MLADC known to our region for depth of knowledge in SUD as well as working with co-occurring disorders. CLM is scheduled to re-start MLADC supervision for eight employees starting January 2019, using funding support from N4H.

An internal ITCOD workgroup/development committee that was developed in January 2018 continues to meet weekly. The goal of this workgroup is to assure implementation and problem-solving strategies are being applied to the overall goals of the ITCOD QIP activities, as well as on an agency wide basis to increase services for the co-occurring disorders population. Focus areas have included group development, training/supervision needs, and use of peer supports/CRSWs.

CLM held Motivational Interviewing & Stages of Change Trainings for Community Support Program (CSP) staff and supervisors in September. These include three explicit trainings aimed at staff within CSP, including: clinical staff, supervisors/CSP team leads, case managers and community support workers. A total of 17 supervisors were trained in MI for Supervisors. Initial progress has also been made on EMR enhancements related to stages of change and outcome measures (DAST/AUDIT).

Regarding peer support, CLM now has a Certified Recovery Support Worker (CRSW) on-site every Friday morning to offer support, guidance, and to further connect clients and/or their family members to community resources. This addition of an on-site CRSW also serves to further educate staff on the advantages of integrating peer support in recovery efforts for better outcomes.

CLM has hired a new medical director with vast experience in SUD and treating co-occurring disorders. He is also experienced with MAT, and will lead the way for CLM to advance toward more comprehensive treatment of co-occurring disorders. On-going SUD program development internal meetings have continued. CLM has also invited peer specialists, community co-occurring resources, South Central Public Health Network, and Granite Pathways' leadership to better coordinate efforts in addressing gaps in our region and upcoming changes to improve access points for those with SUD and co-occurring challenges.

- **Families in Transition- New Horizons (FIT-NH)**
  - <u>QIP Timeline:</u> June 2018 to May 2019
  - <u>Scheduled Program Re-assessment:</u> February 2019
  - <u>QIP Goals:</u>

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

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

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

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

<u>Completed Activities:</u>
Families in Transition-New Horizons has made significant progress in our Integrated Treatment of Co-Occurring Disorder project, completing 50% of all deliverables in their Quality Improvement Plan in the following Dual Diagnosis Capability domains:

- Education about mental health disorders, treatment, and interaction with substance use disorders
- On-site clinical staff members with mental health licensure…or competency, or substantive experience
- Clinical staff members have advanced specialized training in … treatment of persons with
- co-occurring disorder
- Stage –wise Assessment capabilities.

Screening for mental health is being done with the use of standardized, evidence based screening tools. A protocol has been developed to have all clinicians utilize screening tools in their individual sessions to flag mental health disorders. A comprehensive assessment has also been developed in the electronic record system

to help assess for mental health symptoms and aid in diagnosing. FIT-NH finished gathering and expanding educational materials, which are available to all staff in all substance use treatment programs.

FIT-NH hired a Licensed Clinical Mental Health Counselor for their Intensive Outpatient Program, and another clinician with both mental health and substance use licensure(s) is providing intensive family based case management to families receiving recovery housing and treatment. With support of funding from N4H, numerous staff members have renewed existing or applied for initial licensure as a LCMHC/LICSW and/or LADC/MLADC/CRSW. Funding support has also allowed FIT-NH to provide weekly individual and group supervisions to staff interested in obtaining their licensure through the Board of Mental Health, or the Board of Alcohol and Drug Use Professionals.

In an effort to attract and retain quality employees to provide COD treatment services, FIT-NH has been working with consultants to adjust all job descriptions to include core competencies in mental health and substance use disorders for program staff. Existing staff completed a two day introductory Motivational Interviewing training on October 15 and 16, 2018. Additionally, seven clinical and supportive services managers were scheduled to attend a two day training on Motivational Interviewing in Supervision in January 2019.

- **The Mental Health Center of Greater Manchester (MHCGM)**
  - QIP Timeline: June 2018 to May 2019
  - Scheduled Program Re-assessment: February 2019
  - QIP Goals:

    MHCGM has a number of goals for their staff, and assessed programs to increase the treatment capabilities for serving individuals with co-occurring disorders. Goals include increasing and standardizing educational materials that clinicians use with patients, as well as what are available in waiting areas for patients and their families.

    MHCGM intends on supporting licensure activities for both Supervisors and staff in regard to both MH and SUD licensing/certification within New Hampshire. This support includes recertification for existing CRSWs and LADC/MLADC, initial licensure, and weekly supervision for MLADC candidates.

    MHCGM is exploring family programming curriculums to provide a greater range of supportive treatment options. Training in Stages of Change and related co-occurring disorders interventions have been held over the reporting period. To ensure application of skills and support is available, staff are invited to a monthly study group, which focuses on Motivational Interviewing and other co-occurring related interventions. In order to maximize participation, these groups will be available through a web based option, for those unable to attend in person.

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

language, and specific related treatment interventions within numerous clinical notes.

- Completed Activities:
  MHCGM has completed 50% of all deliverables in their Quality Improvement Plan in the following Dual Diagnosis Capability domains:
  - Display and distribution of literature and patient educational materials
  - Family Education and Support and IIIG: Stage-wise Assessment.

  All education materials on co-occurring disorders have been standardized and are accessible to all staff through an internal staff portal. In early 2019, the protocol on how to access and add resources to the portal, as well as an overview of workflow procedures will be presented at department staff meetings across MHCGM. Stages of Change posters have been developed and are being displayed across the Center, which compliments the new substance specific rack cards that are being displayed in all client waiting areas.

  Family programming curriculum for an educational group has been solidified, and is slated to begin in February 2019. The group will be called "Family 411", and will consist of four, 90 minute sessions, offered on a weekly basis at no cost to the attendees. The group will be open to the public for any interested party, although targets family and support networks of those impacted by a loved one with mental illness and substance use. The curriculum is educational in nature, and will help family and support people learn more about each disorder and how they relate to each other, treatments available, developing, maintaining and supporting a recovery plan, communication and stigma reduction, as well as how COD affects a family system including available community resources for support.

  Numerous changes have been made in the EMR to support the treatment of patients with co-occurring disorders, including building in URICA (University of Rhode Island Change Assessment tool), as well as amending clinical documentation to reflect the use of evidence based practices for the co-occurring disorders population including Motivational Interviewing and Stage Wise Treatment Interventions. A sub-committee is working on a set of draft questions to incorporate Stage Wise Assessment as part of the standardized documentation.

  On an ongoing basis, clinicians are being supported through both individual and group supervision to increase and remain in good standing with related licensures and certifications relevant to the treatment of the co-occurring disorders population. A Peer Collaboration meeting for all Certified Recovery Support Workers (CRSWs) has been created and is being facilitated by an MLADC. An ongoing monthly Motivational Interviewing Study Group has increased attendance and is using time to review, practice and brainstorm the use of effective Motivational Interviewing strategies with clients. Currently, MHCGM has fourteen staff members working toward initial MLADC licensure, with funding support from the ITCOD QIP/N4H.

Pastoral Counseling Services (PCS)

- QIP Timeline: August 2018 to July 2019
- Scheduled Program Re-assessment: February 2019
- QIP Goals:

  PCS has a number of goals for their staff, and their Outpatient Services Program to increase the treatment capabilities for serving individuals with co-occurring disorders.

  PCS will work to develop a collection of resources regarding SUD and co-occurring disorders to display in waiting rooms and clinical office space.

  PCS will explore the use of a standardized tool to screen and assess for co-occurring disorders and/or SUD concerns as part of their clinical process (See Table E6). In addition, implementation of clinical SOC/MI tool(s) (i.e. Readiness Ruler, Cost Benefit Analysis and Change Plan Worksheets, etc.) will be utilized with more than 50% of all clients and documented within EHR notes.

  PCS staff will be provided with numerous training opportunities to increase knowledge and skill application in the following topics, specific the co-occurring disorders population: basic SOC and MI, Stigma Reduction (or similar) education (for both clinical and non-clinical staff), and baseline training on a number of topics related to SUD including but not limited to: Provide in house basic training on SUD (including but not limited to: symptoms and recognition, Post-Acute Withdrawal Syndrome, ASAM Criteria, diagnosing, treatment interventions and planning and clinical documentation, etc.). Trainings will be offered by both internal and external training resources.

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

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

- Completed Activities:

  PCS has made good progress in their QIP goals, with 30% of all QIP activities being complete in the following corresponding DDCMHT domains: IIB: Display and distribution of literature and patient educational materials, IVH: Family Education and Support and IIIG: Stage-wise Assessment, IIB: Display and distribution of literature and patient educational materials, IIIG: Stage Wise assessment, and IVD: Stage Wise Treatment.

  Resources to address and educate people on mental health and substance use disorders have been gathered and will be presented to staff in Q1 2019. Additionally, PCS will display resources in client waiting areas, as well as clinical offices. A monthly MLADC Collaboration Group continues to meet. This meeting is offered to all PCS clinical staff to discuss cases with PCS' on-staff MLADC. In addition, four therapists

continue to receive weekly individual supervision as they work towards their MLADC. Supporting staff in acquiring and strengthening knowledge of COD allows for more comprehensive care for clients, and their support systems.

Per the PCS QIP, an eight week co-occurring group series was created and scheduled to begin on January 8, 2019. Topics of the group will include identification of symptoms, relationship between mental health and substance use, recovery plan development and community resources. This group is expected to offer support to PCS clients who are experiencing co-occurring disorders, and also offers one of PCS' MLADC candidates the opportunity to co-facilitate the group under the supervision of the staff MLADC, further strengthening the skill set of the MLADC candidate.

Review of the GAIN-SS, CAGE-AID, and WHO-ASSIST screening tools has taken place, and will be reviewed with staff in January 2019, with the request for immediate implementation where clinically appropriate. In addition, during a February staff meeting the staff MLADC will present interventions specific to Stages of Change and Motivational Interviewing, and discuss with clinical staff how most effectively to implement and document use of such interventions in the clinical record.

PCS has arranged for NH Healthy Families Clinical Training Department to provide a staff training on treating and understanding marijuana and opioid use disorders. The training is scheduled for January 23, 2019.

QIP Funding Review and Contracting

- The Network4Health Steering Committee has approved the following process for the creation, review and funding approval for DDC QIPs. There has been no change in our process since the last reporting period:
    - The network partner participates in site assessment conducted utilizing evidence-based tool promoted by the Case Western Reserve University Center for Evidence Based Practice (CEBP). The tool is administered by assessors who have been trained by CEBP.
    - Results of the assessment are reviewed by the network partner, Network4Health staff and, when requested, by CEBP consultants. As part of this review, potential areas of focus for a quality Improvement plan are identified.
    - A draft Quality Improvement Plan is developed by the Co-occurring Disorders Clinical Director. The draft is presented to the network partner for consideration.
    - Final terms of a Quality Improvement Plan are developed through discussion between the network partner and the Co-occurring Disorders Clinical Director. Funding decisions are based on the scope of the work proposed and availability of budgeted funds. Final scope and funding determinations are made as a result of negotiation and agreement with the network partner.
- Statements of Work (SOWs) were created and approved by Catholic Medical Center's Finance team to support reimbursement on behalf of Network4Health for all QIP activities for the following organizations. There were 4 QIP SOW's with contract execution dates in the reporting period, allowing the following organizations to access their allocated QIP funding:
    - Center for Life Management (July 2018)
    - Families in Transition-New Horizons (July 2018)
    - The Mental Health Center of Greater Manchester (July 2018)
    - Pastoral Counseling Center (September 2018)
- The DDC QIP Statement of Work for Parkland Medical Center is expected no later than Q2 2019. Parkland Medical Center received the Catholic Medical Center/Network4Health base Services

Agreement that establishes Network4Health partners to receive funding. The contract is currently under review at Parkland.

ITCOD Training and Support for Primary Care and Community Based Organizations

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

- Co-Occurring Disorders was offered twice during the reporting period and was delivered by [redacted] of NH Healthy Families, Clinical Training Department. Fifteen participants from nine Network4Health partner organizations attended the August 21, 2018 course, and fifteen participants from six partner agencies attended the October 4, 2018 offering.
- Eighteen individuals from eight partner agencies attended lunch and learn webinars on the ASAM Criteria, presented by [redacted] of NH Healthy Families, Clinical Training Department. This course was offered on October 15 and 24, 2018 respectively.
- Seventeen attendees from four partner agencies attended Adult Mental Health First Aid, delivered by partner agency Center for Life Management. The course was offered on November 29, 2018.
- Ten participants from four partner agencies provided the two day training by [redacted] of NH Healthy Families, Clinical Training Department on Motivational Interviewing. The course was offered on November 1 and 2, 2018.
- Eleven staff at partner agency Crotched Mountain attended Adult Mental Health First Aid, delivered by trainers from partner agency Mental Health Center of Greater Manchester on September 21 and 28, 2018.
- Twenty three Correctional Officers from the Hillsborough County House of Corrections attended an Adult Mental Health First Aid course on September 5 and 6, 2018 delivered by trainers from partner agency Mental Health Center of Greater Manchester .
- Network4Health's Co-occurring Disorders Clinical Director continues to disseminate monthly electronic and hard copy materials to support primary care and community-based support organizations interactions with and treatment of patients with co-occurring disorders. Below were topics for July – December 2018:
    - July – Borderline Personality Disorder
    - August – Opioid Use
    - September – Youth and Trauma
    - October - Wellness
    - November – Pregnant and Parenting Women and Opioid Use
    - December – Peer Supports

In addition to the above mentioned educational materials, the bi-yearly Fall/Winter 2018 Integrated Treatment of Co-occurring Newsletter was disseminated in both electronic and hard copies to partner organizations in December 2018. Topics in this issue included: project updates, upcoming trainings and an update on partner agencies DDC QIP activities and progress. A copy of the newsletter is available as Attachment_E4.1a.

