



**New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver
IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE**

**For
Year 3 (CY2018)
2018-6-30 v.27**

**Region 6 IDN (Seacoast/Strafford)
Writeback Submission #1**

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Introduction

The Centers for Medicare and Medicaid Services (CMS) approved New Hampshire’s application for a five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs are charged with participating in statewide planning efforts and selecting and implementing community-driven projects. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

This Reporting Guide is for use by the IDNs to identify required documentation for achieving project

Submission of the semi-annual report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints, your attachments should also be uploaded separately in the original file version as well (ms project, ms excel, etc.). Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted.

requirements according to the Special Terms and Conditions of the DSRIP Waiver. The state will use the information to review and document the IDNs’ progress on project implementation and to award incentive payments. IDNs are required to complete separate implementation plans for each of their statewide projects (i.e., workforce, health information technology and alternative payment models), core competency project, and community-driven projects. Required deliverables must be submitted to the Department of Health and Human Services by July 31, 2017 and within 31 days after each six-month reporting period, as indicated in below. 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.

See below for illustration of attachment for project B1 deliverable 2A:

Attachment_B1.2A

For the Reporting Period:	Process Measures Reporting Due to DHHS no later than:
January 1, 2017 – June 30, 2017	July 31, 2017
July 1, 2017 – December 31, 2017	January 31, 2018
January 1, 2018 – June 30, 2018	July 31, 2018
July 1, 2018 – December 31, 2018	January 31, 2019

To be considered timely, supporting documentation must be submitted electronically to the State by the dates indicated above into each IDN’s semiannual reporting folder. For questions, contact:

Kelley Capuchino
Senior Policy Analyst
NH Department of Health and Human Services
Division of Behavioral Health
129 Pleasant St
Concord NH 03301

DSRIP IDN Project Plan Implementation (PPI)

Each IDN was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points, evaluation metrics, and Community Input, IDN Network changes, Opioid Crisis Update, Governance, and Budget narrative accompanied by a budget spreadsheet.

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

Please provide a budget of actual expenditures and projected costs to complement narrative.

Soliciting Community Input:

IDN Region 6 has steadfastly kept our commitment to the meaningful engagement and input of a broad representation of community stakeholders in all our DSRIP design and implementation efforts. IDN 6 crafted a Consumer Engagement Work Plan intended to solicit meaningful input and foster active participation in IDN projects from all manner of individuals and family members touched by the efforts of IDN partners. The IDN contracted with Continuum of Care Facilitator from the Seacoast Public Health Network to carry out this Work Plan.

Implementation of all three of the Community Projects in IDN 6 continues to be guided by Workgroups comprised of multiple clinical and non-clinical stakeholders throughout the Region. Workgroups continue to meet at least twice per reporting period to guide implementation of respective projects. To advance the integration of resources and services that address the social determinants of health through Region 6 projects sector-specific work groups address homelessness/housing, and transportation related needs, assets and opportunities across the region.

The Clinical Advisory Team continues to meet to provide expert input on operational considerations and problem-solving related to the care integration objectives across IDN projects (with particular emphasis on B.1).

IDN partner representatives and Operations staff have and will continue to participate on the Statewide HIT, Workforce, and APM Workgroups and subcommittees.

All Partner Meetings continue to be a key aspect of network development throughout the initiative and an especially useful forum to solicit feedback from multiple perspectives, and to inform and engage new network partners. We continued to offer All Partner meetings in the reporting period as a forum to provide detail and answer questions related to IDN updates and progress, and to serve as an information source for partners to understand the larger policy and programming landscape in which DSRIP projects operate. For example, the status and relative influence of Medicaid re-procurement, Granite Advantage logistics, the 10-Year Plan, and APM/VBP development on DSRIP and on partner agencies more generally. And likewise, we continue to participate in numerous opportunities throughout the region to inform, engage and solicit input from groups in every sector.

Network Development:

We have undertaken several strategies to conduct continuous development of the IDN 6 Network. 1:1 meetings were held with all major stakeholders (4 Hospitals, 3 FQHCs, 2 CMHCs and 1 major SUD provider) to share detailed information about DSRIP projects to multiple staff members in each agency, and to conduct environmental scans in order to learn about the current and planned agency efforts related to the coordination and/or integration of care and services.

The embodiment of our network is the Community Care Team (CCT) which has continued to grow, thrive. The IDN officially adopted the oversight, facilitation and resourcing of the CCT and the 50 clinical and non-clinical agencies and organizations that actively participate. The CCT to increase meeting frequency to every other week in Rochester and monthly in Portsmouth.

The Operations Team continues to develop the concept of Health Neighborhoods in the Region to facilitate an understanding and awareness of interagency relational networks that operate among and between four diverse sub-regional clusters of partners.

Our Region Six All Partner Meetings, held roughly every two months (depending on competing meetings, priorities, etc.) have been a key stable of network development since Day One, and will continue to serve as our largest and most diverse in-person network audience.

Operations Team Members continue to be heavily involved in many IDN-related Network activities (e.g. seat on Public Health Advisory Committee; Commissioner of Dover Housing Authority; members of Greater Seacoast Coalition to end Homelessness Steering Committee and Workgroups; Medical Reserve Corps; Recovery Community Organization Advisory Board; and many more). All together and across members, the Operations Team engages in hundreds of contacts, engagements, meetings and interactions of all types that are relevant to Network Development that are too numerous to document or predict systematically.

Of note, no partners have left the IDN network or requested to decrease participation in the Region 6 DSRIP initiative.

Addressing the Opioid Epidemic: The Operations Team

The Region Six Operations Team benefits from the direct involvement of staff members in several local and statewide efforts that seek to address the negative consequences of Opioid misuse in New Hampshire. One Team member sits on the Governor's Commission for Alcohol and Substance Use Prevention, Treatment and Recovery, including serving as Chair of the Recovery Task Force, the Data Task Force, and the Policy Task Force, as well as Chair of the NH Harm Reduction Coalition, and Board Chair of Hope on Haven Hill. Two Team members were employed by our two respective Public Health Networks before joining the IDN and brought with them their extensive engagement in Continuum of Care activities throughout the region that are focused on the Opioid Epidemic, and have been integrating those efforts into the IDN projects.

Members of the Operations Team have been actively involved in existing Network efforts and regularly participate in such groups as the Prevention, Treatment and Recovery Roundtable and The Opioid Taskforce, etc. Operations Team staff have also been very actively involved in providing multiple Overdose Prevention trainings before and since the inception of DSRIP. Additional trainings to be offered include those to First Responders and other non-clinical personnel. Likewise, these team members have also been instrumental in creating one of the first Syringe Services Programs in

NH that serves Region 6 and provides technical assistance and support for an emerging statewide initiative, the New Hampshire Harm Reduction Coalition.

Governance: The primary component of our governance model is the Executive Committee, which is comprised of fourteen people, each representing a different sector of the IDN. At this writing, the Executive Committee will be re-filling the recently vacated seats representing the Housing, Public Health and Hospital sectors. There were no significant changes to governance structure or stability during the reporting period.

Budget: The Master Budget was reviewed and accepted by the Executive Committee. The Executive Committee informs and accepts significant budget adjustments on a rolling basis, at least annually. The initial Master Budget assumed a 15% reduction from maximum possible funding. In this report we detail a number of decisions to redistribute funds that were either allocated but not expended during the reporting period, or to reflect alignment with alterations in project redesign and growth that could not be anticipated in the original project design. The majority of funds that were not distributed were in staff/workforce line items that were not hired due to reorganization of the agency or project they were intended to be associated with. The current master budget maintains funding at approximately 85% of maximum. Additional reduction may be necessary pending CMS/NH DHHS negotiation regarding match funding. The Director of Finance conducts monthly budget reconciliation. The PPI Budget can be found in Attachment_PPI.2, detailing the allocations assigned to infrastructure and capacity building. The master budget is comprised of the PPI budget and the A1,A2,B1,C1,D3, and E5 project budgets included in this report.

Actual expenses for the PPI administrative/capacity expenses can be found in Attachment PPI.1, below:

Attachment PPI.1: PPI Project Actual Expenditures

PPI Actual Expenditures Through 6/30/2018		ACTUAL	ACTUAL		ACTUAL	ACTUAL
		2016	2017		Q1/Q2 2018	To 6/30/18
EXPENDITURES_Actual						
ADMINISTRATION						
22.4119.002	DSRIP - DIRECTOR POPULATION HEALTH					
22.4119.003	DSRIP - DIRECTOR OF OPERATIONS					
22.4119.004	DSRIP - FINANCE STAFF					
22.4119.005	DSRIP - IT STAFF					
22.4119.006	DSRIP - ADMINISTRATIVE STAFF					
22.4119.008	DSRIP - DIRECTOR OF SOLUTIONS INTEGRATI					
22.4119.101	DSRIP - LONGEVITY					
22.4119.102	DSRIP - ACCRUED BENEFITS EXPENSE					
22.4119.103	DSRIP - SOCIAL SECURITY					
22.4119.104	DSRIP - DENTAL INSURANCE					
22.4119.105	DSRIP - HEALTH, LIFE & DISABILITY INSURAN					
22.4119.106	DSRIP - RETIREMENT					
22.4119.107	DSRIP - WORKERS COMPENSATION INSURAN					
22.4119.108	DSRIP - UNEMPLOYMENT INSURANCE					
22.4119.109	DSRIP - WAIVER					
22.4119.217	DSRIP - TRAINING					
22.4119.227	DSRIP - CONTRACTED EXECUTIVE DIRECTOR					
22.4119.228	DSRIP - CONTRACTED CLINICAL DIRECTOR					
22.4119.229	DSRIP - FEES & CONTRACTED SERVICES					
22.4119.235	DSRIP - PHOTO COPY EXPENSE					
22.4119.236	DSRIP - OFFICE SUPPLIES					
22.4119.238	DSRIP - POSTAGE					
22.4119.270	DSRIP - TRAVEL & MILEAGE					
22.4119.297	DSRIP - NEW EQUIPMENT					
	TOTAL EXPENDITURES - ADMINISTRATION	\$144,115.15	\$563,268.49		\$348,428.53	\$1,055,812.17

Budget projections for the Region’s PPI administrative/capacity building work are below, in Attachment PPI.2. Line item totals in this attachment consider expenses to date. The most significant change between the actual budget and the projected budget is the addition of a Director of Care Coordination position. As the Region 6 IDN expands scope and scale of projects underway, additional oversight and supervision is necessary to maintain project integrity.

Attachment PPI.2: PPI Project Projected Budget

Budget Projection: PPI	IDN Network Capacity Bldg	Budget Q3-Q4 2018	Budget 2019	Budget 2020	Budget 2021	TOTAL
Workforce						
	Director of Population Health					
	Director of Operations					
	Director of Care Coordination					
	County - Finance Staff					
	IT Staff - County					
	IDN HIT Project Manager/Dir Sol Integ					
	County Administrative Staff					
	Longevity					
	Accrued Benefits Expense					
	Employee Benefits					
	Social Security /Retirement					
	Retirement-see above					
	Workers Compensation -see above					
	Unemployment Insurance-see above					
	Dental Insurance					
	Health, Life & Disability Insurance					
	Contracted Labor - Executive Director*					
	Contracted Labor - Clinical Director					
	Training/Profess Development for Ops Team					
	Section Subtotal	417,602	842,895	862,929	854,241	4,009,779
Operations						
	Fees & Outside Services					
	Berry Dunn - project management					
	Maria Sillari - Project Manager					
	Consumer Engagement					
	Audit	6,000	12,000	15,000	15,000	64,000
	Photo Copy Expense	500	1,000	1,000	1,000	5,021
	Office Supplies	1,000	2,000	2,000	2,000	11,095
	Postage	600	1,200	1,200	1,200	5,400
	Telephone	1,200	2,400	2,400	2,400	10,800
	Travel & Mileage	3,000	6,000	6,000	6,000	27,372
	New Equipment	5,000	10,000	10,000	10,000	46,970
	Section Subtotal	\$298,300	\$109,600	\$112,600	\$112,600	788,905
	BUDGETED TOTALS	715,902	952,495	975,529	966,841	\$4,798,684

Strengthening Operational Capacity to Administer the DSRIP:

Region 6 continues to make significant investments to build and strengthen our Operations Team knowledge and capacity. Operations Team members continued to rotate attendance at IDN Administrative Lead meetings to ensure comprehensive access to evolving information. IDN Operations team members advised on and participated in knowledge exchange activities during the MSLC state-wide quarterly Learning Collaborative sessions. IDN Operations staff have also attended

a variety of exercises and trainings in Integration, Transformation, and Behavioral Health improvement hosted by diverse entities across the state. Our Director of Population Health also attended a 2-day Academy that delivered training for Care Director from Allscripts, our Shared Care Plan IT solution.

Strengthening Network Partner Readiness for DSRIP Initiatives:

During this reporting period, the IDN Operations team has begun to execute a number of activities designed to strengthen partner readiness for DSRIP Initiatives, especially for multiple types of partner staff beyond executive level and for those agencies who do not yet have key partner role designations. These efforts include:

- Planned re-design of community projects as informed by key member workgroups to ensure operational success
- Expansion # of partner agencies participating on Release of Information for both Community Care Teams
- Use of Community Care Team expertise to define ideal scope of Shared Care Plan solution
- Use of the Clinical Advisory Team to further evaluate resources and best practices to inform development of Core Standardized Assessment protocols.
- Initiation and contracting of collaborative relationship with Southern NH AHEC to oversee and administer regional training efforts including design and delivery of trainings across the IDN projects portfolio.
- Conducted session with over 40 School Counselors and Supportive Services staff from throughout SAU-16 to provide and IDN and Enhanced Care Coordination Project overview.
- Hosted a meeting with Dr. Craig Donnelly and his associates from Dartmouth-Hitchcock Department of Psychiatry and several Youth/Pediatric stakeholders in the Rochester/Somersworth/Dover region to introduce opportunity to participate in Case Consultation of Pediatric Behavioral Health clients. Included representatives from Rochester Pediatrics; Lilac City Pediatrics; Dover Pediatrics; Rochester School System; Community Partners.

PPI Activities Summary: As evidenced by the PPI.1 Table of Activities, the Region 6 IDN Team is highly active and engaged throughout the region and state in numerous efforts that directly support and strengthen capacity for project implementation. Not only convening Work Groups and conducting All Partner Meetings, but the combined deep and wide participation by all members of our Operations Team in literally dozens of groups, coalitions, agencies, organizations and related health initiatives are synonymous to our outreach and engagement. Likewise, Operations Team members are engaged in virtually every aspect of efforts to address the Opioid Crisis regionally and at the state level.

DSRIP IDN Process Milestones

DHHS will use the tool below to review and document each IDN's Implementation activity. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet				

Project A1: Behavioral Health Workforce Capacity Development

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

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.

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.

The Region 6 IDN partners met milestone and deliverable goals that were not impacted by delays or adjustments in other DSRIP processes during this reporting period. Updates to those milestones not fully realized during the reporting period are illustrated in the Implementation Timeline in Attachment_A1.3.

Key progress on the A1 Project at-large includes:

- Recruiting, hiring, and/or onboarding for a number of IDN and partner agency staff across all 6 Region 6 projects.
- Recruitment and hiring of an HIT Solutions project manager for the A2 project
- Recruitment and hiring of one Masters level Team Lead and one CTI Case Manager for the C1: CTI Project

- Recruitment and hiring of one Navigator MLDAC and one SUD Case Manager for the D3: Intensive SUD Expansion project.
- Recruitment and hiring of one Enhanced Care Coordinator for the E5: Enhanced Care Coordination project.
- Engagement of clinical supervision support for D3 and E5 project team members
- Initiated Pediatric Psychiatry Consultation. Dartmouth College Psychiatry faculty have accepted terms of service to Region 6 IDN participating partners under a telemedicine and consultation series subcontract with the IDN.
- Filled the School/Youth Mental Health Integration position via a subcontract. The clinician, a LCMHC, supports the Clinical Advisory Team and the E5 Enhanced Care Coordination community project focused on transition aged youth as a subject matter expert.

Executed a contract with Southern New Hampshire AHEC to develop, deliver, and manage the bulk of the Region 6 IDN training plan. The detailed Training Plan is available Attachment B1.8c2 on page

During this reporting period, the Region 6 IDN made progress on the A1 Workforce Project Implementation Plan in Attachment A1.3a, below. Milestone or deliverable dates highlighted in red in Attachment A1.3a reflect the accompanying strategy has not yet begun or has been cancelled. Dates highlighted in yellow indicate that the strategy was started, but faced barriers or delays that prevented completion. Dates highlighted in green reflect milestones or deliverables that were met. This color legend is standard across the remaining A2, B1, C1, D3, and E5 Implementation Timelines in this document.

Progress in Development of Regional Network Workforce

In Step 1, recruitment for two positions, an Emergency Licensed Mental Health Provider and a Same Day Access Clinician, was suspended. Both roles were identified as workforce development solutions during early collaborative project planning by regional partners who shared a network-wide concern about prolonged wait times for access to urgent or emergency behavioral health evaluation for Medicaid enrollees. Enrolled members were increasingly stuck in partner Emergency Rooms with little to no access to behavioral health assessment and intervention.

Over the course of the reporting period, IDN participating partners came to the consensus in All-Partner and Executive Committee meetings that prioritizing IDN investment in inter-agency coordination instead of direct care would result in more sustainable, efficient and responsive solutions for attributed or eligible members exhibiting signs of behavioral health crisis. This was especially true for community-based encounters with law enforcement personnel. As part of a network-wide effort to facilitate that inter-agency network development and coordination, these two direct care positions were suspended and the Region engaged Dr. Jodi Hoffer Gittell to address integration between partners via region wide training and small group facilitation on her model of Relational Coordination to strengthen existing or build new relationships.

\$622,000 in funds initially allocated to these positions have not been reallocated. When a reallocation plan is identified, it is contingent on DHHS approval of any plan, milestone, and timeline updates or revisions.

There is emerging evidence (drawn from Community Care Team referrals and general network situational awareness) that a significant segment of the most vulnerable members attributed to the Region 6 IDN are not connected to any regular source of primary or behavioral health care. These members require creative alternative methods to access care beyond current standard scheduling/appointment models. The Region 6 IDN anticipates redistribution of these funds to support expanded access to creative alternative methods to access care. Specifically, the Region 6 IDN expects a joint application for workforce development support from Region 6 IDN Community Mental Health Centers, Community Partners and Seacoast Community Mental Health Center will be forthcoming in the 3rd quarter of 2018, as they continue collaborative discussion on development and implementation of a Same Day Access scheduling model. The Region 6 IDN has provided supportive consultation including reiteration that planning and implementation assistance is available to support this exciting shared goal. Psychiatry consultation was contracted from Dartmouth College to provide expert consultation and case review to Region 6 IDN providers using a Project ECHO model, beginning with the Frisbie Hospital system.

The Region 6 IDN expanded a contract with Ben Hillyard, M.Ed, LCMHC, of the Center for Collaborative Change, to serve as the School/Youth Mental Health Integration Clinician based on his very successful participation to date on the Clinical Advisory Team and professional experience and current practice focus.

The Director of Care Coordination role was filled with expansion of a current contract with Maria Sillari, the administrative manager of both the northern and southern regional Community Care Teams.

Progress in Efforts to Support of Partner Capacity to Sustain Workforce Investments

In Step 1, a number of Partner Agencies collaborated with Region 6 IDN Operations Team members to design and submit requests for support of partner capacity to sustain workforce illustrated in Attachment A1.3b using the request form in Attachment A1.3d.

During the reporting period, we received and granted requests for short term assistance in workforce recruitment, retention, or development from the following partners:

- Community Partners: support for the recruitment of two psychiatric nurse practitioners.
- Crossroads House Shelter: support for supervision hours for a Masters Level social worker
- Families First CHC: support for co-location of primary care services at Southeastern NH Services to provide preventative and acute primary care medical services for clients in residential treatment.
- Lamprey Health: support to expand a Nurse Practitioner Fellowship program to include a provider with an X-waiver to strengthen and sustain development of a Medication Assistance Treatment program and expand knowledge transfer. This investment was subsequently developed into a B1 project and is described more expansively there.

Efforts are ongoing to meet milestones and deliverables in Step 2. Progress is detailed in the Training Plan and Delivery reports detailed in Attachment B1.8c2 (p. 101) and B1.8d(p.109).

Progress in Support of Development of Statewide Workforce Capacity

Step 1 performance includes continued promotion and participation in the Statewide Workforce Task Force. The Region 6 is specifically represented on the following A1 Statewide Workforce workgroups:

- Education & Training: Kevin Irwin (IDN), Paula Smith (SNHAHEC)
- Policy: Diane Fontneau (co-chair-SMHC)
- Retention/Sustainability: (Nick Toumpas, co-chair-IDN)

- Recruitment/Hiring: ad hoc participation

Finally, the IDN demonstrated significant and meaningful effort in Stage 3, review of future statewide workforce development efforts, as both the Region 6 IDN Director (Nick Toumpas) and Clinical Director (Dr. Bill Gunn) were invited to participate in development of the NH State 10 Year Behavioral Health Strategic Plan as subject matter experts. In addition, a detailed update on the progress of each of the 4 Statewide Workforce

Task Force working groups follows:

Policy Sub Committee

- Provided testimony on approximately 6 related workforce bill
- Participated in work group with Sen. Feltes and Bradley relative to supervision of license seeking MH professionals
- Met with MH Practice board to establish relationship and outline priorities
- Kept up with WF legislative efforts including Interoperability / telehealth
- Reviewed current efforts relative to expansion of telehealth services in NH
- Crafted letters in support for legislation on behalf of the greater task force
- Attended RACI training
- Provided input for OPLC changes that support recent legislation relative to reciprocity

Recruitment and Hiring Sub Committee

- IDN's across the state have worked with project partners to collect/compile job descriptions with the intent to share amongst all IDNs. Working to have similar language, credentials, and professional expectations for positions specific to integration.
- Progress has been made in the creation of documentation differentiating Community Health Workers, Patient Navigators, Case Managers in support of driving clarification of the roles and usage of common language in an effort to mitigate confusion of different language used for similar positions and tasks.
- IDNs have explored/initiated various incentives to advance the behavioral health workforce including: engaging with local colleges to facilitate field placements; incentivizing behavioral health careers via loan forgiveness, relocation fees, and license fees reimbursement and advocacy for more resources for loan forgiveness. The role of LNA's in the clinical setting is not yet resolved and this will need to be further explored in the coming months.
- IDNs are in various stages in developing student loan repayment programs. All recognize the importance of this incentive given the less than ideal compensation for clinicians. There are different policies and procedures, most require a commitment of employment. We expect there will be more information on state run loan forgiveness programs as the funding is confirmed from the legislature.
- IDNs have been partnering with CMHCs (case manager w/degree positions) and CHW's (peer recovery/recovery support specialists), and promoting BH PA, OT, and Community Paramedicine careers in order to explore alternative licenses for new peer and lived experienced workforce. Note there is a new Medicaid code for SUD peers. CHMC's are working to implement mental health peer codes.
- The Workforce Taskforce was provided insight from Will Stewart from StayWorkPlay New Hampshire regarding the key findings of a recent survey regarding why young adult residents

choose to live in NH, their satisfaction levels and their intent to remain in NH. This insight is helping direct strategies toward retaining a younger workforce within the IDN's.

Retention and Sustainability Sub Committee

- Survey of benefits offered by selection of NH employers completed and shared with all IDN's. Revealed that there is a wide range of benefits available in the private for profit sector that are not possible for BH providers. This work cross walks well with Stay/Work/Play recommendations for a younger workforce: greater autonomy, more responsibility and less structure.
- Completion of Mental Health First Aid training of the trainers. April 2018. 30 new trainers have completed certification and are now training groups. IDN 2 will collect data on who has been trained.
- Telehealth exploration with Dartmouth Hitchcock and with Community Partners which will be the focus for the next SAR period. In addition Sub Committee is inviting vendors in for demonstrations of new tech solutions such as Konica Minolta Business Solutions etc.
- Testimony given in support of Interoperability by 6 IDN Leads to the Interoperability Commission
- Investigative team assembled to look at maximization of billing opportunities across all insurances. Data analyst hired by IDN II. Collection of coding opportunities and exploration of sustainability opportunities with private insurance companies such as Anthem's Value Based Program for Behavioral Health
- Celebration of Behavioral Health professionals planned for the Fall

Training & Education Sub-Committee

Antioch University: New Hampshire Primary Care Behavioral Health Workforce

- List of post-degree programs for licensed behavioral health clinicians such as psychologists, clinical social workers, or other counselors who could use training in how to adapt their clinical skills to a primary care environment
- Negotiated a 25% reduction in cost of the Primary Care Behavioral Health course at the UMass Medical School Center for Integrated Primary Care for any clinician working in New Hampshire. The course is online.
- Negotiated a 25% reduction for the Integrated Care Manager course at the Center. This course is online as well. You could conceivably have a lower level staff member (MA, Community Health Worker, Interpreter) who showed promise take the care manager course and take on new responsibilities.
- Practice Facilitator training modules –training modules to orient PCMH practice facilitators on the ways to combine Behavioral Health Integration with PCMH practice transformation.
- Assembled a list of Master's degree programs for employees interested in becoming a licensed behavioral health clinician. These programs can be completed without having to leave current employment.

- Integrated Primary Care Training Modules for future behavioral health students will be ready later in 2018
 - **Beyond the silos** -This module will introduce the world of primary care and the way that problems that need a biopsychosocial approach are brought by people to their primary care doctors.
 - **Primary Care Behavioral Health** – This module will talk about how behavioral health services are now becoming more common in primary care. There will be a discussion of the different levels of practice models (coordinated care, co-located care, and integrated care) and what each of these entails in terms of practice and workforce structure.
 - **Transformation to Patient Centered Team-Based Care** - This module will provide an overview on the concept of patient centered team-based care and how it is designed to enhance the role of the rest of the healthcare team and relieve the time of the doctor.
 - **Next Steps for You** - This module will discuss how someone can get involved in integrated behavioral health care.

University of NH, Institute on Disability: NH Children’s Behavioral Health Workforce Development Network

UNH has training modules based on the NH Children’s Behavioral Health (NHCBH) Core Competencies. They have formed a task force, NHCBH Workforce Development Network, that is working to design concrete behavioral health workforce development pathways, with a focus on attracting workers from under-represented populations and peer support workers into the BH field.

- **Medication Assisted Treatment (MAT) training module:** MAT Best Practice education program is in final editing stages
- **Addiction 101:** Initial Training on Addiction & Recovery: NH BDAS offers this program in Concord on a quarterly basis but offered to bring 3 trainings to the IDN regions. Region 3 and 4 co hosted a training in May 2018; Region 1, 5, and 7 are co hosting a training in Plymouth on September 20, 2018; and Region 6 will be hosting a training in the fall of 2018

Dartmouth Hitchcock Substance Use and Mental Health Initiative: DHMC working on training modules to address training needs related to substance use disorders and mental health

- **Mental Health First Aid:** Riverbend CMHC hosted a successful Mental Health First Aid train-the-trainer program in April 2018 and trained 30 individuals.
- **Health Career Catalogs:** Area Health Education Centers are working to revise health career catalogs to incorporate more behavioral health careers. The IDNs have each agreed to contribute \$4000 to support the revisions and will receive catalogs for distribution in their networks to promote behavioral health careers.

- **NH Higher Education Behavioral Health Workforce Roundtable:** Southern NH Area Health Education Center has convened a group of higher education academic institutions offering behavioral health programs to gain an understanding of what programs, degrees and certificates are currently being offered through higher education. This roundtable will offer a way to work together to identify potential gaps in workforce development and identify strategies for addressing these gaps. The group will meet quarterly. To date the roundtable has looked at an inventory of existing behavioral health academic programs in NH and has looked at brought employers together from hospital systems, FQHCs, Mental Health Centers, and social service organizations together to look at workforce needs and discuss labor statistics. Future conversations will include discussions on accreditation, clinical rotations, and curriculum development.
- **Centralized Training Calendar:** The Training & Education Subcommittee has recommended that the Myers & Stauffer CPAS website serve as the centralized training calendar for the IDNS. It is suggested that each IDN send Myers & Stauffer their training calendar, and include which trainings are open to other regions, and which are closed.
- **Speaker's Bureau/Training Capacity:** Region 7 IDN has asked members of the Training & Education Subcommittee to send Region 7 IDN a list of any trainers/presenters within other regions, so all this information can be collated together and shared.
- **Integrated care team roles, job descriptions, and functions:** The training and education subcommittee has suggested to use SAMHSA as a resource to define these

[REDACTED]

[REDACTED]

[REDACTED]

- [REDACTED]

[REDACTED]

Attachment A1.3d

**Region 6 Integrated Delivery Network
IDN Partner One-Time Investment Request**

The Region 6 IDN Executive Committee granted authorization to the IDN Operations Team to invest up to \$50,000 per month to partner agencies to stabilize and/or improve regional capacity to meet DSRIP program and regional terms and goals.

This form accommodates requests for support made via **OPTION 2*** in the CAPACITY BUILDING SUPPORT: Attachment A1.3b form (attached).

IDN Partners requesting **OPTION 2** support will receive a consultation with the Region 6 IDN Operations Team to identify the following elements to enable the Region 6 IDN Operations Team to ensure investment is aligned with regional and DSRIP terms and goals. The Region 6 IDN Executive Committee will review investments on a monthly/ongoing basis and provide feedback/guidance as indicated.

**[Option 2 funding is separate from OPTION 1 funding. OPTION 1 funding is allocated via detailed project plans collaboratively crafted in a series of waves, to primary partners in the B1 & C1/D3/E5 Community Projects that will come before the Executive Committee.]*

AGENCY/ORGANIZATION	
CONTACT INFO	
AMOUNT REQUESTED	
SPECIFIC AIM(S)	
SPECIFIC OUTCOME(S)	
JUSTIFICATION	(rationale for support)
IMPACTS IN REGIONAL HEALTH NEIGHBORHOOD	
SUSTAINABILITY	(if capacity improvement is sustainable, how?)
ALIGNED WITH CORE COMPETENCIES	(refer to SAMHSA competencies)
AGENCY CAPACITY	(how does support improve agency capacity?)
REGIONAL CAPACITY	(how does support improve regional capacity?)
DIRECT FUNDING OR IDN PAYMENT?	(Does payment go to partner agency or vendor/individual?)
ACKNOWLEDGEMENT	(how will investment be identified/branded to stakeholders?)

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of participating partner agencies who receive recruitment and/or retention support from the IDN.	10	0	6	
% of participating partner agencies receiving recruitment and/or retention support from the IDN who report positive	70% (or 7)	0	100%	
# of participating partner agency staff who receive IDN sponsored training.	150	0	350	
% of participating partner agency staff who receive IDN sponsored training who report positive impact on knowledge or practice.	75% (or 113)	0	97%	
# of eligible participating provider agencies who were offered a stipend for staff participation on the Clinical Advisory Team	15	0 ¹	15	
# of Members Demonstrating Initiation of Alcohol and Other Drug Dependence Treatment	Target Pending Baseline Measurement			
# and % of new patient calls or referrals from other providers for CMHC intake appointment within 7 calendar days	Target Pending Baseline Measurement			
# and % of new patients for whom time between intake and first follow - up visit was 7 days or less.	Target Pending Baseline Measurement			
# and % of new patients for whom time between intake and first psychiatrist visit was 30 days or less	Target Pending Baseline Measurement			
Staff to support IDN infrastructure are recruited and retained:	1 1 Up to 2			
HIT Solutions Project Manager		0	1	
Director of Care Coordination		0	Contracted APPARPAPP RO	
Pediatric Psychiatry Consultation		0	Contracted	
School/Youth Mental Health Integration Clinician	Up to 1	0	Contracted	

Staff to support IDN Projects are recruited and retained:				
B1: Integration Coach	2	0	Contracted	
C1: Masters Level Team Lead	2	0	1	
C1: CTI case managers	6	0	3	4
D3: Navigator (MLDAC)	2	3	4	
D3: SUD Case Managers	6	0	1	
D3: Clinical Supervision Consultation	0.5	0	1	
E5: Enhanced Care Coordinators	6	0	.5	
E5: Clinical Supervision consultation-Secured	0.5	0	1	
		0	.2	

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.

As discussed in A1.3, the Region 6 IDN workforce plan for providers continues to evolve based on network and organizational learning, fundamental elements of the DSRIP initiative. Adjustments to the workforce plan include reclassifying the HIT/Data Architect role to a HIT role to meet regional project needs, the budget expansion for Administrative Assistance, and the addition of a project manager role to support multi-project implementation. Based on partner feedback and deeper regional capacity assessment, the Region 6 IDN will not recruit for the same-day access clinician or an emergency mental health provider positions at this time. Partner agencies felt the service gaps both those positions were crafted to fill could be better met through increasing efficiencies and collaboration among agencies, as discussed in A1.3.