As reported previously, the Network4Health Co-occurring Disorders Clinical Director was trained in Academic Detailing, as a related activity through a recent CDC grant provided through partner agency Manchester City Health Department. Academic Detailing is an outreach education technique that combines the direct social marketing traditionally used by pharmaceutical representatives with unbiased content summarizing the best evidence for a given clinical issue. Academic Detailing is conducted with

prescribers to encourage evidence-based practices in order to improve the quality of care and patient outcomes. In partnership with the Health Department, the Mental Health Center of Greater Manchester, Catholic Medical Center, Elliot Health System and Dartmouth-Hitchcock, the trained Detailing Team has met with over 50 prescribers at four provider organizations to discuss Opioid Use Disorders and treatment approaches and barriers. A special focus has been on Buprenorphine Waiver Training. The goal is to educate prescribers on best practices and available resources, in addition to encouraging prescribers to get waivered to provide Medication Assisted Treatment (MAT) as an option for patients. A local waiver training supported by Network4Health was provided for interested prescribers in September 2018. In August 2018, the MAT Detailers were sent to Washington DC to meet with the other three pilot sites to further develop their skills and education in Academic Detailing. Additionally, in November 2018, the ITCOD Clinical Director and one other detailer from the Manchester City Health Department were asked to present as members of a Panel at the National Center for Academic Detailing's 6th Annual International Conference. The topic of the panel was discussing the development and strength of our local team. There were over 100 attendees at the conference in Boston, Massachusetts.

Protocols

The Network4Health Co-Occurring Disorders Clinical Director completed Network4Health recommended protocols for patient assessment, treatment, management and referrals for the co-occurring disorders population in December 2018. The recommendations document titled: Integrating Healthcare Delivery: Co-Occurring Disorders Treatment Considerations - Recommended Screening, Assessment, Management, Treatment, Referral and Safe Transition Protocols and Best Practices (Attachment_E4.7) has been made available to all E4 project partners. The document is also generally available on the Network4Health website at https://idn4-network4health-nh.org/co-occurring.

Partner Outreach

The Network4Health Co-Occurring Disorders Clinical Director and Network4Health Executive Director continue to outreach to Network4Health partner organizations to identify additional treatment programs to be assessed utilizing the Dual Diagnosis Capability assessments for 2019. At this time, Catholic Medical Center's Behavioral Health Services department has agreed to participate in a Dual Diagnosis Capability assessment in the first quarter of 2019. Originally, CMC was looking for Q4 of 2018; however, there were a number of staffing changes that affected their ability to engage in "additional" activities, outside of providing clinical care to clients. Discussions continue with Catholic Charities, and Elliot's Partial Hospitalization Program for 2019 assessments.

Progress Assessment

Per our ITCOD project plan, the Network4Health Co-occurring Disorders Clinical Director held the second Integrated Treatment of Co-occurring Disorders Community of Practice with a combined Advisory Board meeting on September 24, 2018. The meeting included partner sharing regarding progress and challenges of their ITCOD Quality Improvement Plans, project progress and updates, and highlighted guest speaker- the Director of Consulting and Training for Substance Abuse and Mental Illness (SAMI) initiatives at the Center for Evidence Based Practice(CEBP) at Case Western Reserve University. The speaker facilitated a discussion around ongoing efforts to expand dual diagnosis capabilities at partner agencies with a specific focus on the use of motivational interviewing and stage specific interventions for the co-occurring disorders population. He strongly encouraged organizations to "never underestimate the importance of supervision" to implement new practices. He further discussed that the work of CEBP has shown that much of the work is done at the supervisor/managerial level to initiate installation of a new practice, rather than by training courses at the clinician level. He reminded the team that supervisors have the real world experience with their staff and should know stages of change and motivational interviewing techniques as well or better than their staff to support the reinforcement

of appropriate and consistent use. The Director expressed his strong support for regular supervision in helping to drive new treatment practice initiatives at all agencies.

Representatives were in attendance from partner agencies the Mental Health Center of Greater Manchester, Center for Life Management, Pastoral Counseling Services, Families in Transition-New Horizons and Granite Pathways.

Project Schedule Modifications

Due to the longer than expected QIP development timeframe, delay in QIP approval and contracting duration, DDC assessment organizations will not have completed sufficient quality improvement activities and will not be ready for a follow-up DDC assessment until Q1 2019. Network4Health has therefore updated the project plan to remove the July – December 2018 goal to re-assess up to 2 organizations between July and December 2018. Re-assessments will begin in Q1 2019. There is a project line item already in place for 2019 re-assessment activities.

In addition, the Quality Improvement Plan for Parkland Medical Center was drafted in 2018, but will be finalized in Q1 2019 due to the availability of the partner team. The funding decision has likewise been moved to Q1 2019 after confirmation that the Parkland Medical Center QIP team is ready to move forward with their QIP activities.

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

E-2. IDN Community Project: Evaluation Project Targets

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of staff trained in identifying individuals with co-occurring conditions and referring them for treatment.	Targets will continue to be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization. **The following targets have been identified in current Quality Improvement Plans:** <u>-Stages of Change and Motivational Interviewing Training:</u> CLM: up to 41 staff FIT-NH: up to 14 staff MHCGM: up to 30 staff PCS: up to 20 staff (Target for 2019) <u>-Overcoming Stigma Training:</u> FIT-NH- up to 10 staff PCS: up to 20 staff (Target for 2019) <u>-Substance Use Disorder Core Competencies:</u> CLM- up to 41 staff PCS: up to 20 staff(Target for 2019)	0 - per our project plan	<u>Overcoming Stigma: Strategies for Healthcare Professionals</u> FIT-NH: 23 staff	<u>Motivational Interviewing I:</u> PCS:5 staff CLM:31 staff FIT- NH: 29 staff MHCGM: 8 staff <u>Motivational Interviewing for Supervisors:</u> CLM: 17 staff FIT-NH: 7 staff <u>Stages of Change:</u> CLM: 68 staff MHCGM: 38 staff <u>Overcoming Stigma Training:</u> FIT-NH: 22 staff <u>Substance Use Disorder Core Competencies:</u> CLM: 2 staff (multi-day training) FIT-NH: 2 staff (multi-day training)

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 as Program Leaders for Integrated Treatment of Co-Occurring Disorders programs.	Up to 25 in 2018	0 - per our project plan	19	19 (per July 2018 reporting)

The number of organizations assessed for fidelity to evidence based practice for the integrated treatment of co-occurring disorders. The measure will include a total count of organizations assessed by the DDCAT or DDCMHT index, as well as the count of organizations by dual diagnosis capability continuum designation:
• Addiction-only services (AOS)
• Mental Health-only services (MHOS)
• Dual-diagnosis capable (DDC)
  ○ AOS/DDC
  ○ MHOS/DDC
  ○ DDC
• Dual-diagnosis enhanced (DDE)
  ○ DDC/DDE
  ○ DDE
	December 2017: Up to 4
	June 2018: Up to 5
	December 2018: Up to 3
		4 Organizations Assessed	1 additional Organization Assessed (total 5)
			
			To date, all organizations have been assessed as Dual-diagnosis capable (DDC), however there is significant variation between organizations within the designation range.
				1 additional organization assessed (total 6)
				
				To date, all organizations have been assessed as Dual-diagnosis capable (DDC), however there is significant variation between organizations within the designation range.

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 patients served in evidence based integrated treatment of co-occurring disorders programs.	As part of their Quality Improvement Plan funding, E4 partners have agree to report the following client counts: • Count of Medicaid patients with co-occurring disorders (COD) served by the Service Provider program(s) assessed using the Dual Diagnosis Capability Index in the last 12 months (last month of the reporting period looking 12 months back) Participating E4 partners will be expected to demonstrate incremental year over year increases in 2019 and 2020 to the volume of patients with co-occurring disorders served by their organization. The 2018 data will be used as a baseline for this assessment.	0 - per our project plan	0 – due to delays in completion and contracting for Quality Improvement Plans, organizations will be submitting this information for the January 2019 Semi-Annual Report	Total Medicaid clients with a co-occurring disorder in Integrated Treatment Programs: **MHCGM:** 1/2018-12/2018: 696 clients **FIT-NH:** 1/2018-12/2018: 322 clients **CLM:** 1/2018-12/2018: 313 clients **PCS:** 1/2018-12/2018: 49 clients **Parkland:** Reporting to begin after completion of Quality Improvement Plan(QIP).

E-3. IDN Community Project: Workforce Staffing

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

There was one staffing change in the July - December 2018 reporting period. One of the Network4Health DDC per diem Assessors retired from his role at partner agency MHCGM in September 2018. At this time, the Network4Health Integrated Treatment of Co-Occurring Disorders Clinical Director, Network4Health's

Executive Director and the remaining members of the DDC per diem Assessor Team agree that there is sufficient capacity with the existing assessor team to support projected 2019/2020 volume of DDC assessments. Should the projected volume increase, Network4Health will reconsider the need to identify and train an additional DDC Assessor.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Co-occurring Disorders Clinical Director	Up to 1	0	1	1	1
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	4 Per diem DDC Assessors	4 Per diem DDC Assessors	3 Per diem DDC Assessors

E-4. IDN Community Project: Budget

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

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

Revenue- All project budgets have been adjusted to reflect the actual receipt of funding. During the reporting period, anticipated funding was not received due to ongoing negotiations between NH DHHS and NH counties. The anticipated, but not yet received, 2018 funding for the Integration of Co-Occurring Disorders Treatment budget totals $285,315. These expected funds have been added to revenue in 2019. If expected revenue is reduced as a result of State negotiations, Network4Health will revise budgets and project plan deliverables, subject to Steering Committee and NH DHHS approval.

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

Reported actual expenses continue to be below budget due in part to expense reporting limited to invoiced and paid. Another significant factor has been the delay of finalizing services agreements and other legal documentation needed for funds disbursements to network partners who are implementing Quality Improvement Plans.

TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual	CY 2018 (Yr3) January to June Actual	CY 2018 (Yr3) July to December Actual	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected

E4 INTEGRATED TX COD Revenue (New)	$ 230,012	$ 128,807	$ 46,002	$ 745,239	$ 468,542	$ 238,530
E4 INTEGRATED TX COD Revenue (Rollover)		$ 221,683	$ 335,984	$ 330,197	$ 301,358	$ 1,481
Total Revenue	$ 230,012	$ 350,490	$ 381,986	$1,075,436	$ 769,900	$ 240,011
Dual Diagnosis Capability Assessor Participation Offset (Training and Assessment Time)	$ 6,848	$ 2,970	$ -	$ 50,563	$ 50,563	
Dual Diagnosis Capability Program Leader Training (2018) Attendee Participation Offset		$ 2,640	$ 3,520			
Dual Diagnosis Program Leader Training (2019) and Attendee Participation Offset				$ 22,659		
Co-Occurring Disorders Capability Quality Improvement Plan Funds			$ 39,891	$ 659,000	$ 676,000	$ 216,000
N4H Assessor Training Course Development and Delivery			$ -	$ 3,150	$ 3,150	$ 3,150
Integrated Treatment Tools & Training for Primary Care and Community Support Organizations		$ 7,801	$ 6,383	$ 35,000	$ 35,000	$ 17,500
Technology (Laptop, Phone, etc.)	$ 1,218	$ 439	$ 1,076	$ 1,694	$ 1,694	$ 1,694
Occupancy	$ 263	$ 656	$ 919	$ 2,012	$ 2,012	$ 1,016
Subtotal	$ 8,329	$ 14,506	$ 51,789	$ 774,078	$ 768,419	$ 239,360

Variation to Budget (Transfer Funds to Subsequent Year)	$ 221,683	$ 335,984	$ 330,197	$ 301,358	$ 1,481	$ 651

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.

Parkland Medical Center was added to our list of participating organizations, and as described above, completed a DDC assessment in December 2018.

Organization/Provider	Agreement Executed (Y/N)
Mental Health Center of Greater Manchester (MHCGM)	Y
Center for Life Management (CLM)	Y
Families in Transition – New Horizons (FIT-NH)	Y
Pastoral Counseling Services (PCS)	Y
Parkland Medical Center (Parkland)	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 and is the same as the list included in the previous SAR. As previously indicated, the team does not intend to dictate to network providers that all tools must be used. During organizational assessments and the creation of a Quality Improvement Plan, Network4Health providers will continue to select specific assessments that are pertinent to their Quality Improvement Plan and treatment of patients with co-occurring disorders. Screening and Assessment protocols for individuals with co-occurring disorders have been developed, and will be shared with all partner agencies.

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

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

Standard Assessment Tool Name	Brief Description
World Health Organization: Alcohol, Smoking and Substance Involvement Test (WHO- ASSIST) **(Assessment/Screening)**	The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings. It can identify a range of problems associated with substance use, including acute intoxication, regular use, dependent or 'high risk' use, and injecting behavior.
Comprehensive Addiction and Psychological Evaluation (CAAPE-5) **(Assessment/Screening)**	The CAAPE (Comprehensive Addiction and Psychological Evaluation) is a structured interview covering seven Axis I conditions and six Axis II personality disorders in addition to substance use disorders in accordance with DSM-IV criteria. The CAAPE is designed so that professionals can use the information for diagnostic purposes within their areas of expertise and can make focused referrals for those areas outside of their areas of practice.
Beck Depression Inventory–II (BDI–II) **(Assessment/Screening)**	Used to screen for the presence and rate the severity of depression symptoms. The BDI–II consists of 21 items to assess the intensity of depression. The BDIII can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. (SAMHSA TIP 42)
CAGE and CAGE-AID **Questionnaire** **(Assessment/Screening)**	The purpose of the CAGE Questionnaire is to detect alcoholism. CAGE-AID detects alcoholism and drug use. The CAGE Questionnaire is a useful bedside, clinical desk instrument. It is a very brief, relatively non-confrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present. (SAMHSA TIP 42).