Workforce Staffing Targets

	IDN Workforce (FTEs)
--	-----------------------------

Provider Type & Project Association (I = Infrastructure, B1 = Integrated Healthcare, C1/D3/E5 = Community Projects)	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Director of Care Coordination (I)	1	0	0	1	
Administrative Assistant (I/B1)	Up to 2	0	0	.5	
HIT Solutions Project Manager (I)	1	0	0	1	
School/Youth Mental Health Integration Clinician (I)	Up to 0.2	0	.05	.1	
Project Manager (B1/C1/D3/E5)	Up to 1.0	0	0	.8	
Integration Coach (B1)	Up to 2	0	0	Paused	
Master Licensed Alcohol and Drug (D3) Counselor Navigators	Up to 2	0	0	1	
Masters Level Team Leader (C1)	Up to 2	0	0	1	
Peer Recovery Coaches (n/a)	0	0	0	0	
Other Front Line Providers:					
Pediatric Psychiatry Consultation (I)	Up to 1	0	0	Per Contract	
SUD Navigator (D3)	Up to 1	0	0	1	
CTI Case Manager (C1)	Up to 6	0	3	4	
SUD Case Manager (D3)	Up to 6	0	0	1	
Enhanced Care Coordinator (E5)	Up to 6	0	0	1	
Clinical Supervision Consultation (D3/E5)	Up to 2	0	0	.05	
Behavioral Health Clinician (B1)	Up to 3	0	0	1	
Behavioral Health Coordinator (B1)	Up to 1	0	0	1	
Waivered Nurse Practitioner (B1)	Up to 1	0	0	1	

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

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

Region 6 IDN Actual expenditures for Project A1 are included below in Attachment A1.6a. These expenses reflect investment in recruitment, retention, and/or professional development efforts for Region 6 IDN partners to date.

Attachment A1.6a: A1 Project Actual Expenditures

A1: Actual Expenditures through 6/60/2018						
WORKFORCE		2016	Q1-Q2 2017	Q3-Q4 2017	Q1-Q2 2018	Actual to 6/30/18
23.7400.217	WORKFORCE - TRAINING	\$0.00	\$0.00	\$0.00		
23.7400.229	WORKFORCE - FEES & OUTSIDE SERVICES	\$0.00	\$0.00	\$0.00		
23.7450.229	CROSS ROADS HOUSE - FEE & OUTSIDE SE	\$0.00	\$0.00	\$0.00		
23.7451.229	LAMPREY HEALTH CARE - FEES & OUTSIDE	\$0.00	\$0.00	\$0.00		
23.7452.229	COMMUNITY PARTNERS - FEES & OUTSIDE	\$0.00	\$0.00	\$0.00		
	Total Actual Expenditures Workforce	\$0.00	\$0.00	\$0.00	\$74,325.69	\$74,325.69

The budget below in Attachment A1.6b outlines projected workforce development costs in two categories; Infrastructure and Regional Capacity. Totals include consideration of expenses to date.

Attachment A1.6b: A1 Project - Projected Budget

Budgeted		Q3- Q4 2018	2019	2020	2021	TOTAL
Section 1: Infrastructure						
	School/Youth Mental Health Integration Clinician					
	Pediatric Psychiatry Consultation					
	Section 1 Subtotal					
Section 2: Regional Capacity						
	Mechanism 1 - Project Driven Support					
	Recruitment/Staffing					
	Retention					
	Training/Education					
	Mechanism 2 - Partner Driven Support					
	Recruitment					
	Retention					
	Training/Education					
	Mechanism 3 - IDN Driven Support					
	Recruitment					
	Retention					
	Training/Education					
Operations						
	Office Space					
	Furniture					
	Supplies/Materials/Equipment					
	Travel					
Clinical Advisory Team						
	Workforce Development Initiatives to support sustainability of IDN investments	50,000	150,000	175,000	125,000	550,000
						0
	Administrative Mgmt Fees for Partners	40,000	40,000	40,000	40,000	140,000
	Section 2 Subtotal	502,000	891,000	977,000	782,000	3,622,000
						0
	Total:	569,000	1,036,000	1,123,000	928,000	4,193,000

The first budget category, Infrastructure, includes operational costs of recruitment and retention expenses for those positions required to develop and maintain a core IDN infrastructure to design and administer the work of the IDN. It also includes funding for training and education for these workforce roles. These positions include:

The School/Youth Mental Health Integration Clinician was contracted to provide subject matter expertise on school-community relations and inter-disciplinary facilitation support to the IDN Operations Team, Clinical Advisory Team, and partners on demand. This position was proposed in the initial project plan and has been contracted. His role is anticipated to grow, especially as the E5 Enhanced Care Coordination project expands services to a pediatric cohort.

Region 6 partners have identified a need for additional psychiatric consultation since the first day they came together 18 months ago to begin discussing needs and opportunities to inform IDN project planning. Pediatric psychiatry services were identified as the biggest category of need within that entire high-need category. Initial environmental scans and discussion with partners suggested that there is a

dearth of workforce available to staff traditional visit based models of pediatric psychiatry. The Region 6 IDN has instead chosen to pursue technology enabled models of care and consultation delivery to increase access for pediatric psychiatric consultation to a range of partners and their clients. Workforce barriers including legislative constraints on cross-border license reciprocity and access to and/or reimbursement for enabling technology like video visits are challenging IDN regions across the state to find innovative ways to meet the desperate need for increased psychiatric care for children.

The second budget category, Regional Capacity, illustrates the Region 6 IDN plan to develop workforce capacity in the region via three mechanisms, Project Driven Workforce support, Partner Driven Workforce support and IDN Driven Workforce support.

The A1 Workforce Budget includes funding for a third category, Operational efforts to support workforce development. This category includes funding for office space, furniture, supplies/materials/ equipment, and travel for Infrastructure and Project staff. Expenses are anticipated in these lines as implementation efforts increase across the region.

The A1 Workforce Budget also includes funding to support stipends, travel, and other meeting and administrative and operational expenses associated with the work of the Clinical Advisory Team, a working advisory group comprised of acute and primary care provider-level representatives from our behavioral health (mental health and SUD), medical care, school, and community agency partners. The Clinical Advisory Team is considered a workforce development initiative of Project A1 because members are subject matter experts and key resources to inform integration design and evaluation. Many are anticipated to serve as provider Champions or in key support roles in their agencies during execution of the B1 and the Community Projects.

The A1 Workforce Budget includes funding to support initiatives that improve the sustainability of IDN workforce efforts implemented through the three mechanisms above. Our partners will incur costs associated with developing and maintaining collaborative relationships with the new positions created by the IDN. These potential costs include direct expenses like staff travel to meetings, increased insurance, and indirect expenses like increased impact on utilities and increased material use with space sharing. These funds will be distributed to participating partners to incent their participation in hosting, sponsoring, and/or collaborating with the regional staff positions to be hired under the IDN initiative. These funds may also be used to conduct Workforce Fairs and/or convene one or more Integration Summits.

The A1 Workforce budget also includes a line for administrative management fee funding to support development of our partner's human resource management capabilities related to integrated care. Integrated care is an evolving model that requires employees to work with internal and external partners and clients in new ways. While the IDN will help implement many strategies to encourage integrated care, the model will require supervisors and human resource managers at all of our partner agencies to develop new skills to ensure those strategies are sustained. For example, many employee job descriptions and performance evaluations will need to be revised to reflect the competencies necessary to deliver efficient integrated care. This budget category will support those efforts as solutions are identified by the Region 6 IDN Workforce working group.

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.

B1 enterprise and practice level corrections have been made below. New enterprise level B1 partners anticipated to execute Certificates of Agreement in the next reporting period are listed below with *. New practice level B1 partners anticipated to complete Site Self-Assessments in the next reporting period are listed below with **.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Appledore Family Medicine**	HBPC	A1, A2, B1, C1, D3, E5
City of Dover Welfare	Soc Service	A1, A2, C1
City of Portsmouth Welfare	Soc Service	A1, A2, C1, E5
Community Partners	CMHC	A1, A2, B1, C1, E5
Core Family Practice – Exeter**	HBPC	B1, A2
Core Family Practice – Stratham**	HBPC	B1, A2
Core Physicians (selected)	HBPC	E5
Cornerstone VNA	HomeCare	A1, A2, C1
Crossroads House Homeless Shelter	Soc Service	A1, A2, C1, E5
Dover Pediatrics*	Primary Care	B1
Exeter Health Resources	Hospital	B1, A2
Frisbie Memorial Hospital	Hospital	A2, B1, C1, D3, E5
Granite/Seacoast Pathways	Peer Support	A1, A2, C1, E5
Greater Seacoast Community Health - Families First	FQHC	A1, A2, B1, C1, E5
Greater Seacoast Community Health - Goodwin Community Health	FQHC	A1, A2, B1, C1, E5
Hilltop Family Practice**	HBPC	A1, A2, B1, C1, D3
Hope On Haven Hill	Residential SUD Treatment	A1, B1, A2, D3
Lamprey Health Care, Raymond	FQHC	A1, A2, B1, C1, E5
Lamprey Health Care, Newmarket	FQHC	A1, A2, B1, C1, E5
One Sky Community Services	Area Agency	A1, A2, E5
Portsmouth Regional Hospital	Hospital	A2, B1, C1, D3, E5

Rochester Pediatrics**	HBPC	A2, B1, C1, D3, E5
Riverside Rest Home (Strafford County)	LTC	A1, C1
Rockingham CAP	Soc Service	A1, A2, C1
Rockingham County Corrections	Corrections	A1, A2, C1
Safe Harbor Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
Seacoast Mental Health Center	CMHC	A1, A2, B1, C1, E5
Seacoast Youth Services*	SUD	A1, A2, B1, C1, E5
Southeastern NH Services	SUD	A1, A2, B1, C1, D3
SOS Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
Strafford County Corrections	Corrections	A1, A2, C1, D3
Strafford CAP	Soc Service	A1, A2, C1
Wentworth Douglass Hospital	Hospital	A2, B1, C1, D3
Wentworth Health Partners / Internal Medicine**	HBPC	A1, A2, B1, C1, D3

Project Scoring: IDN Workforce Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Narrative & Microsoft Project or similar platform				
A1-4	Evaluation Project Targets	Table				
A1-5	IDN-level Workforce Staffing Targets	Table				
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet				
A1-7	IDN Workforce Key Organizational and Provider Participants	Table				

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

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

Each IDN was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

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

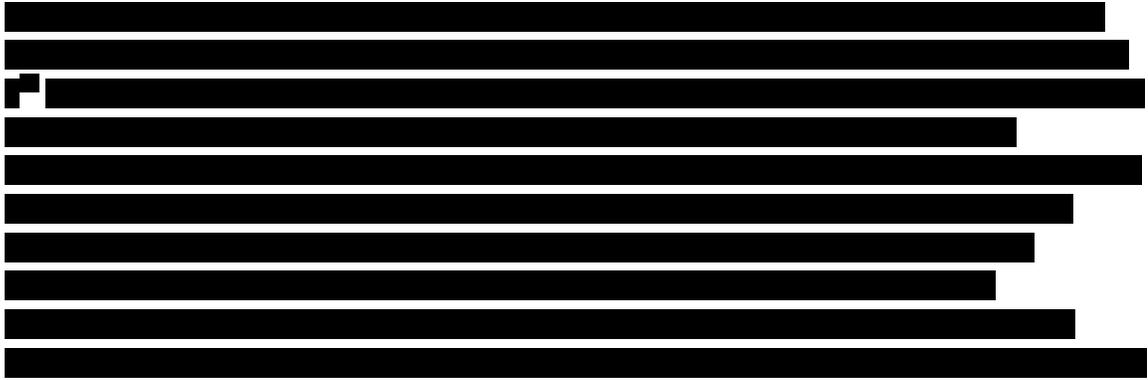
The Region 6 IDN partners met milestone and deliverable goals that were not impacted by delays or adjustments in other DSRIP processes during this reporting period.

Key Progress on the A2 Project at-large includes:

- Completed interviews and extended offer to candidate for HIT Solutions Project Manager.
- Conducted HIT assessments with 7 Key Participating Partners
 - Frisbie Memorial Hospital System
 - Wentworth Douglass Hospital System
 - Exeter Hospital System/CORE Physicians
 - Families First Community Health Center
 - Goodwin Community Health Center & SOS Recovery Center (a Goodwin affiliate program)
 - Lamprey Health Center
 - Seacoast Mental Health Center

Completion of HIT assessments for remaining key participating partners is anticipated during the next reporting period. These partners include:

- [REDACTED]
- [REDACTED]



Key Progress on the Data Aggregator solution includes:

- Region 6 IDN executed a contract for the data aggregator solution with MaEHC.
- Region 6 IDN satisfied reporting requirements to the data aggregator for the first metric reporting period.

Key Progress on the Shared Care Plan solution includes:

- *Executed a contract for Care Director, a shared care plan solution, with Allscripts on 2/8/18.*
- Region 6 IDN staff attended Care Director Administrator training.

Key Progress on Event Notification Service Solution includes:

- Design and preliminary scoping discussion for ENS solution completed with MaEHC
- Request for proposal for ENS service pending from MaEHC. *The Region 6 IDN anticipates that a proposal for provision of ENS services will be provided during July 2018 followed by contract execution shortly thereafter during the 3rd quarter of 2018. The Region 6 IDN anticipates implementation of the scope of services for this contract, including a portal for provider access to ENS data, an interface with the Allscripts Care Director product, and an interface with the CMT ENS product, to be underway by November, 2018.*

Progress is also reflected in Attachment A2.3, the A2 project Timeline. Regional scans have been completed for almost all of the identified partners. Outstanding assessments are a function of agency specific timelines, but the Region 6 IDN anticipates completing targeted scans for all identified partner agencies during the next reporting period

Att_A2.3 A2 Project Implementation Plan			Resp	12/31/2017	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020
HIT Project Phase: Design/Procurement/Preparation									
Step 1	Participate in/perform selection due diligence with region/statewide solution Vendors		HIT/Ops	31-Dec					
	Event Notification - MAEHC								
	Data Aggregator - MAEHC								
	Shared Care Plan/Care Coordination - Allscripts/Care Director								
Step 2	Execute contracts with selected region/statewide solution vendors		IDN ED	31-Mar					
	Event Notification - MAEHC								
	Data Aggregator - MALIC								
	Shared Care Plan/Care Coordination - Allscripts/Care Director								
Step 3	Engage region/statewide solution vendors in regional implementation planning		HIT/Ops	31-Dec					
	Event Notification - MALIC								
	Data Aggregator - MALIC								
	Shared Care Plan/Care Coordination - Allscripts/Care Director								
Step 4	Update/expand knowledge (list) of identified key HIT stakeholders in each partner agency participating in Community Projects		Ops	30-Nov					
Step 5	Perform HIT Environmental Scan of Region and Key Participating Partners to include assessment of ONC technology status, gaps to minimum standards, and capacity to assess/record/share/apply Core Standardized Assessment data		Ops						
	Regional Scan - Prioritizing Key partners participating in Community Projects								
		C1 - Frisbie Memorial Hospital			31-Apr				
		C1 - Community Partners			31-Apr				
		C1 - Crossroads House			31-Apr				
		D3 - Wentworth Douglass Hospital/Primary Care/Behavioral Health			31-Apr				
		D3 - Southeastern NH Services			31-Apr				
		D3 - Families First Health & Support Center			31-Apr				
		D3 - Goodwin Health Center			31-Apr				
		D3 - SOS Recovery Center			31-Apr				
		e5 - Seacoast Mental Health Center			31-Apr				
		e5 - One Sky Developmental Services			31-Apr				
		Statewide - NII Hospital	HIT Taskforce	31-Dec					
		Targeted Scan - Partners in Wave 1 of B1 Core Competency Project	Ops	31-Dec					
		Lemprey Health Care							
		Seacoast Mental Health							
		WDH Partner Practice							
		RMH Partner Practice							
		Targeted Scan - Partners in Wave 2 of B1 Core Competency Project	Ops/Integ Coaches		31-Mar				
		Targeted Scan - Partners in Wave 3 of B1 Core Competency Project			Cancelled				
		Targeted Scan - Partners in Wave 4 of D1 Core Competency Project				15-Aug			
		Targeted Scan - Partners receiving support to meet Regional Workforce Project goals			ongoing				
Step 6	Restructure and Expand HIT Team and establish meeting schedule		Ops	15-Nov					