Standard Assessment Tool Name	Brief Description
Circumstances, Motivation, and Readiness Scales (CMR Scales) **(Assessment/Screening)**	SAMHSA TIP 42 The instrument is designed to predict retention in tr eatment and is applicabl to both residential and outpatient treatment modalities. 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.
Clinical Institute Withdrawal Assessment (CIWA-Ar) **(Assessment/Screening)**	Converts DSMIIIR items into scores to track severity of withdrawal; measures severity of alcohol withdrawal. Aid to adjustment of care related to withdrawal severity. (SAMHSA TIP 42)
Drug Abuse Screening Test (DAST) **(Assessment/Screening)**	The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and misuse. Screening and case finding: Level of treatment and treatment/goal planning. (SAMHSA TIP 42)
Global Appraisal of Individual Needs (GAIN) or GAIN SS - Short Screener **(Assessment/Screening)**	The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling. (SAMHSA TIP 42)
Level of Care Utilization System (LOCUS) **(Assessment/Screening)**	To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time. (SAMHSA TIP 42)
Michigan Alcoholism Screening Test (MAST) **(Assessment/Screening)**	Used to screen for alcoholism with a variety of populations. (SAMHSA TIP 42)
M.I.N.I. Plus **(Assessment/Screening)**	Assists in the assessment and tracking of patients with greater efficiency and accuracy. (SAMHSA TIP 42)

Standard Assessment Tool Name	Brief Description
Psychiatric Research Interview for Substance and Mental Disorders (PRISM) **(Assessment/Screening)**	The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples. (SAMHSA TIP 42)
Readiness to Change Questionnaire **(Assessment/Screening)**	Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. (SAMHSA TIP 42)
Recovery Attitude and Treatment Evaluator (RAATE) **(Assessment/Screening)**	Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. (SAMHSA TIP 42)
Structured Clinical Interview for DSM-IV Disorders (SCID-IV) **(Assessment/Screening)**	Obtains Axis I and II diagnoses using the DSMIV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence." (SAMHSA TIP 42)
Substance Abuse Treatment Scale (SATS) **(Assessment/Screening)**	To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder. (SAMHSA TIP 42)
University of Rhode Island Change Assessment (URICA) **(Assessment/Screening)**	The URICA operationally defines four theoretical stages of change—pre-contemplation, contemplation, action, and maintenance—each assessed by eight items. (SAMHSA TIP 42)
Clinical Opiate Withdrawal Scale (COWS) **(Assessment/Screening)**	The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Assessment/Screening)	Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Promoted by SAMHSA and US Preventive Services Task Force
PHQ-A **(Assessment/Screening)**	Identifying depression in adolescents 11-17

Standard Assessment Tool Name	Brief Description
Brief Psychiatric Rating Scale (BPRS) **(Assessment/Screening)**	A rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored.
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) **(Assessment/Screening)**	Screening to detect and manage substance use and related problems in primary and general medical care settings
SOCRATES 8A(alcohol) or 8D(drugs) Stages of Change Readiness and Treatment Eagerness Scale	A 19 item instrument designed to assess readiness to change in substance users.

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

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

The chart below includes examples of evidence-based treatment protocols for patients with co-occurring disorders. The Network4Health Co-Occurring Disorders Clinical Director completed Network4Health recommended protocols for patient assessment, treatment, management and referrals for the co-occurring disorders population in December 2018. The recommendations document titled: Integrating Healthcare Delivery: Co-Occurring Disorders Treatment Considerations - Recommended Screening, Assessment, Management, Treatment, Referral and Safe Transition Protocols and Best Practices (Attachment_E4.7) has been made available to all E4 project partners. The document is also generally available on the Network4Health website at https://idn4-network4health-nh.org/co-occurring.

The table below includes recommended protocols found within the Network4Health best practices document.

Protocol Name	Brief Description	Use (Current/Under Development)
SAMHSA TIP 42, Chapter 4: Assessment	Co-occurring disorders treatment programs should provide basic assessments that cover the following: · Basic demographic and historical information, and identification of established or probable diagnoses and associated impairments · General strengths and problem areas · Stage of change or stage of treatment for both substance abuse and mental health problems · Preliminary determination of the severity of the COD as a guide to final level of care determination · Note that medical issues (including physical disability and sexually transmitted diseases), cultural issues, gender-specific and sexual orientation issues, and legal issues always must be addressed, whether basic or more comprehensive assessment is performed.	Current
Integrated Treatment for Co-Occurring Disorders (formerly IDDT) (Treatment)	Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery	Current
Multidisciplinary Team (Treatment)	The service team may include the following roles: Team Leader, Nurse, Case Manager, Employment Specialist, SA Specialist, Housing, Counselor, Criminal Justice, and Physician/Psychiatrist. 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, and motivational treatment. These interventions help consumers identify personal recovery goals.	Current
Supported Employment (Treatment)	Motivational interviewing helps consumers identify their goals for daily living, as well as strategies (activities) for achieving those goals.	Current
Assertive Community Treatment (Treatment)	Successful integrated treatment of COD programs utilize assertive outreach to keep clients engaged in relationships with service providers, family members, and friends.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Assertive Outreach (Treatment)	Service providers who utilize assertive outreach meet with consumers in community locations that are familiar to consumers, such as in their homes or at their favorite coffee shops or restaurants.	Current
Substance Abuse Counseling (Treatment)	Counseling that provides recovery skills	Current
Group Treatment (Treatment)	Research indicates that individuals with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders.	Current
Family Psychoeducation (Treatment)	Family psychoeducation fosters social support. It includes consumers, caregivers (family members and friends), and service providers in the treatment process.	Current
Pharmacological Treatment (Treatment)	Medications are effective in the treatment of persons with severe mental illness and co-occurring disorders. Medications generally include the following: Antipsychotics, Mood stabilizers and Antidepressants	Current
Medication Assisted Treatment (Treatment)	Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.	Current
Interventions to Promote Health (Treatment)	Research indicates that individuals with co-occurring disorders are at increased risk for poor health. Treatment team members encourage consumers to live healthy lifestyles	Current
Peer Supports (Management)	Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. The shared experience of being in recovery from a mental health and/or substance use condition or being a family member is the foundation on which the peer recovery support relationship is built in the behavioral health arena	Current
Self Help Groups (Management)	Self-help groups are excellent sources of social support for individuals who are motivated to achieve and maintain abstinence.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
NTOCC Elements of Excellence in Transitions of Care (TOC) Checklist (Referral and Transition Management)	http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. Every element on this checklist may not be relevant to each provider or setting.	Current
PCPI's Closed Loop Referral Toolkit (Referral)	https://cdn.ymaws.com/www.thepcpi.org/resource/resmgr/Final-CRL-Toolkit-6-19-17.pdf A tool kit to improve the referral management process between primary care and specialists.	Current

E-8. IDN Community Project Member Roles and Responsibilities

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

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

Network4Health Integrated Treatment of Co-occurring Disorders (ITCOD) Project Advisory Board: Many of the dedicated planning phase partner organizations remain as members of the ITCOD Project Advisory Board. The Project Advisory Board monitors progress on project activities, milestones and data reporting. The team also serves as 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 provides strategic input to project barriers, issues, risks and project re-alignment when required. The team now meets bi-annually to follow project progress and as needed for approval of Quality Improvement Plans.

Network4Health Dual Diagnosis Capability (DDC) Assessment Team: Network4Health developed a Dual Diagnosis Capability (DDC) Assessment Team using experienced clinical and supervisory staff members currently working within our partner organizations. Per diem members of the DDC Assessor Team include individuals who are employed by the Center for Life Management, Catholic Medical Center Behavioral Health and the Mental Health Center of Greater Manchester. The team is led by the Network4Health Co-occurring Disorders Clinical Director. As reported previously in 2017, 5 team members including the Co-occurring Disorders Clinical Director were trained as DDCAT/DDCMHT Assessors, however due to change in employment (retirement), one assessor is no longer accessible. The four remaining team members continue to work together to provide DDCAT and DDCMHT assessments to participating organizations and has been receive consultative support from the

dual diagnosis capability experts at Case Western Reserve University's Center for Evidence Based Practices throughout the Assessment and QIP Development process.

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

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

The following Network4Health ITCOD Advisory Board Members were included during the reporting period. Harry Cunningham from The Mental Health Center of Greater Manchester and a team member reported in the July 2018 SAR retired from the organization in September 2018 and requested to be removed from the Advisory Board at that time. Given his participation through September 2018, we have included him below. He will be removed in future reporting.

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

Project Team Member	Roles and Responsibilities
[redacted] Center for Life Management	Co-lead, ITCOD Project Advisory Team: See ITCOD Project Advisory Team description above. Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above DDC Primary Care and Support Team Member: See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team
[redacted] MHCGM	Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above
[redacted] MHCGM	Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above
[redacted] Catholic Medical Center (CMC)	Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted] Granite Pathways	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above. DDC Primary Care and Support Team Member: See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team
[redacted] The Upper Room	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted] Elliot Health System	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted] Parkland Medical Center	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted] Hope for NH Recovery	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.

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

A list of participants for completed trainings is included in Attachment_E4.9.

Completed Trainings

The following Network4Health trainings were completed between July 1, 2018 and December 31, 2018.

Training or Training Related Activity	Participants	Completion Progress
DDCAT/DDCMHT Assessment Capacity Development		
Deliver Up To 30 Hours DDCAT/DDCMHT Consulting (Provided by CEBP) • These hours are available to the Dual Diagnosis Capability Assessor team for support and continued learning around	1	[redacted] utilized approximately 7.5 hours of time in monthly sessions with a consultant from Case Western Reserve University.

Co-occurring Disorders Education for Primary Care Providers
 	
Every month, both hard copies and electronic links are sent to all Network4Health partners, providing access to materials and education surrounding the co-occurring population. All materials are sent out prior to the last day of the month. Materials thus far have focused on the following topics:
 	
• **July: Personality Disorders**
  ○ Fact Sheet(s): Borderline Personality Disorder and Self Harm- Brief overview(s) including symptoms, treatment and resources.
  ○ Tips for Communicating Effectively with Someone who is Experiencing Intense Emotions. Suggestions on effective communication.
  ○ Personality Disorder Resource list including videos, webcasts, articles, etc. on numerous Personality Disorders.
	Disseminated to representatives from all Network4Health partners	Completed December 2018

Co-occurring Disorders Education for Primary Care Providers
 	
• **August: Opioid Use**
  ○ Commonly Used Terms in Opioid Use Disorders: A brief list of language commonly used in the identification, treatment and management of Opioid Use Disorders.
  ○ IRETA Opioids Brochure: Brief overview of Opioid use and consequences.
  ○ Free 8 hour MAT Waiver Program: Information on free local training to be offered in September for NPs, PAs and Docs interested in becoming waivered to prescriber Buprenorphine.
  ○ Opioid Crisis by the Numbers: Overview of National Data surrounding the use and consequences of Opioid Use.
  ○ Stay Safe/Keep Safe: Guide sheet for people who inject drugs on how to keep themselves safe and maintain harm reduction strategies.
  ○ NH Guidance Document on Medication Assisted Treatment Best {Practices (April 2018): MULTIPLE TABLES/ excerpts.
  ○ What can Providers do to Help: Pocket Card to remind prescribers how to medically manage Opioid Use Disorders, and other disorders that may have historically resulted in use of Opioid medications.
  ○ Have the Conversation: Caring for People who Inject Drugs: A booklet for providers to encourage and
	Disseminated to representatives from all Network4Health partners	Completed August 2018

help them ask important questions to increase appropriate care for those who inject drugs, including harm reduction strategies.		
Co-occurring Disorders Education for Primary Care Providers • **September: Youth and Trauma** ○ Adolescent Resiliency: Article on how to recognize and build upon resiliency in the adolescent population. ○ Understanding Childhood Trauma: Facts, symptoms, resiliency tips and causes of trauma. ○ Assessment for Trauma by Parents and Caregivers: Checklist tool regarding signs of trauma in youth including referral and treatment guidance. ○ Assessment of Complex Trauma for Non-Mental Health Professionals: Checklist tool regarding signs of trauma in youth including referral and treatment guidance. ○ Understanding Refugee Trauma Series: Three versions provided- Mental Health Professionals, Primary Care Providers, and School Personnel. Includes facts, symptoms, etiology and considerations for supporting youth including individually, within a family system, and environmentally.	Disseminated to representatives from all Network4Health partners	Completed September 2018
Co-occurring Disorders Education for Primary Care Providers • **October: Wellness** ○ 8 Dimensions of Wellness poster (SAMHSA) ○ What health professionals need to know about wellness: Includes elements of wellness, why it is important and how to promote. ○ What people in recovery need to know about wellness: Includes elements of wellness, why it is important and how to increase. ○ Wellness Plan Book: *Creating a Healthier Life, a Step by Step Guide to Wellness.*	Disseminated to representatives from all Network4Health partners	Completed October 2018
Co-occurring Disorders Education for Primary Care Providers • **November: Pregnant and Parenting Women and Opioid Use** ○ Family Support Group handout: Provides state wide resources on peer support for family members who care about someone with a substance use concern. ○ CDC Guidelines and Fact Sheet on Pregnancy and Opioid Medications: CDC recommendations and suggestions for women who are pregnant and taking opioid medications, including risks to fetus.	Disseminated to representatives from all Network4Health partners	Completed November 2018

○ Pregnant Women Support poster: DHHS resources available to help pregnant women access available resources to manage substance use. ○ Pregnancy and Opioids: What families need to know about opioid misuse and treatment during pregnancy: Guide aimed at family and support people of women who are pregnant and using opioids. Includes sections on how to provide support during pre and post-natal care, build social supports, newborn health and what to expect after delivery. ○ Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants: Comprehensive guide for healthcare providers to inform and guide treatment. Includes case scenarios, fact sheets, supporting evidence and clinical action steps.		
Co-occurring Disorders Education for Primary Care Providers • **December: Peer Support** ○ Core Competencies of Peers: Description of competencies of peer level staff. ○ Peer Recovery Resource Guide: Guide to local resource for peer supports. ○ Peers Support Stigma Tip Sheet: How to identify stigma in staff and provide education regarding peer level staff within a workplace. ○ Supervising Peers: Guide for supervisors who work with peers to identify personal beliefs and biases, and increase understanding of peer roles within a workplace. ○ Peer Specialist Toolkit: How to implement, supervise and support peers in the workplace. ○ N4H ITCOD Bi-Annual Newsletter: Included is Attachment_E4.1a	Disseminated to representatives from all Network4Health partners	Completed December 2018
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course) offered for Crotched Mountain **When:** September 21 and 28, 2018 **Where:** Manchester/Wall St **Trainer:** [redacted] and [redacted]	# of Network4Health Partner Organizations: 1 # of Network4Health Participants: 11	Completed September 21 and 28, 2018
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course) **When:** September 5 and 6, 2018	# of Network4Health	Completed September 5 and 6, 2018