Step 7	Hire HIT/Data Architect	Ops	31-Dec				
Step 8	Assign HIT Team Liaisons to support Clinical Advisory Team	Ops	30-Nov				
HIT Project Phase: OnBoarding							
Step 1	Create HIT Roadmap to identify Region 6 HIT solutions to be implemented to support:						
	Regional HIT Infrastructure Goals		31-Dec				
	Regional Workforce Project Goals			31-Jan			
	B1 Core Competency Project Goals in 4 cohort Waves		31-Dec				
	Wave 1			31-Mar			
	Wave 2			30-Jun			
	Wave 3				31-Aug		
	Wave 4				31-Oct		
	C1 Project Goals			30-Jun			
	D3 Project Goals			30-Jun			
	E5 Project Goals			30-Jun			
Step 2	Establish terms for partner Data Sharing Agreements	Ops					
	Draft terms in HIT Team	HIT	15-Nov				
	Review Agreement terms during Collaborative Design Implementation Session Implementation for D1 participating partners	Ops/ Integ Coaches					
	Wave 1		31-Dec				
	Wave 2			31-Mar			
	Review Agreements for other participating partners during Memorandum of Commitment process						
	Regional Workforce Project partners			ongoing			
	C1 Project Partners		15-Dec				
	D3 Project Partners		15-Dec				
	E5 Project Partners		15-Dec				
Step 3	Review and refine HIT budget to reflect Regional HIT Roadmap priorities			30-Jun		30-Jun	
	Region 6 IDN Executive Committee accepts budget		31-Dec		31-Dec		31-Dec

HIT Project Phase: Solution Implementation							
Step 1	Roll-out regional/statewide solutions to support Region 6 A1 workforce, B1 core competency, and community projects (C1/D3/E5)						
	Regional Infrastructure Development			ongoing			
	Event Notification - MaEHC				31-Mar		
	Data Aggregator - MAEHC		31-Dec				
	Shared Care Plan/Care Coordination -Allscripts/Care Director				31-Mar		

Data Reporting								
Semi Annual Reporting and document progress								
		Period Ending 12/31/17			1-Apr			
		Period Ending 6/30/18				1-Aug		
		Period Ending 12/31/18					1-Apr	
		Period Ending 6/30/19						1-Aug
		Period Ending 12/31/19						
		Period Ending 06/30/20						
		Period Ending 12/31/20						

As reflected in the A2.3 Timeline, many targeted scans were completed during the reporting period. A few remain to be completed, most often due to internal partner agency competing priorities or administrative flux that has delayed consultation with the appropriate partner agency representatives. The Region 6 IDN anticipates completing all targeted scans during the next reporting period. As discussed in other sections of this SAR, the 4 wave model of B1 assessments has been condensed to two, so activity noted in Waves 3 & 4 has been condensed. Wave 2 assessments will begin in August 2018. The final outstanding significant timeline activity is procurement of an Event Notification Solution. The Region 6 IDN has completed due diligence on the ENS scope with MaEHC and anticipates executing a contract to begin ENS design and implementation in mid-third quarter 2018.

A revised HIT team was convened to inform HIT project implementation strategies and review regional Allscripts Care Director demos after contract execution as part of readiness planning for design and scoping. The revised core team included representation from CHAN, Seacoast Mental Health Center, and Lamprey Health Care. Representatives were identified and invited from Community Partners, Frisbie Memorial Hospital System, Wentworth Douglass Hospital System, and Southeastern NH Services. This team informed development of an HIT Overview guide for IDN partners that is distributed to all partner agencies/individuals to orient participating partners to the A2 HIT Project. This guide document includes the following 6 sheets:

SHEET 1: Overview of the A2 Project & Partner Engagement

SHEET 2: Reporting At-A-Glance

SHEET 3: Metrics At-A-Glance

SHEET 4: Complete List of DSRIP Metrics

SHEET 5: Table of Potentially Avoidable ED Visit Primary Diagnosis Codes

SHEET 6: Table of Behavioral Health Indicator Logic

Sheets 1, 2 & 3 are included below. Sheets 4, 5 & 6 are both highly technical and created/authored by the NH DHHS, so they are not replicated in this document.

SHEET 1: Overview of the A2 Project & Partner Engagement

Expectations & Opportunities for Region 6 IDN Partners in the A2-Health Informatics Technology Project

-  Participate in Performance Metric Reporting (See Reporting/Metrics/@_a_Glance/DSRIP_Measure tabs)
-  Demonstrate use of required minimum standards for participation in IDN (listed below)

Capabilities & Standards	Data Extraction & Validation	Internet Connectivity	Secured Data Storage	Electronic Data Capture	Direct Secure Messaging	Shared Care Plan	Event Notification System	Transmit Event Notification Service
Description	Ability to validate data for State outcome measures and send it to one single aggregator for all IDNs (REPORTING)	Securely connected to the internet.	Ability and knowledge to secure PHI through technology and training.	Ability to capture and convert documents to an electronic format as a minimum.	Ability to use the protocol DSM to transmit patient information between providers. Can use webmail client as a minimum.	Ability to access and/or contribute an electronic shared care plan for an individual patient.	Ability to receive notifications as a minimum for all organizations.	Hospitals that have the ability to produce ADTs must transmit as a minimum.

A2 Project Participation Checklist

- (Your agency) identifies HIT team to review A2 project & metrics with Tory (Health Informatics Technology)
- (Your agency) signs BAA/QSOA with the Region 6 IDN in consultation with Tory
- (Your agency) reviews minimum IDN capabilities & standards to identify any organizational gaps or barriers
- (Your agency) begins consultation with Tory @ IDN & Jackie/MaEHC team for reporting implementation
- (Your agency) identifies any support necessary to mitigate organizational gaps or barriers to meeting IDN minimum capabilities (resources/training/equipment/services)
- (Your agency) identifies Complex Multi-Disciplinary Core Team protocol to guide adoption of Allscripts Care Director solution

Partner Agencies need to be able to identify & transmit data to the MaEHC QDC Data Aggregator for:

- Individuals enrolled in Medicaid insurance
- Individuals enrolled in Medicaid insurance with a behavioral health condition (see BH Diag Definitions Worksheet)
- Individuals who received a Core Comprehensive Standardized Assessment (CCSA) while enrolled in Medicaid¹
- Individuals with positive screenings for Substance Use or Depression while enrolled in Medicaid.²
- Individuals with documented evidence of a follow-up plan for a positive Substance Use or Depression screen while enrolled in Medicaid.³

METRICS REQUIRE: Data for each of the following measures for Medicaid enrolled/eligible clients:

- Female intimate partner violence screening and intervention
- High blood pressure screening
- Lipid screening
- Child tobacco use intervention or prevention
- Adult obesity screening and intervention
- Child obesity screening and intervention
- Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by IDN Primary Care and BH Providers
- Blood pressure control (> or < 140/90)
- Hgb A1C test results (> or < 8.0)
- Timely Transmission of Transition Record After Hospital Discharge (ADTs sent within 24 hours of discharge)

- ¹ CCSA is an IDN required assessment protocol. Assessment (and response) protocol is collaboratively developed with each individual partner agency.
- ² Per partner agency screening protocols for SUD/Depression
- ³ Per partner agency response protocols for positive SUD/Depression screens

MAeHC QDC & HL7 Messages

Admission, Discharge, Transfer (ADT) messages are one of the most common HL7 transactions. They can cover a lot of use cases such as creation of patients, admission of patients, cancellation of admits, merge of patient information etc. The MaEHC QDC is compatible with HL7 v2.3 & HL7 v2.3.1

MAeHC QDC Inbound Message Communication Protocols

Messages can be sent using one of the following methods: SFTP, TCP/IP, MAHWay. For SFTP, MaEHC can provide a secure account for the facility or pick up from an SFTP site of the source. For TCP/IP, a secure VPN tunnel will be established between the QDC environment hosted in the cloud to the customer's environment. Messages can be sent to the QDC via DIRECT protocol using the MAHWay as well. Any other alternative methods of connection could be supported on request

MAeHC QDC - Outbound Message Communication Protocols

Messages can be sent from the QDC using one of the following ways: SFTP, TCP/IP, MAHWay. For SFTP we can provide a secure account or we can drop the files at an SFTP site hosted by customer. For TCP/IP a secure VPN tunnel will be established between the QDC environment hosted in the cloud to the customer's environment. Messages can be sent to the QDC via DIRECT protocol using the MAHWay as well. Any other alternative methods of connection could be supported on request

Participating partner agencies identified appropriate staff at the individual agency level to participate in agency-specific Data Aggregator project calls led by MaEHC project staff. Progress to date on reporting to the data aggregator is reflected in Table 2.3.a below.

Table 2.3.a: Partner Status re: Reporting to Data Aggregator During Reporting Period

Partner Agency	Initial Discussion Held w/MaEHC	Data Ready For Testing	Data in Production	Data Submitted

Finally, HIT subject matter experts continued to support the Clinical Advisory Team. The goal of including HIT expertise in the discussion is to anticipate and problem solve those scenarios at the planning table to more quickly develop feasible solutions.

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
1	# of participating partners reporting access to a shared care plan solution	25	0	10	
2	# of participating partners reporting meaningful use of a shared care plan solution	20	0	7	
3	# of eligible participating partners utilizing ONC Certified EHRs (CEHRT)	8	5 ²	8	
4	# of participating partners reporting contributions to data aggregator	10	0	2	

5	# of participating partners reporting access to event notification solution	10	0	0	
6	# of participating partners reporting meaningful use of event notification solution	10	0	0	
7	# of participating partner hospitals reporting ADT submissions to IDN associated event notification solution	3	0	0	
8	# of eligible participating partners utilizing ONC Certified technologies	10	5 ²	8	
9	# of eligible participating partners capable of conducting e-prescribing	8	2 ³	8	
10	# of eligible participating partners capable of creating and managing registries	10	0 ⁴	7	
11	# of eligible participating partners able to electronically exchange relevant clinical data w/ others incl. NH Hospital	8	0 ⁵	5	
12	# of eligible participating partners able to protect electronically exchanged data in a secure and confidential manner per state/federal and security laws	30	5 ⁶	24	
13	# of eligible participating partners reporting client access to bi-directional secure messaging, records, apt scheduling, prescription & referral management	8	0	4	
14	# of eligible participating partners identified to report via the data aggregator	10	1	3	

² Number of eligible participating partners with ONC Certified EHRs/technology CONFIRMED through Collaborative Integrated Design process to date. Additional confirmations are anticipated as more partners participate in the Collaborative Integrated Design process.

The IDN did not procure or fund any ONC technology during the reporting period. Current reported capacity is standing capacity. Evaluation targets #3,8,9 & 12 may be considered evidence of assessment.

³ Number of partners with capacity to conduct e-prescribing CONFIRMED through Collaborative Integrated Design process to date. Additional confirmations are anticipated as more partners participate in and advance through the Collaborative Integrated Design process.

Progress toward Evaluation Targets identified in Table A2.4:

Target #1: Six Region 6 IDN partners accessed the Allscripts Care Director demonstration webinars or training environment during the reporting period as part of the contracting and early design process. Multiple partner agencies report use of care coordination tools accessible to internal staff. [These include: non-electronic - huddles, warm-handoff referrals, telephone, and complex care team meetings & electronic- secure messaging via the EHR, DSM, and internal electronic referrals.](#)

Target #2: On-site design and build readiness exercises were held with the Allscripts Care Director team. Implementation is scheduled for October, 2018.

Target #3: Progress was demonstrated for performance measures 3 as the Region 6 IDN confirmed that 8 eligible participating partners have ONC Certified EHRs and 2 were meaningfully utilizing e-prescribing. These confirmations were made during the assessment phase of the B1 Collaborative Integrated Design process for Wave 1 partners. Additional confirmations are anticipated as more partners participate in successive waves of the Collaborative Integrated Design process for the B1 project and the C1, D3, and E5 community projects. The target number of 16 was revised down to 8 based on due diligence and project scoping with partner agencies that demonstrated that for 3 out of 4 hospital system partners, the affiliated primary care providers utilize the same EHR as the hospital, system wide, reducing the need to identify site/practice level differences in EHR use.

Target #4: Two Region 6 partner agencies reported contributions to the data aggregator during the reporting period. One agency reported completing testing and the transmission of actual data. Additional agencies are in discussion with MaEHC to begin delivering reporting to the testing environment in July & August of 2018 to meet the second reporting period deadline in October 2018. The target goal of 20 was revised down to 10 based on due diligence and project scoping with partner agencies that demonstrated that 3 out of 4 hospital system partners use the same EHR/IT platforms, reducing the need to identify site/practice level differences among affiliated primary care providers. [Completion of the data agreements is a critical antecedent for live data transmission to the data aggregator. Data agreement completion is anticipated during the next reporting period. Critical organizational events like CIO transition, CEO transition, organizational acquisition, and cross-IDN region compliance have been barriers to signing data agreements identified by key Region 6 partners.](#)

Target #5 & #6: No partners are reporting access to (or meaningful use of) an [integrated](#) event notification solution, pending execution of a contract with MaEHC for ENS. The target goals of 16 was revised down to 10 based on due diligence and project scoping with partner agencies that demonstrated that 3 out of 4 hospital system partners use the same EHR/IT platforms, reducing the need to identify site/practice level differences among affiliated primary care providers and ongoing discussion about use of ENS data.

Target #7: No hospitals are yet reporting ADT submission to an Event Notification Service, as no contract has yet been executed. The Target has been revised upward from 3 to 4 in recognition that Exeter Hospital became the fourth hospital partner to join the IDN during the reporting period.

Target #8: Eight participating partners identified use of certified ONC technology during the reporting period. In each instance, the identified technology included at least an ONC certified EHR. The Region 6 IDN anticipates at least 2 SUD partners are using non-EHR ONC certified technologies and anticipates confirmation during the next reporting period.

Target # 9: The eight Region IDN partners identified as using ONC certified EHRs also reported or demonstrated the ability to utilize e-prescribing. No other Region 6 IDN partners are anticipated to report this capability.

Target #10: The # of eligible participating partners capable of creating and managing registries to date was identified as 7. This capability is considered met if partner agencies attest to the ability to create, share, and follow/track a client/panel [in any format of electronic database \(Crystal reports, Excel, EHR reports/flat files, SPSS\)](#).

registries. Region 6 IDN partners currently demonstrate a wide range of strategies and tools in registry management from paper and pen to Excel worksheets to database reports to care coordination/care management IT solutions.

Target #11: Five participating partners identified the ability to electronically exchange relevant clinical data w/ others. Mechanisms included direct secure messaging ,secure email and some SFTP to MCOs. For the purpose of this evaluation measure, Fax transmission was not included, although all partners reported Fax as a primary transmission method for clinical data, especially to specialty clinical partners.

Target #12: 24 participating partners reported the ability to protect electronically exchanged data in a secure and confidential manner per state/federal and security laws. This measure includes capacity of agencies participation on the Community Care Team and key IDN partners as identified in other parts of this SAR. The primary mechanisms of protection and secure exchange were reported as data encryption and/or secure email.

Target #13: 4 eligible participating partners (3 CHCs, 1 Hospital based Primary Care partner) reported portal based client access to bi-directional secure messaging, records, apt scheduling, and/or prescription & referral management.

Target #14: During the reporting period, 3 participating partner agencies were identified as eligible to report via the data aggregator. Eligibility was defined as having completed a data agreement in the form of a BAA or QSOA. The template for the Region 6 IDN BAA/QSOA data agreement can be found in Attachment A2.4a, below. The blue line text is absent in a BAA and included in a QSOA for those partners who hold themselves as out as 42 CFR Part 2 providers.

Attachment A2.4a: R6 IDN BAA/QSOA Template for Data Agreements



Region 6 Integrated Delivery Network



WILLIAM A. GRIMES
Justice & Administration Building
259 County Farm Road, Suite 200
Dover, New Hampshire 03820

QUALIFIED SERVICE ORGANIZATION AND BUSINESS ASSOCIATE AGREEMENT (QSO/BAA)

THIS QUALIFIED SERVICE ORGANIZATION AND BUSINESS ASSOCIATE AGREEMENT (the "Agreement"), effective as of _____, 2018 ("Effective Date"), is made and entered into by and between _____ ("Covered Entity") and the Region 6 Integrated Delivery Network/ Strafford County ("Business Associate").

WHEREAS, Business Associate and Covered Entity enter into this Agreement for purposes of taking part in the Region 6 Integrated Delivery Network Program ("IDN Program"). Business Associate acts as the Administrative Lead Agency of the Region 6 IDN Program, and in this role disburses funds as part of the program, facilitates communication between providers related to patient care, and coordinates certain reporting obligations related to the IDN Program. Business Associate also provides data processing and population health management services as the Administrative Lead Agency. Patient information and Protected Health Information ("PHI") will be exchanged between the parties as part of the IDN Program, in accordance with this Agreement.

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, as implemented through the Department of Health and Human Service privacy and security regulations at 45 CFR Parts 160 and 164, and as modified by the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), at Section 13400, *et. seq.* (the "Health Information Technology for Economic and Clinical Health" ("HITECH") Act), and including any subsequently adopted amendments or regulations (collectively referred to herein as "HIPAA");

WHEREAS, the Covered Entity and the Business Associate acknowledge and agree that capitalized terms used, but not otherwise defined, herein are as defined in HIPAA; and

WHEREAS, HIPAA requires that the Covered Entity obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information used or disclosed by the Business Associate in the course of performing services pursuant to the Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

Obligations and Activities of Business Associate

Business Associate shall not use or further disclose Protected Health Information ("PHI") other than as permitted or required by this Business Associate Agreement or as required by law.

Business Associate shall use appropriate safeguards to prevent use or disclosure of the PHI not provided for by this Business Associate Agreement.

Business Associate acknowledges that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received from Covered Entity, identifying or otherwise relating to the patients in the IDN Program, it is fully bound by the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.

Business Associate agrees to resist any efforts in judicial proceedings to obtain access to the protected information except as expressly provided for in the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, as amended.

Business Associate shall report to Covered Entity any use or disclosure of PHI or an Individual's information not permitted under this Business Associate Agreement, including any Breach of Unsecured PHI and any Security Incident involving the PHI of which the Business Associate becomes aware. Business Associate will provide such notification to Covered Entity without unreasonable delay and in any event, no later than ten (10) business days after discovery. Business Associate shall take action necessary or reasonably requested by the Covered Entity to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Breach, Security Incident or other unauthorized use or disclosure of PHI by Business Associate or any agent or subcontractor of Business Associate in violation of the requirements of this Business Associate Agreement. In the event of a Breach of Unsecured PHI, Business Associate's notice to Covered Entity of such Breach shall include, to the extent possible, the identification of each Individual whose PHI has been, or is reasonably believed by the Business Associate, to have been, accessed, acquired, or disclosed during such Breach. Business Associate shall also provide Covered Entity any other available information that the Covered Entity is required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any action necessary as requested by the Covered Entity to assist Covered Entity in complying with any applicable Breach notification requirements.

Both parties agree that this section satisfies any notices necessary by either party of the ongoing existence and occurrence of attempted but unsuccessful Security Incidents, including activity such as pings and other broadcast attacks on either party's firewall, port scans, unsuccessful log-on attempts, denials of services and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

Business Associate shall ensure that any agent of the Business Associate, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Business Associate Agreement to Business Associate with respect to such information.

If the Business Associate maintains PHI in a Designated Record Set, the Business Associate shall:

provide access, at the request of Covered Entity, and in the reasonable time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524; and

make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity, and in the reasonable time and manner designated by Covered Entity. In the event the Business Associate receives a request for amendment

directly from an Individual, Business Associate will forward the individual's request to the Covered Entity.

Business Associate shall make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with HIPAA Standards.

Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity or Business Associate to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

Business Associate shall provide to Covered Entity, in a time and manner designated by Covered Entity, information pertaining to disclosures of PHI by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. In the event the Business Associate receives a request for an accounting directly from an Individual, Business Associate will forward the individual's request to the Covered Entity.

Business Associate shall implement and maintain safeguards as necessary to ensure that all PHI is used or disclosed only as authorized under HIPAA and this Business Associate Agreement. Business Associate shall comply with all requirements of the HIPAA Security Rule applicable to business associates including 45 CFR §§ 164.308, 164.310, 164.312 and 164.316.

Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Business Associate Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate HIPAA if done by Covered Entity.

Except as otherwise limited in this Business Associate Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

Business Associate may provide data aggregation services relating to the health care operations of the Covered Entity.

Except as otherwise limited in this Business Associate Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Except as otherwise permitted by HIPAA, when using or disclosing PHI or responding to a request for PHI, Business Associate will limit such PHI to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request.

Except as otherwise permitted by HIPAA, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any PHI unless Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the Individual's PHI.

Except as otherwise permitted by HIPAA, Business Associate agrees that it will not use or disclose PHI in connection with any fundraising and/or marketing communication for or on behalf of Covered Entity unless Covered Entity has obtained a valid authorization from each Individual who will be a recipient of any such communication.

If an Individual requests that Business Associate restrict the disclosure of the Individual's PHI to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

Obligations of Covered Entity

Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such Notice.

Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, if such restriction affects Business Associate's permitted or required uses and disclosures.

Covered Entity shall obtain from an Individual any consent that may be required by law to disclose PHI to Business Associate hereunder.

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Covered Entity.

Term and Termination

Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation, and Covered Entity shall terminate the Agreement if Business Associate does not cure the breach or end the violation within the time reasonably agreed to by the parties.

Effect of Termination.

Except as provided in paragraph (2) below and as set forth in this paragraph, upon termination of the Agreement or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Notwithstanding the foregoing, to the extent it is necessary for Business Associate to retain PHI following termination of this Business Associate Agreement for purposes of its own management and administration or to carry out its legal responsibilities, Business Associate shall extend the protections of this Business Associate Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes, for so long as Business Associate maintains such PHI.

In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. In such event, Business Associate shall extend the protections of this Business Associate Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

This Section 4(c) shall survive the termination of this Business Associate Agreement.

Miscellaneous

Interpretation. Any ambiguity in this Business Associate Agreement shall be resolved in favor of a meaning that permits the parties to comply with HIPAA.

Relationship to Underlying Agreement. To the extent any provisions of the underlying agreement (the "Memorandum of Understanding") signed on [date MOU signed] conflict with this Agreement, this Agreement shall govern.

No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, HIPAA or other state or federal law or regulation relating to privacy or confidentiality.

Amendment. The Parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for compliance with the requirements of HIPAA and any other applicable law.

Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of New Hampshire. The parties agree that venue shall lie in Federal and State courts in the State of New Hampshire, without regard to its conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and must be delivered in accordance with the notice provisions set forth in the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Business Associate Agreement through their duly authorized representatives intending it to take effect as of the Effective Date specified above.

Region 6 Integrated Delivery Network/ Strafford County	[Covered Entity]
By: _____	By: _____
Title: _____	Title: _____
Date: _____, 2018	Date: _____, 2018

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
Director of Solutions Integration	1	0	0	0	

The Region 6 IDN recruited 14 and interviewed 6 applicants prior to receiving an accepted offer from the selected candidate for the revised Director of Solution Integration role [during this project period](#). [As this staff role is a professional position, the selected candidate’s obligation to provide adequate notice to previous commitments is recognized and accommodated. Per the accepted offer, the scheduled start date for this position is prior to August 15, 2018. The Region 6 IDN anticipates that the candidate will begin work in this role per the terms of the offer and job description during August 2018.](#) The job posting can be found in Attachment A2.5a, below.

Attachment A2.5a

Director of Solutions Integration

Region 6 Integrated Delivery Network

Job Title: Director of Solutions Integration

Reports to: Director of Population Health

Status: Employee/Contract negotiable

Schedule:

Primarily Monday through Friday, with some flexibility for infrequent early/late meetings required (7am-9pm).

General Summary:

The Region 6 Integrated Delivery Network (IDN) is an alliance of health, community and social service stakeholders who serve as the infrastructure for transforming health service delivery by improving integration of Behavioral and Medical Health services throughout the Strafford County and Seacoast area to improve population health for ~ 32,000 Medicaid members. Through a series of statewide and community coordinated initiatives funded by a federal 1115 Medicaid Waiver, the IDN supports and incentivizes partners to build integrated models of service delivery that aim to maximize our region's mental health, substance use, primary care and social services capacity to ensure that the right care is available, accessible and delivered at the right time and place for consumers enrolled in or eligible for Medicaid in New Hampshire.

Position Summary:

The IDN Director of Solutions Integration works with the Director of Population Health to manage diverse projects, processes, and activities in support of Region 6 IDN partner efforts to meet the following minimum HIT standards in pursuit of integrated health care delivery across the continuum of behavioral and medical health care:

- Data Extraction & Validation
- Secure Data Storage
- Electronic Data Capture
- Direct Secure Messaging
- Shared Electronic Care Plans
- Electronic Event Notification

Success in this position will lead to improved data, information, and knowledge exchange among partners to sustain more efficient, acceptable, accessible and sustainable systems of care and support that lead to improved health seeking behavior and outcomes in a resource constrained environment.

Essential Duties and Responsibilities may include:

- Serve as the Region 6 IDN point of contact for regional partner agencies for HIT Project efforts.
- Coordinate partner participation in HIT Project activities including identification of barriers & gaps to meeting minimum standards, identification of partner project teams, and development of project goals.

- Identify and convene/support partner project teams to inform agency assessment, develop business cases, and guide planning and implementation.
- Assess partner HIT environments including infrastructure, strengths, barriers, and gaps and facilitate team based solutions.
- Apply project management tools and techniques when indicated; including (but not limited to) development of project charter, detail planning, task management, risk identification, and budget management.
- Identify and document workflows and protocols associated with or developed during HIT project implementation.
- Educate partner staff and stakeholders on range of methods/solutions to meet minimum standards during project coordination.
- Interact with selected vendors to coordinate site-level solution implementation and reporting.
- Identify and communicate data reliability and validity concerns that may impact accurate reporting or operational, policy and/or procedural issues within and between partner agencies.
- Develop and present informational sessions on project processes, performance and outcomes.
- Collaborate with Region 6 IDN staff and partners to understand and inform data collection and analysis for evaluation and reporting needs across all initiatives.
- Assist with the development of innovative ways to measure, evaluate and share information regarding patient and population health risk.

Education and Experience:

Required:

- Strong group facilitation skills
- Motivational interviewing and./or coaching skills
- Attention to detail
- Capacity to communicate supportively with confidence
- Knowledge of complex health systems and stakeholders
- Experience with strategic planning and/or healthcare workflows and data
- Ability to work autonomously as a consultative, supportive team member

Preferred:

- Familiarity with clinically oriented software solutions in a healthcare environment
- A minimum of 3 years of health care environment experience
- Knowledge of interdisciplinary health care culture across provider types spanning health care continuums of care/networks

The successful team member will have experience or interest in:

- Understanding and explaining population health data sets and analysis techniques
- Providing skilled professional, effective, and tactful communication, including written, verbal & nonverbal skills
- Conceptualizing and communicating HIT solutions for a future-state with significant uncertainties in payment, population, provider, payor and policy environments
- Knowledge of Strafford County/Seacoast health, community, and social service provider networks

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.

Expenses to date for the A1 HIT Project are presented in Attachment A2.6a, below.

Attachment A2.6a: HIT Budget – Actual Expenses

A2 Actual Expenditures Through 6/30/2018	2016	Q1-Q2 2017	Q3-Q4 2017	Q1-Q2 2018	Actual to 6/30/18
HIT					
24. HIT - TRAINING	0	0	0	[REDACTED]	
24. HIT - FEES & OUTSIDE SERVICES	0	0	0		
24. HIT - TELEPHONE	0	0	0		
24. SEACOAST MENTAL HEALTH CTR - FEES & OUTSIDE SER	0	0	0		
Total Expenditures-HIT	\$ -	\$ -	\$ -	\$154,559	\$154,559

The Region 6 IDN actual expenditures reflect expenses for IDN staff training for the Allscripts Care Director product after contract execution, scheduled payments per vendor contracts for the MaEHC data aggregator and Allscripts Care Director solutions, expenses for HIT technology (telephones) to support care coordination for January 2018 warming center CTI clients, and finally, a partner request for a funding allocation to Seacoast Mental Health for a HISP, an HIT solution that supports their ability to meet minimum standard capabilities.

Projected budget costs are presented below in Attachment A2.6b. Totals include consideration of expenses to date.

Attachment A2.6b – Projected Budget for A2 Project

Attachment_A2.6 A2 Health Information Tech		Q3- Q4 2018	2019	2020	2021	TOTAL
A2 HIT Network Expenses						
Solutions to Meet Standard Capabilities						
Event Notification & possible shared care plan						
Data Aggregator Solution MaEHC						
Care Coordination Solution Allscripts Care Director						
GIS Mapping Capabilities/Network Analysis Software/Support						
Section Subtotal						
IDN HIT Project Expenses						
Enabling Technology						
Solutions to meet those minimum standards not identified above		30,000	40,000	40,000	40,000	170,000
Solutions to meet performance expectations not otherwise identified		25,000	50,000	50,000	40,000	190,000
Section Subtotal		55,000	90,000	90,000	80,000	360,000
TOTALS		173,000	201,000	198,000	194,000	1,094,000

The event notification solution cost was estimated from multiple ENS solution vendors to inform budget development and has been confirmed as within 10% of the quote anticipated in July 2018 from MaEHC, the Region 6 IDN selected Event Notification vendor. The Region 6 IDN continues to research solutions and platforms that can provide real-time situational awareness about network provider services and, if possible, current capacity, to both partners and clients.

The IDN has allocated funds to solutions to meet the minimum standards (not otherwise identified above) as a contingency line to support partners to implement the solutions identified. These funds may be used (but are not limited to) additional solution training, ergonomic equipment, hardware to support implementation, and backfill for training time.

Funding has also been budgeted to accommodate any HIT/HIE solutions, training or equipment necessary to meet DSRIP performance expectations. These resources may be used (but are not limited to) to procure enhanced security solutions, upgrade information storage/exchange capacity, and

incent partner participation in minimum solution implementation. This may include optimizing information for wearable technology, alternative communication, or enabling technology.

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

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

Organization Name	Organization Type
Frisbie Memorial Hospital & Primary Care Svcs	HPBC
Wentworth Douglass Hospital & Primary Care Svcs	HPBC
Exeter Hospital & Primary Care Svcs	HPBC
Portsmouth Regional Hospital	HPBC
Lamprey Health Care	FQHC
Families First Health & Support Center	FQHC
Goodwin Health Center	FQHC
Community Partners	CMHC
Seacoast Mental Health Center	CMHC
Southeastern NH Services	SUD
Crossroads House Homeless Shelter	Soc Service
Strafford County Corrections	Corrections
Rockingham County Corrections	Corrections
ROAD to Recovery	SUD
Cornerstone VNA	HomeCare
Strafford Community Action Partnership	Soc Service
Granite/Seacoast Pathways	Peer Support
Rockingham Community Action Partnership	Soc Service
Seacoast Youth Services	SUD
Municipal Welfare Offices	Soc Service
Public Housing Authorities	Soc Service
Wellsense/NH Healthy Families	MCOs

The partners in Table A2.7 above have been involved in HIT project development and in the provision of one or more data elements to inform initial and ongoing regional and/or agency planning. The partners in **BOLD** above demonstrated significant participation in HIT project planning during the reporting

period as a result of early involvement in reporting, B1 Integration project or Community Project participation.

A2-8. IDN HIT. Data Agreement

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

Organization Name	Data Sharing Agreement Signed Y/N/In Process
Frisbie Memorial Hospital System (* & select practices)	In Process
Wentworth Douglass Hospital System (* & select practices)	In Process
Portsmouth Regional Hospital (* & select Appledore practices)	In Process
Exeter Hospital System (* & select CORE practices)	In Process
Lamprey Health Care	In Process
Families First Health & Support Center	In Process
Goodwin Health Center	In Process
Community Partners	In Process
Seacoast Mental Health Center	YES
Southeastern NH Services	In Process
Crossroads House Homeless Shelter	In Process

Two data agreements were executed with participating partners during the reporting period. The Region 6 IDN also executed data agreements with the selected Shared Care Plan vendor, Allscripts, and the Data Aggregator vendor, MaEHC, during the reporting period. The Region 6 IDN continues to pursue data agreements with remaining partners, all of whom have received the IDN data agreement template, but report extended internal processes to execute agreements. Partner agencies have referenced on or more of the following internal concerns as contributory to delays: concerns about patient privacy (including but not limited to messaging, storage, and data exchange), recent or pending changes in EMR vendors, recent or pending organizational mergers, dissatisfaction with DSRIP performance metrics as evaluation criteria, and extended timelines for

internal compliance reviews. Region 6 IDN operations staff continued to support each partner agency with information and guidance during their consideration of the data agreement throughout the reporting period. [While efforts are to obtain agreements from all indicated partners, the Region 6 IDN anticipates at least 6 of the remaining data agreements will be executed during the next reporting period.](#)

Project Scoring: IDN HIT Process Milestones

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

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

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.

Primary B1 Changes of Note in Reporting Period:

To better reflect the realities of partner implementation the B1 Work Plan has been condensed from 4 Waves into 2 Waves. Partners currently contemplated for each Wave can be seen in Table B1-6, new tables for better and more accurate tracking IDN Trainings being offered throughout the region and some in conjunction with partner IDN Regions. High level trainings in Integrated Care have been delivered by Cherokee Health to our primary B1 partners. As described earlier, we have paused on contracting Integration Coaches after finding that some partners had their own internal resources for coaching, while other preferred to receive consultation from our own Operations Team expert, Clinical Director Dr. Bill Gunn.