Where: Hillsborough County Department of Corrections **Trainer:** [redacted] and [redacted]	Partner Organizations: 1 # of Network4Health Participants: 23	
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course) **When:** November 29, 2018 **Where:** Center for Life Management **Trainer:** [redacted] and [redacted]	# of Network4Health Partner Organizations: 4 # of Network4Health Participants: 17	Completed November 29, 2018
Lunch and Learns: ASAM Criteria (two offered)	# of participating Network4Health Partner Organizations: 7 # of participants completing the series: 18	Completed October 24, 2019
Co-Occurring Disorders Trainings (two offered)	# of participating Network4Health Partner Organizations: 10 # of participants: 30	Completed August 21, 2018 and October 4, 2018
Motivational Interviewing	# of participating Network4Health Partner Organizations: 4 # of participants: 10	Completed November 1 and 2, 2018
Intro to Motivational Interviewing (QIP Activity FIT-NH)	# of participating Network4Health Partner Organizations: 1 # of participants: 29	Completed October 15 and 16, 2018

Motivational Interviewing (QIP Activity CLM)	# of participating Network4Health Partner Organizations: 1 # of participants: 31	Completed September 13, 2018
Motivational Interviewing (QIP Activity MHCGM)	# of participating Network4Health Partner Organizations: 1 # of participants: 16	Completed November 1, 2018
Motivational Interviewing for Supervisors (QIP Activity CLM)	# of participating Network4Health Partner Organizations: 1 # of participants: 17	Completed September 14, 2018
Motivational Interviewing Study Group (QIP Activity MHCGM)	# of participating Network4Health Partner Organizations: 1 # of participants: 5	Completed October 10, 2018
Stages of Change and Motivational Interviewing (QIP Activity CLM)	# of participating Network4Health Partner Organizations: 1 # of participants: 68	Completed September 28, 2018

Training Plan (Future Trainings)

In addition to our use of CEBP services, Network4Health will continue to promote and expand training services currently available within our partner organizations. The table below provides the trainings that are currently scheduled, though additional trainings may be added to support Quality Improvement Plans or identified need for our partners.

Training or Training Related Activity	Participants	Status of Scheduling	Completion By…

DDCAT/DDCMHT Assessment Capacity Development			
Deliver Up To 30 Hours DDCAT/DDCMHT Consulting (Provided by CEBP) - These hours are available to the Dual Diagnosis Capability Assessor team for support and continued learning around	Up to 5	Monthly sessions scheduled with Case Western Reserve University, Center for Evidence Based Practice Consultant	18.5 Hours used as of December 31, 2018
Quality Improvement Plan Related Trainings			
Motivational Interviewing and Stages of Change Supervisory Training (QIP Activity FIT-NH)	TBD	Scheduled: 1/10 and 1/11/19	1/10 and 1/11/19
Understanding and Treating Marijuana and Opioid Use (Pastoral Counseling Services)	TBD	Scheduled: 1/25/2019	1/25/2019
Substance Use Disorder Core Competency Topics (Center for Life Management)	TBD	To Be Scheduled	5/31/2019
Stages of Change and Motivational Interviewing Training (Pastoral Counseling Services)	TBD	To Be Scheduled	5/31/2019
Substance Use Disorder Core Competency Trainings (Pastoral Counseling Services)	TBD	To Be Scheduled	5/31/2019
Overcoming Stigma Training (Pastoral Counseling Services)	TBD	To Be Scheduled	5/31/2019
Primary Care and Support Organization Development			
Co-occurring Disorders Education for Primary Care Providers and Support Organizations • Dissemination of hard copy materials • Topics to include (but not limited to):	All primary care provider practices and support organizations	Disseminated by the last day of each month in 2019	Materials disseminated monthly on a selected topic (see list in title)

• Post-Acute Withdrawal Syndrome (PAWS), Geriatric, Vaping, Infectious Diseases, Medical Marijuana, Harm Reduction, Methamphetamines, etc.			
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course)	Up to 10 primary care or community support organizations	A minimum of 1 training will be offered each quarter starting in January 2019 To Be Scheduled	12/31/19
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 **Expected Topics include:** • **Substance Use Disorder Overview** • • **Specific Substance Use Disorders** - **Hallucinogens** - **Inhalants** • **Poverty Competency** • **Non-Suicidal Self Injury** • **Psychotropic Medications for co-occurring disorders** • **Cultural Competency with LGBTQ Community**	Up to 50 attendees	March 2019 April 2019 June 2019 August 2019 September 2019 October 2019 TBD	12/31/19
Substance Use Disorders Overview and Sedative Hypnotic Use Disorder **Substance Use Disorders Overview and Cannabis Use Disorder**	TBD TBD	February 2019 May 2019	12/31/19

NH Substance Use Disorders with Opioid Use Disorders Focus	TBD	July 2019	
Training Event Seats to support additional education of primary care and community support organizations around patients with co-occurring disorders and tools for their identification and treatment	Up to 50 seats for primary care or community support organizations	Seats will be offered through 2019 as trainings become available	12/31/19

DHHS Project Scoring: IDN Community Project Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
E -1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
E -2	IDN Community Project Workforce Staffing	Table				
E -3	IDN Community Project Evaluation Project Targets	Table				
E -4	IDN Community Project Budget	Narrative and Spreadsheet				
E -5	IDN Community Project Key Organizational and Provider Participants	Table				
E -6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
E -7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
E -8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

NETWORK 4 HEALTH

Region 4/E4 Project
FALL/WINTER 2018

Integrated Treatment of Co-Occurring Disorders (ITCOD) Newsletter

Welcome to the third 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 our community driven project that addresses Co-Occurring Disorders!

INSIDE THIS ISSUE:

Overview

1

What's happening?

2

DDC Initiatives

3-4

What's coming?

5

ITCOD 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.

It has been a busy year in Region 4!

In addition to monthly resources being provided to each partner agency on topics related to co-occurring disorders and the population that experiences them, we have offered numerous trainings to increase learning opportunities. According to a quick count, we have had over 250 people attend ITCOD sponsored trainings!

Interested in a specific topic or resource regarding co-occurring disorders? email [redacted]

Communities in Region 4:

*Atkinson *Auburn *Bedford *Candia *Chester

*Danville *Deerfield *Derry *Goffstown *Hampstead

*Hooksett *Londonderry *Salem *New Boston

*Manchester *Plaistow *Sandown *Windham

What has been happening?

Dual Diagnosis Capability Assessments

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. It turn, this will increase the availability and access to integrated care for our patients.

What: The DDCAT/DDCMHT Index is used to assess treatment agencies on their capacity to deliver services to people with co-occurring disorders. There are two versions (DDCAT/ DDCMHT) that provide program-level assessments by gathering information during a site visit including assessor team observations, interviews with staff and patients, and review of materials. This data is then used to complete ratings on 35 benchmarks regarding policy, clinical practice, and workforce domains.

Who: Mental Health or Substance Use Agencies that provide clinical treatment services to the COD population are eligible for the DDC.

What are Partners saying about their DDC experience?

"Our progress through the ITCOD project continues to help move us in the direction we have always hoped for…We are most proud of the staff that has been able to newly obtain or renew existing licensure and certification with the support of this project."

"We continue to show deep gratitude for this opportunity to not only impact our staff and provide them with more concrete tools but to enhance the work they are able to do alongside those accessing treatment and supportive services"

"We feel very fortunate to be able to take advantage of this opportunity, which will continue to help our agency grow and allow us to train staff to provide more effective and comprehensive services to clients who present with both a mental health issue and a substance use problem"

"The process has been inspiring and rejuvenating for our staff…we appreciate the leadership, support and ideas"

"Working together helps us move to a position that will best support the folks who put their trust in us during a time in their lives when they need hope in the face of a very complex problem"

Turn the page to learn more about specific ways our partners are working to improve treatment for our community members

HELPFUL ACRONYMS

SUD: Substance Use Disorder(s)

MH: Mental Health Disorder/Diagnosis

N4H: Network for Health

DDCAT: Dual Diagnosis Capability Assessment

COD: Co-Occurring Disorders

IDN: Integrated Delivery Network

MLADC: Master Level Alcohol and Drug Counselor

LADC: Licensed Alcohol and Drug Counselor

CRSW: Certified Recovery Support Worker

QIP: Quality Improvement Plan

PCS Pastoral Counseling Services

Outpatient Therapy Programs

PCS has completed a Substance Use Resource Guide, which includes the treatment centers in and around Manchester, NH and is available to both staff and clients! The guide includes information about outpatient services, intensive outpatient services, partial hospitalization programs, residential treatment programs, sober living environments, medicated assisted therapy (MAT), and additional resources.

PCS is also providing weekly MLADC supervision to four therapists who are interested in obtaining their MLADC. In addition, a monthly collaboration meeting has been developed, which allows the entire PCS staff to participate and receive consultation on clients who present with co-occurring disorders.

Coming in 2019, there will be multiple trainings scheduled for all PCS staff to increase their knowledge and skills in working with individuals that are experiencing a COD. Additionally, [redacted] and [redacted] will run a psychoeducational group for men and women who have been diagnosed with both substance use and mental health disorders!

CLM Center for Life Management

Adult Outpatient Services Program

CLM has made steady progress toward increasing staff competencies in the knowledge base of co-occurring disorders and in responding more effectively to the needs of this population. Three staff attended full week targeted trainings through AdCare Educational Institute of New England, in addition to numerous on site trainings that are being offered for the entire clinical adult team inclusive of Motivational Interviewing and Stages of Change. Supervisors and team leaders have been provided additional hours of training to strengthen on-going sustainability of these best practices.

Group supervision and collaboration for LADCs and MLADCs has increased from weekly to twice per week, encouraging more clinicians and case managers to get “on board” for this specialized licensure opportunity! CLM also now has a CRSW on-site every Friday morning to offer support, guidance, and to further connect clients and/or their family members to community resources. This addition of an on-site CRSW also serves to further educate staff on the advantages of integrating peer support in recovery efforts for better outcomes.

Family Willows Program

Families in Transition-New Horizons has been able to closely look at their Willows Substance Use Treatment Center to ensure they are providing more fidelity to evidence based co-occurring treatment. They have successfully gathered all client resources from their providers to be examined thoroughly, and allowing them to identify more comprehensive screening tools and documents to help facilitate treatment of both mental health and substance use disorders for their clients. The Willows Program has also increased client education content and availability; they are hearing from clients that the information given out has helped them access more services in the community!

Recently the staff attended a two day Motivational Interviewing and Stages of Change training conducted by the Changes Companies. They are excited about the next steps of this process which will allow all of the clinical and supportive service managers to attend two day training on Supervising using Motivational Interviewing. They are excited to continue to look at different ways to implement Stages of Change into their treatment; knowing many of the individuals and families they are serving are in different stages because of their unique circumstances.

Emergency and Interim Services, Cypress Center and Continuous Treatment Team

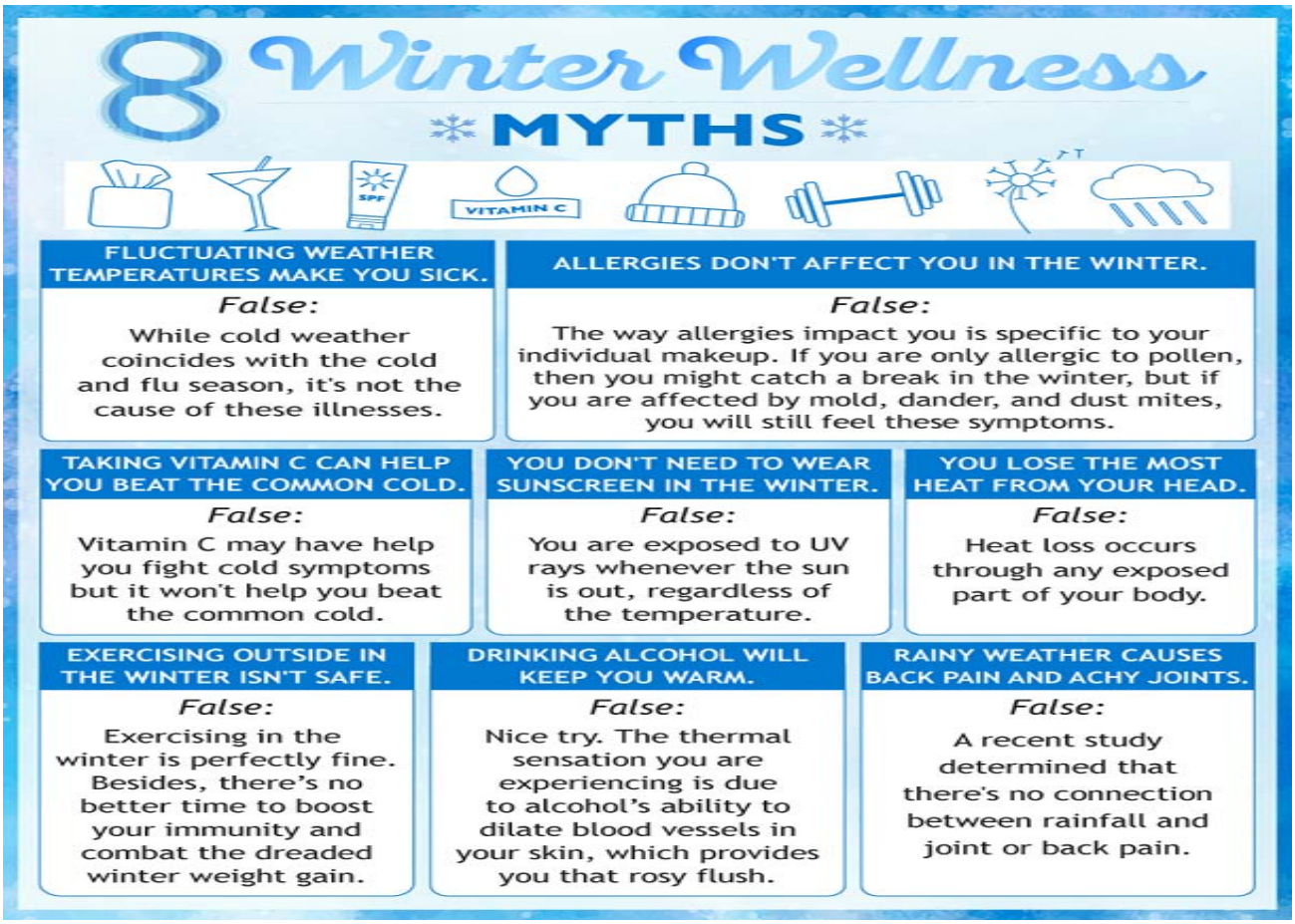
In June of 2018, a subcommittee of MHCGM's existing Substance Misuse Committee was formed to fulfill a number of targeted objectives brought forward by the ITCOD QIP through Network4Health, including reviewing and standardizing resources for staff and clients related to COD. In part, the Subcommittee reviewed existing staff resources that were stored on a network drive accessible by all staff, deciding if the resource was current, useful, and reflective of their overall mission. In addition, a guide to local resources was developed and will be available to all staff through the Staff Portal, for both staff education, and to provide to clients as well. MHCGM will be presenting at all staff meetings to notify staff about the location, accessibility and ability to add resources through a formalized process.

All location waiting room areas now contain fourteen different substance related rack cards aimed at educating and bringing awareness to clients and family members, regarding various substances that may be misused, and the potential consequences.

MHCGM is also excited to report that they currently have fourteen clinicians in the process of obtaining their MLADC. This will complement the other staff working on initial licensure as a LADC or certification as a CRSW and those who maintain an existing license!

ITCOD will continue to provide support to our partners by…

- ✓ Offering monthly education and resources related to co-occurring disorders, and the individuals and families we serve
- ✓ Completing *NEW* program site assessments with interested and applicable partner agencies to increase their capacity to provide services
- ✓ Providing targeted DDC re-assessments of the 2017/2018 agency programs, complete with additional funding to support ongoing quality improvement initiatives
- ✓ Training clinical and non-clinical staff in evidence based practices and interventions related to COD, including Mental Health First Aid, Motivational Interviewing and Stages of Change, etc.
- ✓ Offering Mental Health First Aid Training to partner agencies, including in-house trainings for correctional staff at both Hillsborough and Rockingham County House of Corrections



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E4-ITCOD-012019

	Task Name	Duration	Start	Finish	% Complete
1	**N4H: Integrated Treatment of Co-occurring Disorders Implementation**	936d	06/30/17	01/29/21	45%
2	**Workforce Plan**	126d	07/03/17	12/25/17	100%
3	Recruit N4H Co-Occurring Disorders Clinical Director	126d	07/03/17	12/25/17	100%
4	Recruit N4H DDCAT/DDCMHT Assessors	45d	07/03/17	09/01/17	100%
5	**Training Plan**	909d	07/03/17	12/24/20	63%
6	**DDCAT/DDCMHT Assessment Capacity Development**	335d	09/04/17	12/14/18	100%
7	Deliver DDCAT/DDCMHT Assessor Training	80d	09/04/17	12/22/17	100%
8	Deliver Up To 30 Hours DDCAT/DDCMHT Consulting	335d	09/04/17	12/14/18	100%
9	**Program Leader Development**	147d	09/07/17	03/30/18	100%
10	Schedule Co-Occurring Disorders Program Leader Training	79d	09/07/17	12/26/17	100%
11	Deliver Co-Occurring Disorders Program Leader Training	60d	01/08/18	03/30/18	100%
12	**Primary Care and Support Organization Development**	909d	07/03/17	12/24/20	44%
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	100%
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	100%
17	Deliver 2019 ITCOD Training for Primary Care and Support Organizations	255d	01/02/19	12/24/19	
18	Deliver 2020 ITCOD Training for Primary Care and Support Organizations	256d	01/02/20	12/24/20	
19	**DDCAT/DDCMHT Organizational Assessments**	864d	09/04/17	12/24/20	44%
20	**July - December 2017**	82d	09/04/17	12/26/17	100%
21	Deliver Up to 4 Organizational Assessments with DDC Consultants and N4H Trainees	64d	09/04/17	11/30/17	100%
22	Create Up to 4 Organizational Assessment Reports	40d	10/10/17	12/04/17	100%
23	Deliver Up to 4 Organizational Assessment Report Presentations	20d	11/07/17	12/04/17	100%
24	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	36d	11/07/17	12/26/17	100%
25	**Progress Assessment Checkpoint**	14d	11/03/17	11/22/17	100%
26	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	11/03/17	11/16/17	100%
27	Document feedback and any areas of improvement for future DDC reviews	2d	11/17/17	11/20/17	100%
28	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/21/17	11/22/17	100%
29	Gather Feedback from Assessor Trainees from Dual Diagnosis Capability Review Training and Shadowing	1d	11/03/17	11/03/17	100%
30	Document feedback and incorporate any areas of need for additional training in project schedule	5d	11/06/17	11/10/17	100%
31	**January - June 2018**	128d	01/02/18	06/28/18	100%
32	Deliver Up to 5 New Organizational Assessments (N4H Assessors)	105d	01/02/18	05/28/18	100%
33	Create Up to 5 Organizational Assessment Reports	90d	01/23/18	05/28/18	100%
34	Deliver Up to 5 Organizational Assessment Report Presentations	90d	01/23/18	05/28/18	100%
35	Create Up to 5 Dual Diagnosis Capability Quality Improvement Plans	70d	03/06/18	06/11/18	100%

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	Task Name	Duration	Start	Finish	% Complete
36	N4H ITCOD Team Approves Funding for up to 5 Organization Dual Diagnosis Capability Quality Improvement Plans	72d	03/21/18	06/28/18	100%
37	**Progress Assessment Checkpoint**	56d	04/02/18	06/18/18	100%
38	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	15d	04/02/18	04/20/18	100%
39	Modify in-progress Quality Improvement Plans (if required)	5d	04/23/18	04/27/18	100%
40	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	04/30/18	05/04/18	100%
41	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	05/30/18	06/12/18	100%
42	Document feedback and any areas of improvement for future DDC reviews	2d	06/13/18	06/14/18	100%
43	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	06/15/18	06/18/18	100%
44	**July - December 2018**	225d	07/02/18	05/10/19	86%
45	**New Organization Assessments**	225d	07/02/18	05/10/19	82%
46	Deliver Up to 3 New Organizational Assessments (N4H Assessors)	109d	07/02/18	11/29/18	100%
47	Create Up to 3 Organizational Assessment Reports	90d	07/30/18	11/30/18	100%
48	Deliver Up to 3 Organizational Assessment Report Presentations	90d	07/30/18	11/30/18	100%
49	Create Up to 3 Dual Diagnosis Capability Quality Improvement Plans	66d	12/28/18	03/29/19	40%
50	N4H ITCOD Team Approves Funding for up to 7 Organization Dual Diagnosis Capability Quality Improvement Plans	30d	04/01/19	05/10/19	0%
51	**Progress Assessment Checkpoint**	62d	09/03/18	11/27/18	100%
52	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	09/03/18	09/28/18	100%
53	Modify in-progress Quality Improvement Plans (if required)	5d	10/01/18	10/05/18	100%
54	Present to Project Advisory and Steering Committee (if funding changes needed)	1d	10/08/18	10/08/18	100%
55	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	11/06/18	11/19/18	100%
56	Document feedback and any areas of improvement for future DDC reviews	2d	11/20/18	11/21/18	100%
57	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/26/18	11/27/18	100%
58	**January - December 2019**	255d	01/02/19	12/24/19	
59	**New Organization Assessments**	255d	01/02/19	12/24/19	
60	Deliver Up to 2 New Organizational Assessments (N4H Assessors)	225d	01/02/19	11/12/19	
61	Create Up to 2 Organizational Assessment Reports	190d	03/13/19	12/03/19	
62	Deliver Up to 2 Organizational Assessment Report Presentations	175d	04/03/19	12/03/19	
63	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	165d	04/17/19	12/03/19	
64	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plans	170d	05/01/19	12/24/19	
65	**12 month Organization Re-assessments**	255d	01/02/19	12/24/19	
66	Deliver Up to 5 Organizational Re-assessments (N4H Assessors)	230d	01/02/19	11/19/19	
67	Create Up to 5 Organizational Re-assessment Reports	190d	03/20/19	12/10/19	
68	Deliver Up to 5 Organizational Re-assessment Report Presentations	175d	04/10/19	12/10/19	
69	Create Up to 5 Dual Diagnosis Capability Quality Improvement Plan UPDATES	165d	04/24/19	12/10/19	
70	N4H ITCOD Team Approves Funding for up to 5 Organization Dual Diagnosis Capability QIP Updates	170d	05/01/19	12/24/19	
71	**Progress Assessment Checkpoint**	128d	05/20/19	11/13/19	

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	Task Name	Duration	Start	Finish	% Complete
72	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	05/20/19	06/14/19	
73	Modify in-progress Quality Improvement Plans (if required)	20d	06/18/19	07/15/19	
74	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	07/16/19	07/22/19	
75	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	10/25/19	11/07/19	
76	Document feedback and any areas of improvement for future DDC reviews	2d	11/08/19	11/11/19	
77	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/12/19	11/13/19	
78	**January - December 2020**	254d	01/06/20	12/24/20	
79	**New Organization Assessments**	254d	01/06/20	12/24/20	
80	Deliver Up to 2 New Organizational Assessments (N4H Assessors)	225d	01/06/20	11/13/20	
81	Create Up to 2 Organizational Assessment Reports	190d	03/16/20	12/04/20	
82	Deliver Up to 2 Organizational Assessment Report Presentations	175d	04/06/20	12/04/20	
83	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	165d	04/20/20	12/04/20	
84	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plans	179d	04/20/20	12/24/20	
85	**12 month Organization Re-assessments**	254d	01/06/20	12/24/20	
86	Deliver Up to 14 Organizational Re-assessments (N4H Assessors)	225d	01/06/20	11/13/20	
87	Create Up to 14 Organizational Re-assessment Reports	190d	03/16/20	12/04/20	
88	Deliver Up to 14 Organizational Re-assessment Report Presentations	175d	04/06/20	12/04/20	
89	Create Up to 14 Dual Diagnosis Capability Quality Improvement Plan UPDATES	165d	04/20/20	12/04/20	
90	N4H ITCOD Team Approves Funding for up to 14 Organization Dual Diagnosis Capability QIP Updates	179d	04/20/20	12/24/20	
91	**Progress Assessment Checkpoint**	136d	05/04/20	11/09/20	
92	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	05/04/20	05/29/20	
93	Modify in-progress Quality Improvement Plans (if required)	20d	06/02/20	06/29/20	
94	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	06/30/20	07/06/20	
95	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	10/21/20	11/03/20	
96	Document feedback and any areas of improvement for future DDC reviews	2d	11/04/20	11/05/20	
97	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/06/20	11/09/20	
98	**ITCOD Practice Improvement Community Meetings (Bi-Yearly)**	780d	01/01/18	12/25/20	33%
99	Jan - June 2018 ITCOD Practice Improvement Community Meeting	128d	01/01/18	06/27/18	100%
100	July - Dec 2018 ITCOD Practice Improvement Community Meeting	126d	07/02/18	12/24/18	100%
101	Jan - June 2019 ITCOD Practice Improvement Community Meeting	128d	01/01/19	06/27/19	
102	July - Dec 2019 ITCOD Practice Improvement Community Meeting	128d	07/01/19	12/25/19	
103	Jan - June 2020 ITCOD Practice Improvement Community Meeting	129d	01/01/20	06/29/20	
104	July - Dec 2020 ITCOD Practice Improvement Community Meeting	128d	07/01/20	12/25/20	
105	**ITCOD E-Newsletters (Bi-Yearly)**	865d	09/01/17	12/24/20	43%
106	Create July - December 2017 ITCOD E-Newsletter to Network 4 Health Participants	82d	09/01/17	12/25/17	100%
107	Create Jan - June 2018 ITCOD E-Newsletter to Network 4 Health Participants	85d	03/01/18	06/27/18	100%