Network Capacity Building

The IDN Team continues to invest considerable time and effort into the building of Network Capacity as the foundational objective of the IDN.

Step 3: Developing a "continuum of care" framework for SUD and BH to map existing and new initiatives. This work is being extended into the Community Care Team.

Step 5: As described in earlier reporting the IDN Team has worked closely with our network partners to align our training offerings with their current needs, and has reorganized our general training strategy to increase overall participation, increase diversity of participation within agencies, increase continuous learning and support at the agency level, and increase the overall capacity-building impact of trainings.

Step 7: The IDN Team has paused on contracting Integration Coaches after finding that some partners had their own internal resources for coaching, while other preferred to receive consultation from our own Operations Team expert, Clinical Director Dr. Bill Gunn.

Steps 9-18: All are either met or ongoing efforts that have been initiated.

Added Step 19: The facilitation and support of the Community Care Team is fundamentally a network capacity building enterprise. With 50 regional agencies on one Release of Information, the coordination work of the CCT continues to build and strengthen the connective tissue of the network across partners in practically every domain.

Added Step 20: IDN 6 crafted a Consumer Engagement Work Plan intended to solicit meaningful input and foster active participation in IDN projects from all manner of individuals and family members touched by the efforts of IDN partners. The IDN contracted with Continuum of Care Facilitator from the Seacoast Public Health Network to carry out this Work Plan (attached).

All Partners Capacity Building

Steps 1-9: All are either met or ongoing efforts that have been initiated.

Step 11: See Step 5 above in “Network Capacity Building”

Step 12: Both CMHC partners are included in Wave One, however the IDN Team found it premature to repeat these steps for all PCP and SUD partners.

Step 13: The IDN Team has continued to meet and craft work plans, agreements and other requisite tasks with each of our Wave One partners. Progress along very diverse agencies and priorities has been slowed by considerable internal changes among partners’ infrastructure and staffing, but continues to move.

Wave One: Collaborative Integrated Design – Assessment

All are either met or ongoing efforts that have been initiated.

Wave One: Collaborative Integrated Design – Planning

All are either met or ongoing efforts that have been initiated.

Wave One: Collaborative Integrated Design – Implementation

Step 12: The IDN Team offered to contract Integration Coaches for B1 Partners but none requested this resource in this reporting period. We will continue to offer this resource, and alternative approaches have also been discussed.

Step 13a: See Step 5 above in “Network Capacity Building”

Wave One: Collaborative Integrated Design – Evaluation

Step 15: The IDN Team has continued to meet and craft work plans, agreements and other requisite tasks with each of our Wave One and Two partners. Progress along very diverse agencies and priorities has been slowed by considerable internal changes among partners’ infrastructure and staffing, but continues advance. Likewise, the absence of adequate service utilization data have constrained the establishment of performance measures.

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.

As described earlier, we have paused on contracting Integration Coaches after finding that some partners had their own internal resources for coaching, while other preferred to receive consultation from our own Operations Team expert, Clinical Director Dr. Bill Gunn.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
IDN Operations Team conducts Environmental Scan w/Key Partners	Environmental Scan Complete for 10 Key Partners	5 <i>(See Above)</i>	6 <i>(Wave 2 scheduled)</i>	
Selected IDN partners complete CHI Integration Self-Assessment	Up to 25 practices complete CHI Integration Practice Self-Assessment	16 <i>(See Above)</i>	17 <i>to repeat Fall 2018</i>	
Partners/Practices/Providers Use Dashboard in Integration Planning	Dashboard template is developed by Clinical Advisory Team	<i>(See Above)</i>	<i>Rollout with 2nd Round</i>	
	105 Partners/Practices/Providers Report using Dashboard	<i>(in Process)</i>	64	
B1 Partner practices are enrolled in Collaborative Integrated Design Process	Up to 5 Practices in the first Wave (and up to 5 in each of the 3 successive Waves) will complete all 4 components of the Collaborative Integrated Design Process Components include: Assessment/Integration Design Planning/ Implementation/Evaluation	5 Wave One Partners <i>(in Process)</i>	5	
Assessment		<i>(in Process)</i>	5	
Integration Design Planning		<i>(in Process)</i>	5	
Implementation		<i>(in Process)</i>	3	
Evaluation		<i>(in Process)</i>	<i>(in Process)</i>	

Participating Practices report data on IDN Outcome Performance Measures	10 participating practices meet reporting standards for IDN Outcome Performance Measures		1	
Increase Number of attributed beneficiaries who received a Preventative Care visit in the previous calendar year by age range:			Data Not Available	
Age 0-11:	Increase by 127, or 2% above baseline of 6335 (or most current baseline), then 2% increase each year thereafter		Data Not Available	
Age 12-17:	Increase by 45, or 2% above baseline of 2239 (or most current baseline), then 2% increase each year thereafter		Data Not Available	
Age 18-64:	Increase by 56, or 2% above baseline of 2817 (or most current baseline), then 2% increase each year thereafter		Data Not Available	
Age 65:	Increase by 6, or 15% above baseline of 39 (or most current baseline), then 2% increase each year thereafter		Data Not Available	
Increase number of Medicaid beneficiaries receiving Comprehensive Core Standardized Assessment (period & cumulative)	Increase by 10% each reporting period	0	342	
Increase number of Medicaid beneficiaries scoring positive on screening tools who are referred for additional intervention	Increase by 10% each reporting period	0	342	

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.

NOT MET – B1-4 – Please document any progress made toward workforce staffing during this reporting period. All budget expenses and reallocations must be preapproved by DHHS. The creation of an Implementation Plan with each B1 partner was not addressed in the implementation plan.

Pg. 51 – Thank you for the update on workforce staffing. Identified progress is reflected in your B1-2 incentive payment. Incentive payments for onboarding staff will be set aside to the subsequent reporting period available if the position is filled.

The IDN Team has met this requirement by taking several steps to build the staffing capacity of integrated care on the Operations Team as well as direct investments in positions at partner agencies. We offered Implementation coaching to our partners and found that they either already indicated adequate internal capacity or preferred consultation from our Clinical Director, Dr. Bill Gunn (0.4 FTE). Thus, we have paused any movement on Implementation Coaches as a position. [REDACTED]

Provider Type	Projected Total Need	IDN Workforce (FTEs)			
		Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Implementation Coaches	2.0	0	0	Paused	
Clinical Director - Consultation	0.4	0	0	0.4	
Administrative Assistant	0.5	0	0	0.5	
Project Manager	0.8	0	0	0.8	
Behavioral Health Clinician	Up to 3	0	0	0.4	
Behavioral Health Coordinator	Up to 2	0	0	0.5	
Waivered Nurse Practitioner	1	0	0	1	

B1-5. IDN Integrated Healthcare: Budget

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

NOT MET - B1-5 – Please provide ACTUALS for CY 2017. Also include a detailed narrative on spending in this reporting period. DHHS needs to know what the funds were spent on. Include a narrative to speak to funds spent.

a. Pg. 66 – It appears this budget is not actuals as the Information provided to date would indicate that there is no staff, no requests for funding for recruitment and retention were received. However, the budget reflects \$148,500 in funds spent. Funds will be carried over to the subsequent reporting period.

The B1 Project Budget has been spent down modestly, as significant funds that have been committed that are not yet spent down, and there is significant overlap between the A1 Workforce investments we are making and the aims and objectives of the B1 Integration project. [REDACTED]

[REDACTED]

Actual expenditures are illustrated in Attachment B1.5a below.

Attachment B1.5a: B1 Project Actual Expenses

B1 Actual Expenditures through 6/30/2018		2016	Q1-Q2 2017	Q3-Q4 2017	Q1-Q2 2018	ACTUAL TO 6/30/18
<u>INTEGRATION</u>						
25.7400.217	INTEGRATION - TRAINING	0	0	\$0.00	[REDACTED]	
25.7400.229	INTEGRATION - FEES/OUTSIDE SERVICES	0	0	\$0.00		
25.7453.229	WENTWORTH HEALTH PARTNERS - FEES & OUTSIDE S	0	0	\$0.00		
25.7454.229	GREATER SEACOAST COMM HEALTH - FEES & OUTSID	0	0	\$0.00		
	Total	\$ -	\$ -	\$ -		\$ 26,620

B1 project budget projections are included in Attachment B1.5b below. Totals include consideration of expenses to date.

Attachment B1.5b: B1 Projected Budget

Attachment_B1.5 Competency	B1 Core	Q3-Q4 2018	2019	2020	2021	TOTAL
B1 Core Competency Project Expenses						
Immediate Intervention Expenses						
	Recruitment	30,000	40,000	30,000	-	145,000
	Retention	30,000	60,000	60,000	-	195,000
	Training/Education	30,000	70,000	60,000	-	200,000
Core Competency Project Design						
Wave 1						
	Recruitment	15,000	30,000	20,000	-	90,000
	Retention	20,000	40,000	20,000	-	120,000
	Training/Education	35,000	50,000	10,000	-	140,000
Wave 2						
	Recruitment	10,000	40,000	20,000	-	90,000
	Retention	30,000	35,000	15,000	-	100,000
	Training/Education	25,000	40,000	10,000	-	105,000
Wave 3						
	Recruitment	25,000	30,000	20,000	-	90,000
	Retention	20,000	30,000	20,000	-	90,000
	Training/Education	30,000	40,000	10,000	-	90,000
Wave 4						
	Recruitment	35,000	30,000	20,000	-	90,000
	Retention	25,000	30,000	20,000	-	80,000
	Training/Education	30,000	30,000	30,000	-	100,000
Enabling Technology		40,000	60,000	50,000	-	185,000
Operations						
	Office Space	7,000	15,000	17,000	-	52,000
	Furniture				-	4,000
	Supplies/Materials/Equipment	2,000	5,000	5,000	-	16,000
	Travel	5,000	12,000	12,000	-	35,000
Administrative Mgmt Fees for partners		5,000	15,000	15,000	-	42,500
Section Subtotal		449,000	702,000	464,000	-	2,059,500
B1 Core Competency Workforce Expenses						
Workforce						
	Implementation Coach 1					
	Implementation Coach 2					
Section Subtotal						
TOTALS		519,000	852,000	624,000	0	2,559,500

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

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

The IDN has executed Certificates of Authorization with all Wave One and Wave Two partners listed below. During the current report period, the IDN successfully added two new B1 enterprise partners, Exeter Health Resources / Exeter Hospital and Hope on Haven Hill. Hope on Haven Hill is added to the B1 participant list during this submission based on the DHHS published guidance regarding SUD providers engaged in community projects also being listed as B1 partners.

The IDN anticipates executing agreements with during the next reporting period with additional B1 enterprise partners. Based on ongoing strategic planning conversations, the IDN 6 anticipates the addition of Dover Pediatrics and Seacoast Youth Services at the enterprise partner level. They are included in the table below with *.

It is the IDN 6 model to build B1 partnerships at a practice level on an ongoing basis. Practices within our established B1 partner enterprises have expressed new interest in B1 project development but have not yet completed an SSA. To capture the continual progress of the IDN 6, these practices are listed below with **. These practices are anticipated to become practice level B1 partners with Site Self-Assessment completed within the next reporting period.

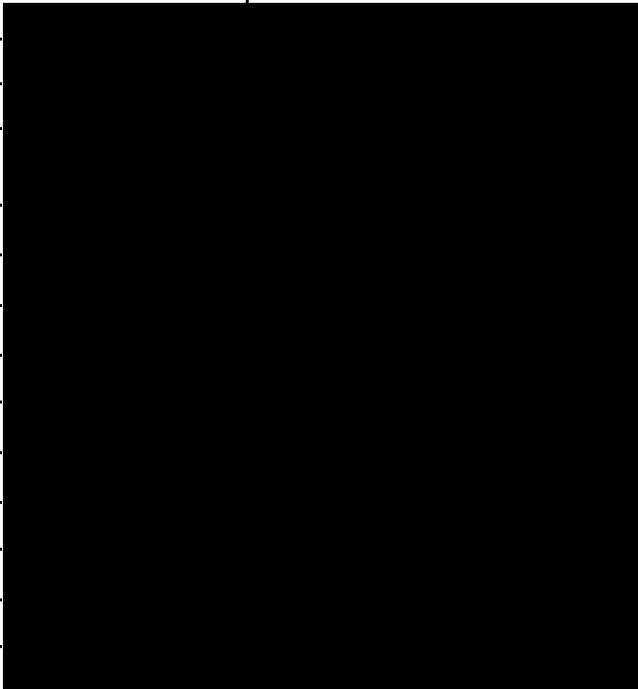
Correction to previous submission: Removed ROAD to Recovery as they are not anticipated to be B1 within the next report period. They were engaged in regional project planning but have not engaged as a participating partner agency in the implementation of any A1, A2, B1 or Community project.

Organization/Provider	Agreement Executed (Y/N)	Date of COA with enterprise - Date of onboarding to IDN at practice level based on SSA #1 completion
WAVE ONE		
Frisbie Memorial Hospital	Yes	10/2016
Rochester Pediatrics**	<i>yes</i>	<i>pending</i>
Wentworth Douglass Hospital	Yes	10/2016
Wentworth Health Partners / Internal Medicine**	<i>yes</i>	<i>pending</i>
Hilltop Family Practice**	<i>yes</i>	<i>pending</i>
Seacoast Mental Health Center	Yes	9/2016
Lamprey Health Care - Newmarket	Yes	11/2016
Lamprey Health Care - Raymond	Yes	11/2016
Community Partners	Yes	9/2016
WAVE TWO		
Exeter Health Resources/CORE	Yes	5/2018
Core Family Practice – Stratham**	<i>yes</i>	<i>pending</i>

Core Family Practice – Exeter**	yes	<i>pending</i>
Greater Seacoast Community Health – Goodwin Community Health	Yes	9/2016
Greater Seacoast Community Health - Families First	Yes	9/2016
Southeastern NH Services	Yes	9/2016
Hope on Haven Hill	Yes	10/2016
Seacoast Youth Services*	Pending	n/a
Portsmouth Regional Hospital / HCA	Yes	10/2016
Appledore Family Medicine**	yes	<i>pending</i>
Dover Pediatrics*	Pending	n/a

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

If all IDN Governance sign-offs 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.

Name	Title	Organization	Sign Off Received
		Strafford County Commissioners	Yes
		HCA Portsmouth Hospital	Yes
		SOS Recovery/Goodwin Health Center	Yes
		Strafford County Community Corrections	Yes
		Seacoast Mental Health Center	Yes
		Strafford Community Action Partnership	Yes
		Southeastern NH Services	Yes
		Community Partners	Yes
		Dover Housing Authority	Yes
		Goodwin Community Health	Yes
		NAMI - NH	Yes
		Families First Health & Support Center	Yes
		Lamprey Health Care	Yes
		Rockingham County Nursing Home	Yes

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

a. 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 Services
- Suicide Risk Assessment
- Functional Status Assessment
- Universal screening using depression screening (PHQ 2 & 9)
- 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 screening.

b. 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

c. Multi-disciplinary core team training for service providers on topics that includes, at minimum:

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

d. Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management.

e. Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions.

f. Secure Messaging

g. Closed Loop Referrals

h. Documented workflows 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
- Adherence to NH Board of Medicine guidelines on opioid prescribing.

B1-8a: See Attachment B1-8a for agency assessment. CCSAs under review during this reporting period include the Accountable Health Communities Health-Related Social Needs Screening Tool from CMS (Attachment B1-8a1), Arizona Self Sufficiency Matrix (Attachment B1-8a.2), the PRAPARE tool (Attachment B1-8a3), the Adult Needs and Strengths Assessment (Attachment B1-8a4) and the Children and Adolescent Needs and Strengths Assessment (Attachment B1-8a5). Although Rochester Pediatrics is a subsidiary practice of Frisbie Hospital, it was extracted and added to Attachment B1.8a based on DHHS WriteBack guidance for item B1-8b, which appears to be related to pediatric providers in B1.8a, not related to the actual requirements for B1.8b (Names and Positions of Multi-Disciplinary Core Team Providers), which was accurately provided in the initial SAR for this reporting period.