Attachment_E4.1b

	Task Name	Duration	Start	Finish	% Complete
108	Create July - December 2018 ITCOD E-Newsletter to Network 4 Health Participants	83d	09/03/18	12/26/18	100%
109	Create Jan - June 2019 ITCOD E-Newsletter to Network 4 Health Participants	84d	03/04/19	06/27/19	
110	Create July - December 2019 ITCOD E-Newsletter to Network 4 Health Participants	84d	09/02/19	12/26/19	
111	Create Jan - June 2020 ITCOD E-Newsletter to Network 4 Health Participants	85d	03/02/20	06/26/20	
112	Create July - December 2020 ITCOD E-Newsletter to Network 4 Health Participants	83d	09/01/20	12/24/20	
113	**Evaluation Metrics Reporting (Data)**	935d	07/03/17	01/29/21	57%
114	**July - December 2017**	152d	07/03/17	01/30/18	100%
115	Select data collection tool(s)	64d	07/03/17	09/28/17	100%
116	Implement data collection tool for July - December 2017 Assessment Organizations (post assessment)	62d	10/02/17	12/26/17	100%
117	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	22d	01/01/18	01/30/18	100%
118	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	22d	01/01/18	01/30/18	100%
119	Report # of organizations assessed by DDCAT or DDCMHT index	22d	01/01/18	01/30/18	100%
120	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	22d	01/01/18	01/30/18	100%
121	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	22d	01/01/18	01/30/18	100%
122	**January - June 2018**	128d	02/01/18	07/30/18	100%
123	Implement data collection tool for Jan - June 2018 Assessment Organizations	106d	02/01/18	06/28/18	100%
124	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	21d	07/02/18	07/30/18	100%
125	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	07/02/18	07/30/18	100%
126	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	21d	07/02/18	07/30/18	100%
127	Report # of organizations assessed by DDCAT or CCMHT index	21d	07/02/18	07/30/18	100%
128	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	07/02/18	07/30/18	100%
129	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	21d	07/02/18	07/30/18	100%
130	**July - December 2018**	132d	08/01/18	01/31/19	100%
131	Implement data collection tool for July - December 2018 Assessment Organizations (post assessment)	105d	08/01/18	12/25/18	100%
132	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	23d	01/01/19	01/31/19	100%
133	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	23d	01/01/19	01/31/19	100%
134	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/19	01/31/19	100%
135	Report # of organizations assessed by DDCAT or CCMHT index	23d	01/01/19	01/31/19	100%
136	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	23d	01/01/19	01/31/19	100%
137	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	23d	01/01/19	01/31/19	100%
138	**January - December 2019**	23d	01/01/20	01/31/20	
139	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	23d	01/01/20	01/31/20	
140	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	23d	01/01/20	01/31/20	
141	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/20	01/31/20	
142	Report # of organizations assessed by DDCAT or CCMHT index	23d	01/01/20	01/31/20	
143	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	23d	01/01/20	01/31/20	
144	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	23d	01/01/20	01/31/20	

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	Task Name	Duration	Start	Finish	% Complete
145	**January - December 2020**	283d	01/01/20	01/29/21	
146	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	21d	01/01/21	01/29/21	
147	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	01/01/21	01/29/21	
148	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/20	01/31/20	
149	Report # of organizations assessed by DDCAT or CCMHT index	21d	01/01/21	01/29/21	
150	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	01/01/21	01/29/21	
151	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	21d	01/01/21	01/29/21	
152	**Process Milestones by Reporting Period**	914d	06/30/17	12/31/20	20%
153	**Period ending June 30, 2017**	0	06/30/17	06/30/17	100%
154	Develop Implementation Plan	0	06/30/17	06/30/17	100%
155	Create Implementation Schedule/Timeline	0	06/30/17	06/30/17	100%
156	Create Budget	0	06/30/17	06/30/17	100%
157	Create Workforce Plan	0	06/30/17	06/30/17	100%
158	Create Training Plan	0	06/30/17	06/30/17	100%
159	Vendor Selection for Dual Diagnosis Capability Assessments	0	06/30/17	06/30/17	100%
160	Participant Selection through 12/31/17	0	06/30/17	06/30/17	100%
161	Organizational Leadership Sign-off	0	06/30/17	06/30/17	100%
162	**July - December 2017**	85d	09/01/17	12/29/17	100%
163	Recruit N4H DDCAT/DDCMHT Assessors (Workforce Plan)	0	09/01/17	09/01/17	100%
164	Complete Schedule for July - December 2017 Dual Diagnosis Capability Organizational Assessments	0	09/15/17	09/15/17	100%
165	Complete up to 4 Dual Diagnosis Capability Organizational Assessments	0	12/04/17	12/04/17	100%
166	Deliver DDCAT/DDCMHT Assessor Training (Training Plan)	0	12/27/17	12/27/17	100%
167	Recruit N4H Co-Occurring Disorders Clinical Director (Workforce Plan)	0	12/29/17	12/29/17	100%
168	Schedule Co-occurring Disorders Program Leaders Training (Training Plan)	0	12/29/17	12/29/17	100%
169	Complete up to 1 Dual Diagnosis Capability Quality Improvement Plan	0	12/29/17	12/29/17	100%
170	Define 2018 ITCOD Training Program for Primary Care and Support Organizations	0	12/29/17	12/29/17	100%
171	Deliver ITCOD e-Newsletter	0	12/29/17	12/29/17	100%
172	**January - June 2018**	73d	03/19/18	06/28/18	100%
173	Complete Schedule for January - June 2018 Dual Diagnosis Capability Organizational Assessments	0	03/19/18	03/19/18	100%
174	Deliver Co-Occurring Disorders Program Leader Training	0	03/30/18	03/30/18	100%
175	Complete up to 5 Dual Diagnosis Capability Organizational Assessments	0	05/29/18	05/29/18	100%
176	Complete up to 5 Dual Diagnosis Capability Quality Improvement Plans	0	06/12/18	06/12/18	100%
177	Complete Jan - June 2018 ITCOD Practice Improvement Community Meeting	0	06/28/18	06/28/18	100%
178	Deliver ITCOD e-Newsletter	0	06/28/18	06/28/18	100%
179	**July - December 2018**	346d	09/01/17	12/31/18	0%
180	Complete Schedule for Jul - Dec 2018 Dual Diagnosis Capability Organizational Assessments	0	09/01/17	09/01/17	100%

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	Task Name	Duration	Start	Finish	% Complete
181	Complete up to 3 Dual Diagnosis Capability Organizational Assessments	0	12/05/18	12/05/18	100%
182	Complete up to 2 Dual Diagnosis Capability Organizational Re-assessments	0	12/05/18	12/05/18	0%
183	Complete up to 7 Quality Improvement Plans	0	12/14/18	12/14/18	0%
184	Complete up to 2 Dual Diagnosis Capability QIP UPDATES	0	12/14/18	12/14/18	0%
185	Deliver 2018 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/18	12/31/18	100%
186	Define 2019 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/18	12/31/18	100%
187	Complete July - Dec 2018 ITCOD Practice Improvement Community Meeting	0	12/31/18	12/31/18	100%
188	Deliver ITCOD e-Newsletter	0	12/31/18	12/31/18	100%
189	**January - December 2019**	151d	06/03/19	12/31/19	
190	Deliver 2019 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/19	12/31/19	
191	Define 2020 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/19	12/31/19	
192	Jan-Dec 2019 Dual Diagnosis Capability Organizational Assessments SCHEDULED	0	06/03/19	06/03/19	
193	Complete up to 2 NEW Dual Diagnosis Capability Organizational Assessments	0	12/09/19	12/09/19	
194	Complete up to 2 NEW Quality Improvement Plans	0	12/09/19	12/09/19	
195	Complete up to 12 Dual Diagnosis Capability Organizational Re-assessments	0	12/16/19	12/16/19	
196	Complete up to 12 Dual Diagnosis Capability QIP UPDATES	0	12/16/19	12/16/19	
197	Complete Jan - June 2019 ITCOD Practice Improvement Community Meeting	0	06/28/19	06/28/19	
198	Complete July - Dec 2019 ITCOD Practice Improvement Community Meeting	0	12/31/19	12/31/19	
199	Deliver ITCOD e-Newsletter (Jan - Jun 2019)	0	06/28/19	06/28/19	
200	Deliver ITCOD e-Newsletter (July - Dec 2019)	0	12/31/19	12/31/19	
201	**January - December 2020**	153d	06/01/20	12/31/20	
202	Complete Schedule for Jan-Dec 2020 Dual Diagnosis Capability Organizational Assessments	0	06/01/20	06/01/20	
203	Deliver ITCOD e-Newsletter (Jan - Jun 2020)	0	06/29/20	06/29/20	
204	Complete Jan - June 2020 ITCOD Practice Improvement Community Meeting	0	06/30/20	06/30/20	
205	Complete up to 2 NEW Dual Diagnosis Capability Organizational Assessments	0	12/10/20	12/10/20	
206	Complete up to 2 NEW Quality Improvement Plans	0	12/10/20	12/10/20	
207	Complete up to 14 Dual Diagnosis Capability Organizational Re-assessments	0	12/10/20	12/10/20	
208	Complete up to 14 Dual Diagnosis Capability QIP UPDATES	0	12/10/20	12/10/20	
209	Deliver ITCOD e-Newsletter (July - Dec 2020)	0	12/30/20	12/30/20	
210	Complete July - Dec 2020 ITCOD Practice Improvement Community Meeting	0	12/31/20	12/31/20	
211	Deliver 2020 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/20	12/31/20	

Integrating Healthcare Delivery: Co-Occurring Disorders Treatment Considerations

Recommended Screening, Assessment, Management, Treatment, Referral and Safe Transition Protocols and Best Practices

This document provides Network4Health recommendations for the following protocols and best practices:

- Screening and Assessment Protocols for Co-occurring Disorders Treatment Programs
- Management and Treatment for Co-occurring Disorders Treatment Programs
- Referral from a Co-occurring Disorders Treatment Program
- Referral and Transition Management to a Co-occurring Disorders Treatment Program from another program or agency

Screening and Assessment Protocols for Co-occurring Disorders Treatment Programs

Network4Health recommends that programs providing integrated treatment of mental health and substance use disorders (co-occurring disorders treatment programs) align their screening and assessment protocols with the recommendations found in TIP 42: Substance Abuse Treatment for persons with Co-occurring Disorders provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), see Source link below.

Screening

Network4Health recommends that co-occurring disorders treatment programs align their screening protocols with the recommendations found in SAMHSA's TIP 42, Chapter 4, page 66: Screening. As described in this section "The screening process for COD seeks to answer a "yes" or "no" question: Does the substance abuse (or mental health) client being screened show signs of a possible mental health (or substance abuse) problem?" Network4Health also supports the SAMHSA recommendation that screening protocols "indicate what constitutes scoring positive for a particular possible problem (often called "establishing cut-off scores")" and "the screening protocol details exactly what takes place after a client scores in the positive range".

A list of evidence based screening tools approved by Network4Health can be found in the Screening and Assessment Tools section below.

Assessment

At minimum and as described in Chapter 4 of TIP 42, co-occurring disorders treatment programs should provide basic assessments that cover the following:

- Basic demographic and historical information, and identification of established or probable diagnoses and associated impairments
- General strengths and problem areas
- Stage of change or stage of treatment for both substance abuse and mental health problems
- Preliminary determination of the severity of the COD as a guide to final level of care determination
- Note that medical issues (including physical disability and sexually transmitted diseases), cultural issues, gender-specific and sexual orientation issues, and legal issues always must be addressed, whether basic or more comprehensive assessment is performed.

As co-occurring disorders treatment programs increase skill and capacity, they will move along the dual diagnosis capability continuum and should strive to evolve their assessment protocol as described on page 68 of SAMHSA's TIP 42, Chapter 4.

Finally Network4Health also recommends that programs implement assessment protocols that allow for the continuous collection and revision of assessment information as a patient moves through recovery, as recommended by SAMHSA in TIP 42.

A list of evidence based assessment tools approved by Network4Health can be found in the Screening and Assessment Tools section below.

Screening and Assessment Tools

Per page 69 of SAMHSA's TIP 42, "There is no single gold standard assessment tool for COD." Network4Health recommends that organizations select evidence based screening and assessment tools appropriate to your workflows and agency staff. Network4Health currently recommends use of any of the following screening and assessment tools. These tools will be updated as research evolves around the treatment of patients with co-occurring disorders.

Standard Assessment Tool Name	Brief Description

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

Standard Assessment Tool Name	Brief Description
Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index **Organizational Assessment Tool**	Similar to the DDCAT, the DDCMHT index is designed to determine how effectively mental health treatment programs provide services for patients with co-occurring substance use disorders. The DDCMHT utilizes the same 35 items across the 7 domains described above for DDCAT and organizations are scored across the following continuum of capability. • Mental-health-only services (MHOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE)
The Mental Health Screening Form-III (Assessment/Screening)	Screening assessment for clients seeking SUD treatment to identify any co-occurring disorders. (SAMHSA TIP 42)
Simple Screening Instrument for Substance Abuse (SSI-SA) **(Assessment/Screening)**	Designed for use within a clinical setting for clients receiving or seeking treatment and for administration and use under the standard conditions found in most substance abuse and/or mental health clinics. (SAMHSA TIP 42)
PHQ-9 Depression Screening **(Assessment/Screening)**	The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
PHQ-2 Depression Screening **(Assessment/Screening)**	The PHQ-2, comprising the first 2 items of the PHQ-9, inquires about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.
Generalized Anxiety Disorder Screening (GAD 7) **(Assessment/Screening)**	Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (GAD).
Addiction Severity Index (ASI) **(Assessment/Screening)**	The ASI is a general screening tool used extensively for treatment planning and outcome evaluation. (SAMHSA TIP 42)

Standard Assessment Tool Name	Brief Description
Alcohol Use Disorders Identification Test (AUDIT) **(Assessment/Screening)**	The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health. The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. (SAMHSA TIP 42)
Beck Depression Inventory–II (BDI–II) **(Assessment/Screening)**	Used to screen for the presence and rate the severity of depression symptoms. The BDI–II consists of 21 items to assess the intensity of depression. The BDIII can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. (SAMHSA TIP 42)
CAGE and CAGE-AID **Questionnaire** **(Assessment/Screening)**	The purpose of the CAGE Questionnaire is to detect alcoholism. CAGE-AID detects alcoholism and drug use. The CAGE Questionnaire is a useful bedside, clinical desk instrument. It is a very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present. (SAMHSA TIP 42).
Circumstances, Motivation, and Readiness Scales (CMR Scales) **(Assessment/Screening)**	SAMHSA TIP 42 The instrument is designed to predict retention in treat ment and is applicabl to both residential and outpatient treatment modalities. 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.