Att_B1.8a		Initial Assessment: Pediatric Partner Use of Core Standard Assessments by						
Domain	Practice/Partner:	Frisbie Hospital and PCP Affiliates	Wentworth Douglass Hospital & PCP Affiliates	Portsmouth Hospital & PCP Affiliates	Families First Health & Support Center	Goodwin Health Center	Lamprey Health Care	Rochester Pediatrics
• Demographic information		YES	YES	YES	YES	YES	YES	YES
• Physical health review		YES	YES	YES	YES	YES	YES	YES
• Substance use review		SOME	SOME	SOME	YES	YES	YES	@ Age Appropriate
• Housing assessment		SOME	SOME	SOME	YES	YES	YES	YES
• Family and support services		SOME	SOME	SOME	YES	YES	YES	YES
• Educational attainment		RARELY	RARELY	RARELY	SOME	SOME	SOME	YES
• Employment or entitlement		RARELY	RARELY	RARELY	YES	YES	YES	SOME
• Access to legal services		RARELY	RARELY	RARELY	SOME	SOME	SOME	RARELY
• Suicide risk assessment		RARELY	RARELY	RARELY	SOME	SOME	SOME	@Age Appropriate
• Functional status assessment		SOME	SOME	SOME	SOME	SOME	SOME	
• Universal screening using depression screening (PHQ 2 & 9) and		RARELY	RARELY	RARELY	SOME	SOME	SOME	@Age Appropriate
• Universal screening using SBIRT		RARELY	RARELY	RARELY	SOME	SOME	SOME	RARELY
<i>For pediatric providers, the CCSA must also include:</i>								
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ:SE at 9, 18 and 24/30 month pediatric visits		YES	UNKNOWN	UNKNOWN	YES	YES	YES	YES
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool		YES	UNKNOWN	UNKNOWN	YES	YES	YES	YES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?³

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?⁴

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were **OFTEN**, **SOMETIMES**, or **NEVER** true for you and your household in the last 12 months.⁵

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

³ National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <http://www.nachc.org/research-and-data/prapare/>

⁴ Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. *Journal of Healthcare for the Poor and*

Underserved, 26(2), 321-327.

- 5 Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. *Pediatrics*, 126(1), 26-32. doi:10.1542/peds.2009-3146

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
- Often true
 - Sometimes true
 - Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?⁶**
- Yes
 - No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?⁷**
- Yes
 - No
 - Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.⁸

7. **How often does anyone, including family and friends, physically hurt you?**
- Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

6 National Association of Community Health Centers and Partners, National Association of Community

7 Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <http://www.nachc.org/research-and-data/prapare/>Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. *Pediatrics*, 122(4), 867-875. doi:10.1542/peds.2008-0286

- 8 Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine*, 30(7), 508-512

8. How often does anyone, including family and friends, insult or talk down to you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

9. How often does anyone, including family and friends, threaten you with harm?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

AHC HRSN Screening Tool Supplemental Questions

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:⁹

- Very hard
- Somewhat hard
- Not hard at all

Employment

12. Do you want help finding or keeping work or a job?¹⁰

- Yes, help finding work
- Yes, help keeping work
- I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?¹¹

- I don't need any help
- I get all the help I need
- I could use a little more help
- I need a lot more help

14. How often do you feel lonely or isolated from those around you?¹²

- Never
- Rarely
- Sometimes
- Often
- Always

9 Hall, M. H., Matthews, K. A., Kravitz, H. M., Gold, E. B., Buysse, D. J., Bromberger, J. T., . . . Sowers, M.

(2009). Race and Financial Strain are Independent Correlates of Sleep in Midlife Women: The SWAN

Sleep Study. *Sleep*, 32(1), 73-82. doi:10.5665/sleep/32.1.73

10 Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of

Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

11 Kaiser Permanente. (2012, June). Medicare Total Health Assessment Questionnaire. Retrieved from

https://mydoctor.kaiserpermanente.org/ncal/Images/Medicare%20Total%20Health%20Assessment%20Questionnaire_tcm75-487922.pdf

12 Northwestern University. (2017). PROMIS Item Bank v. 1.0 – Emotional Distress - Anger - Short Form 1

Education

15. Do you speak a language other than English at home?¹³

- Yes
- No

16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.¹⁴

- Yes
- No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?¹⁵

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

18. On average, how many minutes did you usually spend exercising at this level on one of those days?¹⁶

- 0
- 10
- 20
- 30
- 40
- 50
- 60

13 United States, US Census Bureau. (2017). American Community Survey. Retrieved from <https://www.census.gov/programs-surveys/acs/>

14 Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

15 Coleman, K. J., Ngor, E., Reynolds, K., Quinn, V. P., Koebnick, C., Young, D. R., . . . Sallis, R. E. (2012). Initial Validation of an Exercise "Vital Sign" in Electronic Medical Records. *Medicine and Science in Sport and Exercise*, 44(11), 2071-2076. doi:10.1249/MSS.0b013e3182630ec1

16 Ibid

- 90
- 120
- 150 or greater

Follow these 2 steps to decide if the person has a physical activity need:

1. Calculate ["number of days" selected] x ["number of minutes" selected] = [number of minutes of exercise per week]
2. Apply the right age threshold:
 - Under 6 years old: You can't find the physical activity need for people under 6.
 - Age 6 to 17: Less than an average of 60 minutes a day shows an HRSN.
 - Age 18 or older: Less than 150 minutes a week shows an HRSN.

Substance Use

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you.¹⁷

19. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

20. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

- Never
- Once or Twice
- Monthly
- Weekly

□ Daily or Almost Daily

17 United States, U.S. Department of Health and Human Services, National Institutes of Health.
(n.d.). Helping Patients Who Drink Too Much:
A Clinician's Guide (2005 ed., pp. 1-34).

21. How many times in the past year have you used prescription drugs for non-medical reasons?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

22. How many times in the past year have you used illegal drugs?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

Mental Health

23. Over the past 2 weeks, how often have you been bothered by any of the following problems?¹⁸

a. Little interest or pleasure in doing things?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

b. Feeling down, depressed, or hopeless?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

If you get 3 or more when you add the answers to questions 23a and 23b the person may have a mental health need/

18 Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care*, 41(11), 1284-1292.

- 24. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?¹⁹**
- Not at all
 - A little bit
 - Somewhat
 - Quite a bit
 - Very much

Disabilities

- 25. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?²⁰ (5 years old or older)**

- Yes
- No

- 26. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?²¹ (15 years old or older)**

- Yes
- No

19 Elo, A.L., Leppänen, A., & Jahkola, A. (2003). Validity of a Single-Item Measure of Stress Symptoms. *Scandinavian Journal of Work*, 29(6), 444-451.

20 United States, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (n.d.). (2011). Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. Retrieved from <https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status>

21 Ibid.

Attachment B1.8a.2

Participant Name _____

DOB / /

Assessment Date / / Initial Interim Exit

Self-Sufficiency Matrix

Program Name _____ HMIS ID _____

Domain	1	2	3	4
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.
Child Care	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized child care is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.
Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) have medical coverage.	All members can get medical care when needed, but may strain budget.
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.

Domain	1	2	3	4
Family/Social Relations	Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.

Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.
Disabilities	In crisis - acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable - sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe - rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity - asymptomatic - condition controlled by services or medication
Other: (Optional)	In Crisis	Vulnerable	Safe	Building Capacity

Attachment B1.8a.3

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE for Implementation As of September 2, 2016

Personal

1. Are you Hispanic or

7. What is your housing

2. Which race(s) are you? Check all

8. Are you worried about losing

3. At any point in the past 2 years, has
season or migrant

9. What address do you

Street: __

City, State, Zipcode: _____

4. Have you been discharged from the
armed forces of the

Money & Resources

5. What language are you most

11. What is your current work

Family &

12. What is your main

6. How many family members, including
yourself, do you

Personal Characteristics

1. Are you Hispanic or Latino?

2. Which race(s) are you? Check all that apply.

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of

4. Have you been discharged from the armed forces of the

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you

7. What is your housing situation today?

8. Are you worried about losing your housing?

9. What address do you live at?

Street: _____

City, State, Zipcode: _____

Money & Resources

11. What is your current work situation?

12. What is your main insurance?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
--------------------------	-----	--------------------------	----	--------------------------	--------------------------------------

<input type="checkbox"/>	I have housing
--------------------------	----------------

	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
Other (please write):			
I choose not to answer this question			

	Yes		No		I choose not to answer this question
--	-----	--	----	--	--------------------------------------

	Yes		No		I choose not to answer this question
--	-----	--	----	--	--------------------------------------

	Yes		No		I choose not to answer this question
--	-----	--	----	--	--------------------------------------

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

	English
	Language other than English (please write)
	I choose not to answer this question

	Unemployed	Part-time or temporary work	Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:			
I choose not to answer this question			

	None/uninsured	Medicaid
	CHIP Medicaid	Medicare
	Other public insurance (not CHIP)	Other Public Insurance (CHIP)
	Private Insurance	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Optional Additional Questions

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
I choose not to answer this question					

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question
--	-----	--	----	--	--------------------------------------

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes		No		I choose not to answer this question
--	-----	--	----	--	--------------------------------------

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

19. Are you a refugee?

| | | |

	No
	I choose not to answer this question

20 Do you feel physically and emotionally safe where you currently live?

	Yes	No	Unsure
	I choose not to answer this question		

Social and Emotional Health

16. How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Yes	No	Unsure
	I have not had a partner in the past year		
	I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		5 or more times a week
I choose not to answer this question			

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)
NEW HAMPSHIRE COMPREHENSIVE
 Ages 18+



MENTAL HEALTH NEEDS				
ITEM RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating:	Comments:	
Psychosis	N/A			
Cognition¹	N/A			
Impulse Control	N/A			
Depression	N/A			
Mania	N/A			
Anxiety	N/A			
Personality Disorder	N/A			
Antisocial Behavior	N/A			
Adjustment to Trauma^{2s}	N/A			
Anger Control	N/A			
Substance Use³	N/A			
Eating Disturbance	N/A			
Autism Spectrum	N/A			

LIFE FUNCTIONING				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating:	Comments:	
Physical/Medical	B			
Intellectual Functioning	N/A			
Communication	A			
Family	N/A			
Employment⁴	Employment			
Cultural⁵	N/A			
Social Functioning	A			
Caregiving Role	B			
Intimate Relationships	A			
Sexuality	N/A			
Living Skills	A			
Residential Stability	A			
Legal	N/A			
Sleep	A			
ADLs/Self Care	A			
Decision-making	A			

Medication Adherence	Medication	
Transportation	N/A	
Financial Resources	N/A	
Isolation	A	

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

NEW HAMPSHIRE COMPREHENSIVE Ages 18+

RISK BEHAVIORS

RATINGS: 0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

Item	Level	Rating	Comments:
Agitation	C		
Self Injurious Behavior	C		
Other Self Harm	C		
Wandering	C		
Gambling	N/A		
Exploitation	C		
Criminal Behavior	N/A		
<i>Suicide</i> ⁶	C		
<i>Danger to Others</i> ⁷	C		
<i>Sexual Aggression</i> ⁸	C		

STRENGTHS

0=Centerpiece 1=Useful 2=Identified 3=Not yet identified

Item	Level	Rating	Comments:
Family	N/A		
Social Connectedness	N/A		
Optimism	N/A		
Involvement in Recovery	N/A		
Educational	N/A		
Job History	N/A		
Talents/Interests	N/A		
Leisure Activities	N/A		
Meaningfulness	N/A		
Spiritual/Religious	N/A		
Community Strengths	N/A		
Volunteering	N/A		
Natural Supports	N/A		
Resiliency	N/A		
Resourcefulness	N/A		

CAREGIVER(S) STRENGTHS & NEEDS

0=No Evidence 1= Watch/Prevent 2= Act 3= Act Immediately/Intensively

Item	Level	Rating	Comments:
Physical/Behavioral	N/A		
Involvement	N/A		
Knowledge	N/A		
Social Resources	N/A		

Family Stress	N/A
Adult Protection	N/A
Paid Caregiver	N/A

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

NEW HAMPSHIRE COMPREHENSIVE

Ages 18+

EXTENSION MODULES

Extension modules are required for any italicized items with ratings >0.

MODULE 1: COGNITION

RATINGS:				
	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Memory	N/A			
Planning	N/A			
Visual-Spatial Abilities	N/A			
Motor Skills	N/A			

MODULE 2: TRAUMA

RATINGS:				
	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Sexual Abuse*	N/A			
Physical Abuse	N/A			
Emotional Abuse	N/A			
Medical Trauma	N/A			
Natural Disaster	N/A			
Witness to Family Violence	N/A			
Witness to Community Violence	N/A			
Witness/Victim – Criminal Acts	N/A			
*If sexual abuse >0, complete the following				
Emotional Closeness to Perpetrator	N/A			
Frequency of Abuse	N/A			
Duration	N/A			
Force	N/A			
Reaction to Disclosure	N/A			
Adjustment				
Affect Regulation	N/A			
Intrusions	N/A			
Attachment	N/A			
Dissociation	N/A			
Hyperarousal	N/A			

MODULE 3: SUBSTANCE USE

RATINGS:				
	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Severity of Use	N/A			
Duration of Use	N/A			

Stage of Recovery	N/A		
Peer Influences	N/A		
Environmental Influences	N/A		
Please specify the drug(s) of choice:			

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

NEW HAMPSHIRE COMPREHENSIVE

Ages 18+

MODULE 4: EMPLOYMENT			
0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments
Job Performance	N/A		
Job Attendance	N/A		
Job Relations	N/A		
Career Aspirations	N/A		
Job Skills	N/A		

MODULE 5: CULTURE			
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act 3=Act Immediately/Intensively
Item	Level	Rating	Comments:
Language	N/A		
Identity	N/A		
Ritual	N/A		
Cultural Stress	N/A		

MODULE 6: SUICIDE			
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act 3=Act Immediately/Intensively
Item	Level	Rating	Comments:
Suicide Risk*	N/A		
*If suicide risk >0, complete the following			
Ideation	N/A		
Intent	N/A		
Planning	N/A		
History	N/A		

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

NEW HAMPSHIRE COMPREHENSIVE

Ages 18+

MODULE 7: DANGER TO OTHERS				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Frustration Management	N/A			
Hostility	N/A			
Paranoid Thinking	N/A			
Secondary Gains from Anger	N/A			
Violent Thinking	N/A			
Aware of Potential for Violence	N/A			
Response to Consequences	N/A			
Commitment to Self-Control	N/A			
Treatment Involvement	N/A			

MODULE 8: SEXUAL AGGRESSION				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Relationship	N/A			
Physical Force/Threat	N/A			
Planning	N/A			
Age Differential	N/A			
Type of Sex Act	N/A			
Response to Accusation	N/A			
Temporal Consistency	N/A			
History of Sexual Behavior	N/A			
Severity of Sexual Abuse	N/A			

ADULT ELIGIBILITY DETERMINATION

Diagnosis*:		Diagnostic Code:				
Eligibility Effective Date:		Eligibility End Date:				
Eligibility Determination:	Severe Mental Illness (SMI) < 1 year	Severe & Persistent Mental Illness (SPMI) > 1 year	Low Utilizer (LU)	Presumed Eligible for 10 days	Not Eligible	Waiver Requested Date Approved: ____/____/____
	SMI/SPMI: An adult shall be determined by a CMHP to have a severe mental illness (SMI) or severe and persistent mental illness (SPMI) if he or she meets one of each of the following criteria, as per He-M 401.05 - .06:					

Criteria I (required): Eligible diagnosis (e.g., schizophrenia and other psychotic disorders, mood disorders, borderline personality disorder, post-traumatic stress disorder, obsessive compulsive disorder, eating disorders, panic disorder, or dementia, where the psychiatric symptoms cause functional impairments and one or more of the followings co-morbid symptoms exist: anxiety, depression, delusions, hallucinations, or paranoia) (He-M 401.02).

Criteria II (check one) The assessment of functional impairment demonstrates at least 1 of the following:

A "3" rating in any Level A or Level C item

2 or more Level A items rated >1

1 Level A item rated >1 and 1 Level B item rated >1

A "2" rating for 1 Level A item and a rating >1 for Medication Adherence A "2" rating for 1

Level A item and a rating >1 for Employment

2 or more Level C items rated

>1 OR the following exceptions apply:

Exception: The individual does not currently meet Criteria II as a result of the use of clozaril or clozapine or as a result of close supervision such as that provided in a community residence as defined in He-M 1002.02.

Low Utilizer (LU): An adult shall be determined by a CMHP to have a severe mental illness (SMI) or severe and persistent mental illness (SPMI) with low service utilization if he or she meets one of the following criteria, as per He-M 401.07:

The adult

- Has a diagnosed mental illness but no longer meets all the criteria for SPMI or SMI and receives services that are designed to prevent relapse; OR
- Has functional impairments that are due to developmental disability or receives services primarily through another agency such as a provider for persons with developmental disabilities or New Hampshire Hospital; OR
- Meets criteria for SPMI or SMI but has refused recommended services and for whom the CMHP is providing outreach.