Standard Assessment Tool Name	Brief Description
Clinical Institute Withdrawal Assessment (CIWA-Ar) **(Assessment/Screening)**	Converts DSMIIIR items into scores to track severity of withdrawal; measures severity of alcohol withdrawal. Aid to adjustment of care related to withdrawal severity. (SAMHSA TIP 42)
Drug Abuse Screening Test (DAST) **(Assessment/Screening)**	The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and mis-use. Screening and case finding: Level of treatment and treatment/goal planning. (SAMHSA TIP 42)
Global Appraisal of Individual Needs (GAIN) or GAIN SS - Short Screener **(Assessment/Screening)**	The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling. (SAMHSA TIP 42)
Level of Care Utilization System (LOCUS) **(Assessment/Screening)**	To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time. (SAMHSA TIP 42)
Michigan Alcoholism Screening Test (MAST) **(Assessment/Screening)**	Used to screen for alcoholism with a variety of populations. (SAMHSA TIP 42)
M.I.N.I. Plus **(Assessment/Screening)**	Assists in the assessment and tracking of patients with greater efficiency and accuracy. (SAMHSA TIP 42)
Psychiatric Research Interview for Substance and Mental Disorders (PRISM) **(Assessment/Screening)**	The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples. (SAMHSA TIP 42)
Readiness to Change Questionnaire **(Assessment/Screening)**	Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. (SAMHSA TIP 42)

Standard Assessment Tool Name	Brief Description
Recovery Attitude and Treatment Evaluator (RAATE) **(Assessment/Screening)**	Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. (SAMHSA TIP 42)
Structured Clinical Interview for DSM-IV Disorders (SCID-IV) **(Assessment/Screening)**	Obtains Axis I and II diagnoses using the DSMIV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence." (SAMHSA TIP 42)
Substance Abuse Treatment Scale (SATS) **(Assessment/Screening)**	To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder. (SAMHSA TIP 42)
University of Rhode Island Change Assessment (URICA) **(Assessment/Screening)**	The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items. (SAMHSA TIP 42)
Clinical Opiate Withdrawal Scale (COWS) **(Assessment/Screening)**	The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Assessment/Screening)	Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Promoted by SAMHSA and US Preventive Services Task Force
PHQ-A **(Assessment/Screening)**	Identifying depression in adolescents 11-17
Brief Psychiatric Rating Scale (BPRS) **(Assessment/Screening)**	A rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored.

Standard Assessment Tool Name	Brief Description
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) **(Assessment/Screening)**	Screening to detect and manage substance use and related problems in primary and general medical care settings
Comprehensive Addictions And Psychological Evaluation-5 (CAAPE-5)	The CAAPE-5 is a comprehensive diagnostic assessment interview providing documentation for substance-specific diagnoses based on DSM-5 criteria.
SOCRATES 8A(alcohol) or 8D(drugs) Stages of Chain Readiness and Treatment Eagerness Scale	A 19 item instrument designed to assess readiness to change in substance users.

Sources:

SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders; https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

Management and Treatment Protocols for a Co-occurring Disorders Treatment Programs

Network4Health recommends any of the below evidence based protocols for the treatment or management of patients with co-occurring mental health and substance use disorders.

Protocol Name	Brief Description
Integrated Treatment for Co-Occurring Disorders (formerly IDDT) **(Management and 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
Multidisciplinary Team **(Treatment)**	The service team may include the following roles: Team Leader, Nurse, Case Manager, Employment Specialist, SA Specialist, Housing, Counselor, Criminal Justice, and Physician/Psychiatrist. The list is not exclusive and may include additional roles as required for a client.
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
Motivational Interventions **(Treatment)**	Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment. These interventions help consumers identify personal recovery goals.

Protocol Name	Brief Description
Supported Employment (Treatment)	Motivational interviewing helps consumers identify their goals for daily living, as well as strategies (activities) for achieving those goals.
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.
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.
Substance Abuse Counseling (Treatment)	Counseling that provides recovery skills
Group Treatment (Treatment)	Research indicates that individuals with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders.
Self Help Groups (Management)	Self-help groups are excellent sources of social support for individuals who are motivated to achieve and maintain abstinence.
Family Psychoeducation (Treatment)	Family psychoeducation fosters social support. It includes consumers, caregivers (family members and friends), and service providers in the treatment process.
Pharmacological Treatment (Treatment)	Medications are effective in the treatment of persons with severe mental illness and co-occurring disorders. Medications generally include the following: Antipsychotics, Mood stabilizers and Antidepressants
Medication Assisted Treatment (Treatment)	Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.
Interventions to Promote Health (Treatment)	Research indicates that individuals with co-occurring disorders are at increased risk for poor health. Treatment team members encourage consumers to live healthy lifestyles
Peer Supports (Management)	Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. The shared experience of being in recovery from a mental health and/or substance use condition or being a family member is the foundation on which the peer recovery support relationship is built in the behavioral health arena

Referral from a Co-occurring Disorders Treatment Program

Network4Health recommends that programs providing integrated treatment of mental health and substance use disorders (co-occurring disorders treatment programs) align their referral protocols with the recommendations found in TIP 42: Substance Abuse Treatment for persons with Co-occurring Disorders

provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), see Source link below.

In particular, Network4Health recommends that organizations review and align with the information found on page 138, Essential Programming for Clients With COD: Screening, Assessment, and Referral:

> "If the screening and assessment process establishes a substance abuse or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of persons with COD."

Additionally, organizations may wish to review and align with the recommendations on page 508: Referral Issues.

Sources:

SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders; https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

Referral and Transition Management to a Co-occurring Disorders Treatment Program from another program or agency

Successful referrals and transitions for individuals with co-occurring mental health and substance use disorders, be it from the inpatient, addiction treatment, mental health treatment or primary care setting, need to address the needs and goals of both the patient/client and identified by the provider. In accordance with SAHMSA best practices, ideally, referrals made will be to organizations/programs that offer evidence based treatment services to individuals with co-occurring disorders. The organization/programs should support the use of a recovery philosophy (vs. symptom remission only) for both substance use as well as mental health disorders.
Key to successful referrals are:

- Understanding an individual's readiness for change and motivation to change both mental health and addiction issues
- The [provider's/ treatment site's] ability to providing care for individuals with co-occurring disorders who present with mental health symptoms, and if not, can systematically make appropriate referrals to providers/programs that can address the individual's needs
- Including an equivalent focus on needed follow-up services for **both** mental health and substance use disorders

A patient may have a very satisfying encounter with a Mental Health(MH) or Substance Use Disorder(SUD) provider or specialist, but if a PCP fails to send relevant information or the MH/SUD

provider or specialist fails to communicate with the referring provider, care for that patient or others with similar problems may well suffer.

Network4Health recommends aligning referral and transitions management protocols with the following NTOCC Elements of Excellence in Transitions of Care (TOC) TOC Checklist. NH's 1115 waiver requirements, particularly the comprehensive core assessment (CCSA) address many of the NTOCC Elements of Excellence, which include the following:

1. **All members of the multi-disciplinary care team–including patients and their family caregivers–need access to key pieces of information in order to make transitions of care smooth, safe, and effective. NTOCC has described several steps that are critical to achieving this kind of information sharing:**
   • Improve communication during transitions between providers, patients, family caregivers and community supports;
   • Develop standardized processes for medication reconciliation and care coordination;
   • Establish accountability for sending, receiving and acting upon information necessary for safe, effective transitions of care;
   • Increase the use of case management and professional care coordination;
   • Expand the role of the pharmacist in medication reconciliation in transitions of care;
   • Develop performance measures to encourage better transitions of care; and
   • Implement payment systems that align incentives.
   Note: NTOCC believes that for HIT to make a difference in transitions of care, the technology must address each of these critical steps. Without addressing each step, the promise of HIT's affect on overall transition of care improvement will not be realized.
2. **Standardized Processes and Performance Goals Related to Transitions of Care** While some elements of facilitating care transitions might best be left to individual providers to design, the safety and effectiveness of care transitions requires some degree of standardization among providers to ensure the completion of critical activities common to all transitions of care. At a very basic level, there should be a list of key pieces of information to be conveyed to the next care site for every care transition. These standardized processes can be used to develop measures that will indicate provider performance in facilitating safe, effective transitions of care. Ultimately, there should be cross- cutting measures to indicate better outcomes resulting from better coordination among providers during a care transition.
3. **To ensure safe care transitions, standard transition processes must be in place.** Unfortunately, standard processes are generally lacking in rigor, do not include

policies and procedures to make processes enforceable, and simply are not rewarded. Medication reconciliation is one such task that is critical to safe transitions. Medication reconciliation is the process of creating the most current, complete, and accurate list possible of a patient's medications, comparing that list against other medication lists at transitions in care, and resolving any discrepancies. Medication reconciliation can be assessed as a static event (i.e., performance documentation by signature and completion of a medication reconciliation form) and by detecting errors that occurred during the process (i.e., medication discrepancies resolved). These processes address the Joint Commission's National Patient Safety Goal on medication reconciliation.

4. **Expand the Role of the Pharmacist in Transitions of Care** - Many transition of care problems relate to the safe and effective use of medications. HIT has the potential to reduce the rate of medication related problems and improve the rate and accuracy of reconciled medication lists between providers. Pharmacists have an integral part in establishing a smooth transition of care and can provide expertise in a patient's drug therapy regimen. Case managers can help patients navigate to community pharmacists for optimal medication management that can assist prescribers and patients managing complex medication schedules. Appropriate medication management promotes medication compliance and helps avoid unnecessary health care utilization.

Elements of Excellence in Transitions of Care (TOC) Checklist

*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and

other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. **Every element on this checklist may not be relevant to each provider or setting.**

*For purposes of brevity, the term patient/client is used throughout this checklist to describe the client and client system (or patient and family). The patient/client system (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client's informal support network. Depending on the setting in which this checklist is used, providers may wish to substitute resident, consumer, beneficiary, individual, or other terms for patient/client.

Overarching Concepts

Engagement

- Maximize patient/client involvement in all phases of intervention by promoting self-determination and informed decision-making.
- Provide educational information to support the patient/client's participation in the plan of care.
- Protect patient/client's right to privacy and safeguard confidentiality when releasing patient/client information.
- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess and promote the patient/client's efforts to participate in the plan of care.

Collaboration

- Define multidisciplinary team participants.
- Build relationships with all team members, with the patient/client at the center of the collaborative model.
- Communicate with other professionals and organizations, delineating respective responsibilities.
- Create awareness of patient/client and provider accountability for receiving and sending patient/client care information to and from care settings. • Provide services within the bounds of professional competency and refer patient/client as needed.

Strengths-based assessment

- Use respect and empathy in patient/client interactions.
- Recognize patient/client's strengths and use those abilities to effect change.
- Help patient/client use effective coping skills and insights to manage current crises.

- Recognize and help resolve patient/client's difficulties.
- Distinguish cultural norms and behaviors from challenging behaviors

Assessment as an ongoing process

- Keep assessments flexible, varying with presenting problem or opportunity.
- Regularly reassess patient/client's needs and progress in meeting objectives.
- Facilitate goal-setting discussion based upon the patient/client's needs during all phases of care.
- Assess effectiveness of interventions in achieving patient/client's goals.
- Communicate changes in assessment and care plan to the health care team.

Common Elements for Assessment and Intervention

- Assess patient/client's understanding of diagnosis, treatment options, and prognosis.
- Evaluate patient/client's life care planning and advance directive status.
- Evaluate impact of illness, injury, or treatments on physical, psychosocial, and sexual functioning.
- Evaluate patient/client's ability to return to or exceed pre-illness or pre-injury function level. Psychosocial functioning
- Assess past and current mental health, emotional, cognitive, social, behavioral, or substance use/abuse concerns that may affect adjustment to illness and care management needs.
- Assess effect of medical illness or injury on psychological, emotional, cognitive, behavioral, and social functioning.
- Determine with patient/client which psychosocial services are needed to maximize coping.

Cultural factors

- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess cultural values and beliefs, including perceptions of illness, disability, and death.
- Use the patient/client's values and beliefs to strengthen the support system.
- Understand traditions and values of patient/client groups as they relate to health care and decisionmaking. Health literacy and linguistic factors
- Provide information and services in patient/client's preferred language, using translation services and interpreters.
- Use effective tools to measure patient/client's health literacy.
- Provide easy-to-understand, clinically appropriate material in layperson's language.
- Use graphic representations for patients/clients with limited language proficiency or literacy.
- Check to ensure accurate communication using teach-back methods.
- Develop educational plan based upon patient/client's identified needs.

- Evaluate caregiver's capacity to understand and apply health care information in assisting patient/client.

Financial factors

- Identify patient/client's access to, type of, and ability to navigate health insurance.
- Identify patient/client's access to and ability to navigate prescription benefits.
- Evaluate impact of illness on financial resources and ability to earn a living wage.
- Provide feedback on financial impact of treatment options.
- Educate patient/client about benefit options and how to access available resources.
- Assess barriers to accessing care and identify solutions to ensure access.

Spiritual and religious functioning

- Assess how patient/client finds meaning in life.
- Assess how spirituality and religion affect adaptation to illness.

Physical and environmental safety

- Evaluate patient/client's ability to perform activities of daily living and meet basic needs
- Assess environmental barriers that may compromise the patient/client's ability to meet established treatment goals.
- Determine with patient/client the appropriate level of care.
- Assess ability of family or other informal caregivers to assist patient/client.
- Assess for risk of harm to self or others.

Family and community support

- Identify patient/client's formal and informal support systems.
- Assess how patient/client's illness affects family structure and roles.
- Provide support to family members and other informal caregivers.
- Assess for, and if appropriate help resolve, conflicts within the family.
- Evaluate risk of physical, emotional, or financial abuse or neglect, referring to community social services as needed.

Assessment of medical issues

- Patient/client diagnosis
- Symptoms
- Medication list and reconciliation of new medications throughout treatment
- Adherence assessment and intention
- Substance use and abuse disorders
- Lab tests, consultations, x-rays, and other relevant test results

Continuity/Coordination or Care Communication

- Specific clinical providers
- Date information sent to referring physician, PCP, or other clinical providers

- Necessary follow-up care

Source: (**http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf**)

Institute of Medicine (IOM)

Network4Health also recommends aligning all patient referrals and transitions management protocols with the six Institute of Medicine (IOM) aims of high-quality health care :

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

Timely communication

Network4Health recommends the following protocols regarding timely communication and closed loop referrals.

Time Stratified Referrals

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

Referral Type

Based on urgency of care required, the referral can be marked as:

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

Appointment Scheduling

The patient/client is scheduled for an appointment with the office schedules per type of referral and patient/client preference

Closing the Loop

Once the patient/client is seen by the provider referred to, the provider sends the visit note to the referring provider with the clinical issue answered within one week of the appointment.

No Shows

If the patient/client doesn't show up as per the scheduled appointment, the provider referred to marks it as one of the following and sends it back to the referring provider:

No Show – Priority Referral (within 14 days)
No Show – Routine Referral (within 28 days)

Delayed referral timing due to:

- Delayed Priority Referral – Patient/client preference
- Delayed Routine Referral – Patient/client preference

Mutual Agreement for Referral Management

- Review the level of care tables and determine which services you can provide.
- The Mutual Agreement section of the tables reflects the core element of integrated care (aligning with PCMH) and outline expectations from both primary care and mental health care providers.
- The Expectations section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement.
- The Additional Agreements/Edits section provides an area to add, delete, or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.

- When patients/clients self-refer to primary care or mental health provider, processes should be in place to determine the patient's overall needs and reintegrate further care with the primary care or mental health provider, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements necessary to provide timely and necessary medical care to the patient/client.
- Each provider should agree to open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- **Optimally, this agreement should be reviewed every year.**
- Source: https://c.ymcdn.com/sites/www.thepcpi.org/resource/resmgr/Final-CRL-Toolkit-6-19-17.pdf

For more detail see N4H Protocol for Effective Care Coordination and Referral / Transition Management Recommendations that include:

- Safety Net Medical Home Initiative referral guidelines that itemize issues and expectations to consider when developing referral and transitions workflows
- Referral/transition tracking system development
- The Joint Commission's important elements of transitions of care

REFERENCES

SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders; https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

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

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

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

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

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

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

SAMHSA Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit and Dual Diagnosis Capability In Mental-Health Treatment (DDCMHT) Toolkit
; https://www.centerforebp.case.edu/resources/tools/best-of-samhsa-resources-for-ddcat-and-ddcmht

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

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

Attachment_E4.9

Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
ASAM Levels of Care	10/15/2018	[redacted]	[redacted]	Elliot Hospital	Director, Behavioral Health	4
ASAM Levels of Care	10/15/2018	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
ASAM Levels of Care	10/15/2018	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Catholic Medical Center Behavioral Health	Certified Medical Assistant	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	Coordinator, Drug Court	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	Director, Substance Use Services	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	Clinical Supervisor, Drug Court	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	Case Manager, Drug Court	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	LADC	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	Case Manager	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Elliot Hospital	Case Manager	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Manchester Community Health Center	Clinician	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Manchester Community Health Center	Clinician	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Executive Vice President/COO	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Rockingham County Department of Corrections	Case Manager	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Southern NH Health	Program Director	3
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Coordinator, North End Counseling	4
ASAM Levels of Care	10/24/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Willows	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Fusion Health Services	Nurse Practitioner	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Elliot Hospital	Clinical Nurse Leader	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Parkland Medical Center	Mental Health Technician	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Pastoral Counseling Center	Clincian	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Center for Life Management	Clincian	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Catholic Medical Center	Social Worker	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Transitions Coach	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Center for Life Management	Emergency Services Clinician	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Derry Friendship Center	Board Member	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Derry Friendship Center	Board Member	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Transitions Coach	4
Co-Occurring Disorders	8/21/2018	[redacted]	[redacted]	Granite Pathways	RAPS Specialist	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Transitions Coach	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Elliot Hospital	Director, Behavioral Health	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Granite Pathways	Case Manager	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Catholic Medical Center Behavioral Health	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Healthcare for the Homeless	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Case Manager	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Healthcare for the Homeless	Clinician	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Health Mentor Counselor	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Elliot Hospital	Nurse	4
Co-Occurring Disorders	10/4/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Director	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Housing Advocate	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	MSW Intern	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Intake Coordinator	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Clinician	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Case Manager	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Angie's Place	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Clinician	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Director, Housing Supports	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Recovery Care Specialist	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Open Doors	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Clinician	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Housing Advocate	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Family Place	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Vice Presicent, Clinical and Supportive Services	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Therapist	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Intake Coordinator	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Therapist	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Willows	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Treatment Coordinator	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Treatment Coordinator	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Recovery Care Specialist	4

Attachment_E4.9

Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, New Horizons	4
Intro to Motivational Interviewing (QIP Activity)	10/15 and 10/16/18	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Hope House	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	Catholic Medical Center: Behavioral Health	Coordinator, Behavioral Health Department	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Driver/Peer Support	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Driver/Peer Support	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Program Director	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Program Assistant	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Program Assistant	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Peer Support Assistant	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Program Assistant	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Program Aide	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	The Upper Room	Young Adult Program Specialist	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	Catholic Medical Center: Behavioral Health	Coordinator, Behavioral Health Department	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	The Upper Room	Adolescent Wellness Coordinator	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Program Assistant	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	The Upper Room	Events Facilitator/Administrative Assistant	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Driver/Peer Support	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Driver/Peer Support	4
Mental Health First Aid	11/29/2018	[redacted]	[redacted]	On the Road to Wellness	Peer Support Assistant	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Team Coordinator	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/21 and 9/28/18	[redacted]	[redacted]	Crotched Mountain Community Care	Case Manager	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Disciplinary Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Sergeant	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Lieutenant	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Field Training Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Sergeant	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4

Attachment_E4.9

Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Sergeant	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Mental Health First Aid	9/5 and 9/6/18	[redacted]	[redacted]	Hillsborough County House of Corrections	Correctional Officer	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Pastoral Counseling Center	Clincian	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Elliot Hospital	Director, Substance Use Services	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Pastoral Counseling Center	Clincial	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Manchester City Health Department	Community Health Worker	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Pastoral Counseling Center	Clinician	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	o	Pastoral Counseling Center	Clincian	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Director	4
Motivational Interviewing	11/1 and 11/2/18	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Transitions Coach	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	EFAC	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Quality Improvement	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Quality Improvement	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Motivational Interviewing (QIP Activity)	9/13/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Supervisor	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing (QIP Activity)	11/1/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Clinical Supervisor, Drug Court	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Children's Clinical Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Children's Clinical Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Coordinator	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Quality Improvement	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Coordinator	4
Motivational Interviewing for Supervisors (QIP Activity)	9/14/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Angie's Place	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Willows	4
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Family Place	4
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Director, Housing Supports	4
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Hope House	4
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Vice Presicent, Clinical and Supportive Services	4
Motivational Interviewing for Supervisors (QIP Activity)	01/10 and 1/11/19	[redacted]	[redacted]	Families in Transition- New Horizons	Program Manager, Open Doors	4
Motivational Interviewing Study Group (QIP Activity)	10/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing Study Group (QIP Activity)	10/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing Study Group (QIP Activity)	10/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing Study Group (QIP Activity)	10/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing Study Group (QIP Activity)	10/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Clinician	4
New England School of Best Practices in Addiction Treatment (QIP Activity)	8/27 - 8/30/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
New England School of Best Practices in Addiction Treatment (QIP Activity)	8/27 - 8/30/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Quality Improvement	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	MSW Intern	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Intern	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Psychiatrist	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Wellness Coach	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Wellness Coach	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Coordinator	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	OT Intern	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	MSW Intern	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Quality Improvement	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Supervisor	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance
E4 Completed Trainings July- December 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Director	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Team Leader	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Clinician	4
Stages of Change and Motivational Interviewing (QIP Activity)	9/28/2018	[redacted]	[redacted]	Center for Life Management	Case Manager	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Catholic Medical Center	Hospital	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Emergency Services Clinician	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCM	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Residential Services	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCU	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	NEC L2	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Residential Services	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Network4Health, Care Transitions	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	GCTT	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	HOT	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	MCST	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Residential Services	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Emergency Services Clinician	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCM	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCU	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	GCTT	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CTT	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Residential Services	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Network4Health, Care Transitions	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	MCST	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	InShape	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	C&A	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCU	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	MCST	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CSS Intake	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	NEC	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Med Services	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Cypress Center	4
Stages of Change	9/27/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Network4Health, Care Transitions	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Elliot Health System	Hospital	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Willows	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Willows	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Families in Transition- New Horizons	Willows	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	IPS	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Intensive Transition Team	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Intensive Transition Team	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCU	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCU	4

Attachment_E4.9
Training Attendance

Network4Health Training Attendance **E4 Completed Trainings July- December 2018**						
Course Name	**Date(s)**	**First Name**	**Last Name**	**Organization**	**Role**	**IDN**
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Intensive Transition Team	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CCU	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Intensive Transition Team	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Intensive Transition Team	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Intensive Transition Team	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Waypoint (FKA Child & Family Services)	n/a	4
Stages of Change	12/12/2018	[redacted]	[redacted]	Waypoint (FKA Child & Family Services)	n/a	4

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

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

Provide a brief narrative describing the current use of APMs among partners.

As noted in previous submissions, alternative payment models are utilized by some Network4Health partners. Larger health care provider partners are most experienced with these arrangements. Our acute care hospital partners participate in multiple value based payment programs. For example, the Dartmouth Hitchcock Clinics in Manchester and Bedford participate in alternative payment models utilized by the NH Dartmouth Hitchcock system. The region's two community mental health centers continue to be involved in a population-based capitation payment within the Medicaid managed care program. One of our two federally qualified heath centers participates in a value based payment model with one of the current Medicaid managed care organizations.

In a survey of partners, only Catholic Medical Center (CMC) reported a change in alternative payment models implemented during the reporting period. CMC has entered into a voluntary bundled payment APM initiative with CMS for its Medicare population. At the same time, CMC has discontinued a Medicare APM program with NH Accountable Care Partners with plans for a replacement to be implemented by July of 2019.

Use the format below to: identify the IDNs participation in workgroups for the development of the DSRIP APM Implementation Plan; assess the current use and/or capacity for engaging APMs amount IDN participants; develop an IDN-specific plan for implementing the roadmap to include IDN-specific outcome measures; and develop the financial, clinical and legal infrastructure required to support APMs.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Yes	Yes	Yes
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		In progress	Yes

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Develop the financial, clinical and legal infrastructure required to support APMs		In progress	In progress
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs		In progress	In progress

During the reporting period, Network4Health has placed a significant focus on sustainability of successful innovations achieved as part of our project implementation. It is clear that a transition to Alternative Payment Models (APM), that support and incentivize integrated care delivery, must be in place following the expiration of the waiver. These new approaches must move reimbursements from volume based to value based in order to continue to achieve improved health outcomes resulting from an integrated approach to care. As this process moves forward, Network4Health anticipates that consultants may be necessary to provide technical support to Network4Health and its partners in efforts to implement alternative payment models.

Network4Health has been actively engaged in all statewide waiver efforts to address the needed changes in funding of healthcare including the development of the DSRIP Alternative Payment Models Roadmap. During this reporting period, NH DHHS issued an RFP for a re-procurement of Medicaid Care Management Services. The RFP states, “MCOs are required to develop a strategy for moving fifty percent (50%) of their medical expenditures into qualifying APM’s”. Network4Health participated in public hearings related to issuance of the RFP and subsequently met on multiple occasions with the prospective Medicaid managed care organizations to discuss collaboration in APM development.

Network4Health has created an initial Alternative Payment Model Implementation Plan, included below, that will be modified and expanded once the managed care organizations are selected. This will include IDN specific outcome measures, infrastructure required as well as measures related to financial, legal and clinical preparedness and engagement of Network4Health and its partners with the MCOs.

Network4Health Initial Alternative Payment Model Implementation Plan (Achievements July, 2018 through December, 2018 & Plans)

Focus Area and Goal	Accomplishments	Planned Next Steps
Education Provide and assure the availability of APM related educational opportunities and resource materials to partner organizations.	1. Current NH Medicaid managed care organizations presented on "payment and integrated care delivery" to the B1 Integrated Care (IC) workgroup. 2. The December IC workgroup focused on identification of high risk patients/clients in the context of population health management and value based payment models. 3. Partner participation in the NH Citizens Health Initiative Annual Symposium that included a focus on value based payment models. Sixteen individuals from 5 Network4Health partners attended this symposium. 4. In October, seven individuals attended the Xtelligent Media 3rd Annual Value Based Care Summit in Boston. 5. Cherokee Health Systems presentations (June and September) included information on alternative payment models. 6. Shared the Health Care Payment Learning and Action Network APM framework with partners.	1. Alternative Payment and Value Based Models will be featured at the March 2019 Network4Health All Partners meeting (rescheduled from September 2018). 2. As a follow up to the March 2019 All Partners Meeting, offer a focused APM 101 for partners who have no current or prior experience by July 2019. 3. Once NH DHHS announces the selection of the new Medicaid Managed Care Organizations, meetings with those companies will be scheduled to begin a joint planning process for alternative payments models. 4. Provide technical assistance, as needed to network partners.
Readiness Provide support and assistance to partner organizations in preparation for APM's	1. Support and encourage participation of partners involved in the Northern New England Practice Transformation Network that offers tools, information and support in the shift to valued based care. Currently The Mental Health Center of Greater Manchester and Center for Life Management participate. These organizations	1. Introduce readiness tools such as the HITEQ Payment Reform Readiness Tool or the National Association of Community Health Centers Payment Readiness Assessment Tool. Encourage use of tools in coordination with Medicaid MCO planning once NH selects MCO's for upcoming contract period.

	have shared best practices and information with other IDN partners that participate in the B1 Integrated Care workgroup meetings. 2. Alternative payment models have been introduced and discussed with all B1 IC partners as part of the integration enhancement plan development and implementation.	2. Provide technical assistance, as needed, to network partners.
Monitoring Update baseline of existing APM implementation.	1. Conducted baseline assessment and six month updates to the use of alternative payment models among Network4Health partners. Only one partner made a change in implemented APM's during this reporting period.	1. Continue to monitor network partner participation in alternative payment models. 2. Assure that Network4Health and its partners participate in the development of new Medicaid alternative payment models. 3. Network4Health will monitor implementation of new Medicaid alternative payment models across all partners.

Network4Health remains committed to working with NH DHHS, the state's Medicaid MCOs and others in working with its partners to implement APMs that work best for all involved in the state's care delivery system, particularly the patients.