The following dated signature is only needed if an electronic signature elsewhere in the clinical record is not employed.

Staff Printed Name, Credential, Title:

Staff Signature, Credential, Title

_____ **Date:** _____

QUARTERLY REVIEW OF THE INDIVIDUAL SERVICE PLAN

Time period covered by this review:	Start Date:		End Date:	
Date of quarterly review:				

Change in Status (for the last 90 days):	
Employment Status	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed

	<input type="checkbox"/> Not in labor force				
Housing Status	<input type="checkbox"/> Homeless Residential <input type="checkbox"/> Care Crisis Residence <input type="checkbox"/> Institutional Setting Jail <input type="checkbox"/> Private Residence – Independent Living <input type="checkbox"/> Private Residence – Dependent Living <input type="checkbox"/> Private Residence – Living Arrangement Not Available <input type="checkbox"/> Other _____				
Was the client hospitalized for any psychiatric issues in the last 90 days?	<table border="1"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td># days hospitalized: _____</td> <td></td> </tr> </table>	Yes	No	# days hospitalized: _____	
Yes	No				
# days hospitalized: _____					

Individual's Goals and Objectives (for the last 90 days):

Goal & Objectives:
Progress: <i>Note: Please describe specific progress towards goals (i.e., Client was able to go grocery shopping without anxiety 4 out of 8 times). If there is no progress, please explain why not.</i>
Revisions:
Goal & Objectives:
Progress:
Revisions:
Goal & Objectives:

Progress:
Revisions:
Goal & Objectives:
Progress:

Revisions:								
Services provided in the last 90 days:								
<table border="1"> <thead> <tr> <th>Service</th> <th>Frequency</th> <th>Duration</th> <th>Purpose of Service</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td><i>Note: Please describe both the appropriateness of services being provided AND the need for a participant's continued participation in services</i></td> </tr> </tbody> </table>	Service	Frequency	Duration	Purpose of Service				<i>Note: Please describe both the appropriateness of services being provided AND the need for a participant's continued participation in services</i>
Service	Frequency	Duration	Purpose of Service					
			<i>Note: Please describe both the appropriateness of services being provided AND the need for a participant's continued participation in services</i>					

<i>Please explain why any services documented in the Individual Service Plan were not provided during the past 90 days.</i>			

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change(s) to the Individual Service Plan during the reporting quarter:		
Eligibility Category:		
Persistent Mental Illness	Low Utilizer (LU)	Severe Mental Illness (SMI)
		Severe & (SPMI)

Consumer Signature:

Date:

Staff Signature:

Date:

Physician's Signature:

Date:

Attachment B1.8a.5

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)
Age 0 to Transition Age

CHILD BEHAVIORAL/EMOTIONAL NEEDS			
0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
	Level	Rating	Comments:
Psychosis	N/A		
Impulsivity/Hyperactivity	N/A		
Depression	N/A		
Anxiety	N/A		
Oppositional (Non-compliance with authority)	N/A		
Conduct	N/A		
Adjustment to Trauma	N/A		
Substance Use	N/A		
Autism Spectrum	N/A		
Anger Control	N/A		
Eating Disturbance	N/A		
Attachment	N/A		
CHILD LIFE FUNCTIONING			
0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
	Level	Rating	Comments:
Family Functioning	A		
Living Situation	A		
SOCIAL FUNCTIONING	A		
DECISIONMAKING	A		
ADLs/Self Care	A		
Sleep	A		
Sexual Development	A		
School	A		
Medical/Physical	N/A		
Developmental/Intellectual	N/A		
Self-Regulation	A		
Communication	A		
CHILD RISK BEHAVIORS			
0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
	Level	Rating	Comments:
Non-Suicidal Self Injurious Behavior	A		
Other Self Harm/Recklessness	A		
Suicide Risk (Danger to Self)	A		
Danger to Others	A		
Sexual Aggression	A		

Exploited	A		
Runaway/Elopement	A		
Delinquent Behavior	A		
Firesetting	A		
Animal Cruelty	A		

NEW HAMPSHIRE
CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Age 0 to Transition Age

Intentional Misbehavior	A		
-------------------------	---	--	--

CULTURAL FACTORS

Language	N/A		
Traditions and rituals	N/A		
Cultural Stress	N/A		

CHILD STRENGTHS

0=Centerpiece	1=Useful Strength	2=Potential Strength	3=None Identified
Level	Rating	Comments:	
Family Strengths	N/A		
Interpersonal	N/A		
Natural supports	N/A		
Educational setting	N/A		
Talents/Interests	N/A		
Spiritual/Religious	N/A		
Cultural identity	N/A		

Community Life	N/A		
Optimism	N/A		
Resilience	N/A		

CAREGIVER(S) STRENGTHS & NEEDS

0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Level	Rating	Comments:	
Supervision	B		
Involvement With Care	B		
Knowledge	B		
Organization	B		
Social Resources	B		
Residential Stability	B		
Medical/physical	B		
Mental health	B		
Substance Use	B		
Child Care Accessibility	B		
Military Transitions	B		
Child Safety	B		

Family Stress	B	
---------------	---	--

NEW HAMPSHIRE
CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Age 0 to Transition Age

SUBSTANCE USE			
0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
	Level	Rating	Comments:
Severity of Use	N/A		
Duration of Use	N/A		
Stage of Recovery	N/A		
Peer Influences	N/A		
Parental Influences	N/A		
Environmental Influences	N/A		
Please specify the drug(s) of choice:			

B1-8b: The names and positions of multi-disciplinary core team members are collected during the Collaborative Design Assessment Phase with each wave of the B1 Project. This process was initiated during this reporting period, but not completed. The Community Care Teams serve as the region’s multi-disciplinary core team. See Attachment B1.8e for a detailed summary of Community Care Team participants.

NOT MET - B1-8b - Provide a table and timeline for completion. Please provide a narrative describing when all participating practices will be incorporating the required domain areas and progress made during this reporting period. Provide a table listing names or positions comprising multi-disciplinary core team members. Include detailed narrative in B1-2 describing your plan and schedule to achieve this requirement no later than December 2018. Update your timeline to include measurable milestones in each reporting period through December 2018 toward meeting this goal. Identify progress made during this reporting period towards achieving this deliverable.

a. Pg. 69 – As indicated in this milestone was not achieved. Funds for B1-8b will be carried over to the subsequent reporting period.

The IDN Team has met this requirement through the provision of the table below that depicts the identification and onboarding of specific individuals who are currently filling each role in the Multidisciplinary Core Team for B1 practices. Practices and Team members will be added through the next reporting period as Wave One and some Wave Two partners continue to build the Multidisciplinary Core Teams. Narrative describing additional anticipated Core Team assessment is added to the table below. The Region 6 IDN maintains that the addition of partner agencies to both the Northern (Greater Rochester) and Southern (Greater Portsmouth) Community Care Teams each reporting period is also ample and adequate evidence of progress in the development of regional access to effective Multi-disciplinary Core Teams.

Practice and MDC Team Roles	Multidisciplinary Core Team Development			
	Practice Specific Title	Core Staff	Staff 6/30/18	Staff 12/31/18
Wentworth Health Partners				
Primary Care Providers				
Behavioral Health Coordinator				
Care Manager				
Social Worker				
Psychiatry (WHP Consult)				
Incorporating Required Domains				
Rochester Pediatrics				
Primary Care Provider				

Behavioral Health Coordinator		1	
Care Manager		1	
Social Worker		1	
Psychiatry (D-H Consult)		1	
Incorporating Required Domains		no	expected
Lamprey Health Care			
Primary Care Provider			
Behavioral Health Coordinator			
Care Manager			
Social Worker			
Psychiatry (WHP Consult)			
Incorporating Required Domains		no	expected
Frisbie Primary Care Practices	Core Team Assessment delayed @ agency request to next reporting period due to senior leadership reorganization and EHR vendor change		
Goodwin Community Health Center	Core Team Assessment delayed @ agency request to next reporting period due to agency re-organization		
Families First Community Health Center	Core Team Assessment delayed @ agency request to next reporting period due to agency re-organization		
Southeastern NH Services	Core Team Assessment will be completed during next reporting period per Project Plan Timeline		
Portsmouth Hospital/Appledore	Core Team Assessment anticipated to be complete during next reporting period		

B1-8c & B1-8d:

NOT MET - B1-8c - Provide a table listing all provider practice sites and number of individuals to be trained. Progress needs to be made in every reporting period to qualify for incentive payment and Coordinated Care Practice Designation must be met no later than December 2018. Payment is tied to progress in each reporting period. Incentive funds can be earned in one subsequent reporting period.

a. Pg. 70 – Inaccurately states that the expectation for training tables with training sites and staff members not identified in prior guidance. In fact, the requirement is clearly specified in the SAR Template. The expectation is that the contracted IDN Lead is demonstrating knowledge of the number of partners in their region that require training. This is key to establishing and executing the training requirements within the expected timeframes. This was discussed at numerous IDN Lead meetings. There is

no progress reflected on the Attachment_B1-8c from prior submission. The only change noted is the removal of the training schedule. Funds for B1-8b will be carried over to the subsequent reporting period.

The IDN Team has met B1-8c primarily through engaging and supporting our B1 clinical provider and administrative partners to attend a 2-Day training in Integrated Care presented by Cherokee Health Systems (for attendee list see Attachment B1-8c.1) and ongoing regional trainings (see Attachment B1-8c.2)

There is no way to confidently assess, predict or dictate the number of clinical providers to be trained as there are too many mitigating factors. It is important to note that many trainings are appropriate for and attended by clinical and non-clinical staff alike. We have found it far more effective to offer region-wide and site-specific trainings on an ongoing basis to meet shifting partner needs and priorities shaped by flux in demands, funding opportunities, staffing turnover etc. We have also found that some agencies have internal capacity to deliver these trainings and ongoing support to their own staff. Likewise the IDN Team is diligent about informing Regional partners about training opportunities throughout the region, the state, and some in other states. A Training Calendar based on these findings is included (Attachment B1-8c.2) following the Cherokee Attendee list (Attachment B1-8c.1)

Region 6 Integrated Delivery Network

IDN 6 Continuing Education Training

Through JUNE 30

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
Cultural Competency Unpacking Assumptions A one hour cultural competency training focused on the culture of mental illness and substance misuse.	2 Delivered	2018 Q2 4/24/18 Newmarket 4/26/18	Min. enrollment: 10 Mutli-disciplinary Available as large group OR to specific practices/organizations	\$4455	\$935
Stigma Across Cultures 4 hour CC training	In Development	Spring 2018 Before 6/30 if possible	Min. enrollment: 10	\$2530	\$2090
SBIRT A one hour training on the Screening, Brief Intervention & Treatment process with web-based follow-up/community of practice to reinforce, support and sustain learning.	Available	May-June 2018		\$1375	\$440

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
Motivational Interviewing for Non-Clinical Staff Lisa Stockwell	1 Delivered	June 19	Min. enrollment: 10		
Trauma Informed Care Casey Yackley	In Development	June 15 – half-day	Min enrollment: 10	TBD as faculty is secure	
				Minimum \$1925	Minimum
Shared Care Planning	Developed and Delivered first training	June 20	Up to 20	IDN Provided	
Trauma Informed Care Healing In Action Gretchen Schmelzer, PhD	Delivered	June 1&2	Min enrollment: 10	Shared cost with SOS R	

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
Compassion Fatigue for First Responders Kevin Irwin and Tory Jennison	In Development	Fall 2018	Anyone who considers themselves a first responder		
Enhancing Provider Skills in Serving Active Substance Users Kerry Nolte For clinical providers interested in enhancing their skills in talking with active substance users, especially injection drug users.	Description Complete Ready to Announce	Begin September 2018	Clinical Providers Lunch & Learn	To be determined as training is developed.	
Integrated Care Training Cherokee Health Systems	Initial Completed	June 14-15, 1.5 days	IDN Partner Teams incl'g clinicians and ops staff; 40 slots for Region 6	\$7,500 shared by 3 regi	

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
Mental Health First Aid Evidence based program, perhaps offer twice in region. 2-3 hours	In Development	Early July, after 4 th but before last two weeks?	Min enrollment: 10 Non-clinical: First responders, volunteer drivers, recovery coaches, para-professionals	TBD as faculty is secure Minimum \$1925	Minimum
Mental Health First Aid Train-the-Trainer	Complete	April 23-27	SENHS Staff	Non-AHEC	
MAT Niki has requested. Nursing-specific.	In Development	Fall 2018	Could do for multiple agencies offering MAT: Goodwin/FF, SMHC,, Lamprey	To be determined as training is developed. Minimum \$1925	Minimum

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
Motivational Interviewing Train the Trainer Pete Fifield MI training that builds capacity to develop champions within own practice.	In Development	Fall 2018	Min. enrollment TBD	TBD as faculty is secure	Minimum
				Minimum \$1925	Minimum
Diabetes and Behavioral Health Program focused on hyperlipidemia, dyslipidemia, hypertension, (effects of medication, patient adherence)	In development-reached out to CDE. Could potentially be offered as online training.	Fall 2018		\$4675	\$990 (face)
				Cost for web-based del TBD	

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
<p>Chronic Pain Self-Management Training Evidence based self-management workshops 2.5hrs/wk for 6 weeks</p> <p>Currently working on mini community needs assessment. Hope to have a leader training within 6 mos.</p>	<p>In development</p>	<p>Fall 2018</p>		<p>To be determined as training is developed</p>	

Training	Status	Timeframe	Min. Enrollment & Audience	Initial Cost	Subseq Cost
Sustaining Integration in Practice (aka BH101) One hour program	HOLD	Up to Bill. Does AHEC do? Need to address extra cost.		Minimum \$1925	Minimum
Billing and Coding Silvia Ronda Enhancing knowledge of billing and coding, including around coding for care coordination, to maximize revenue	In development	Spring/Summer 2018?	Back office staff health care practices	To be determined as training is developed	
42 CFR Lucy Hodder 2-part series	To be developed	Summer/Fall 2018	In person: 10??	To be determined as training is developed	

NOT MET - B1-8d - Provide a table listing all staff and number of individuals to be trained.

Identify any progress made during this reporting period.

- a. Pg. 70 – During IDN Lead meetings the IDN Executive Leads specifically asked DHHS to accept numbers of staff by practice site for this deliverable and DHHS agreed as staff turnover occurs. DHHS is concerned that the IDN Lead had not determined the number of staff providers in the region that required identified trainings. There is no progress reflected on the Attachment_B1-8d. The only change noted is the removal of the training schedule. Funds for B1-8b will be carried over to the subsequent reporting period.

The IDN has met this requirement as depicted in the Training Summary (see following Attachment B1-8d) on trainings that have been delivered in the reporting period. It should be noted that several trainings include attendance by both clinical and non-clinical staff. We don't report names or disaggregate by role, rather, as agreed, the report is organized into both the agencies and service sectors represented by attendees.

In our interest and needs assessment of trainings for IDN partners the responses overwhelmingly indicated that demand for the trainings already contemplated to be offered through the IDN, but that it is not possible to predict or dictate the number of individuals to be trained as there are too many mitigating factors. It is important to note that many trainings are appropriate for and attended by clinical and non-clinical staff alike. We have found it far more effective to offer region-wide and site-specific trainings on an ongoing basis to meet shifting partner needs and priorities shaped by flux in demands, funding opportunities, staffing turnover, staff coverage, etc. We have also found that some agencies have internal capacity to deliver these trainings and ongoing support to their own staff. Likewise the IDN Team is diligent about informing Regional partners about training opportunities throughout the region, the state, and some in other states.

The trainings identified in the Region 6 (held & anticipated) training calendars reflect tremendous effort to accommodate the most participants possible from our partner agencies. As the DSRIP is an incentive based demonstration project, we work diligently to determine which incentives and what type of educational formatting will result in the most uptake of training by our partners. Since the Region 6 IDN cannot mandate attendance at trainings, we believe the trainings (and associated attendance) indicated in Attachment B1-8d reflect meaningful and adequate progress.

Attachment B1.8d: Region 6 IDN Training

Training provided	Date	Project Relevance	Total Attendance	Agencies attending
Overdose Prevention	1/24/18	A1, B1, C1, D3, E5	45	UNH Nursing Students
Human Trafficking	3/29/18	C1	3	Region 6 CTI staff
Mental Health First Aid Train the Trainer	4/23-27/2018	A1, B1, C1, D3, E5	2	Southeastern NH Services
Cultural Competency	4/24/18	A1, B1, C1, D3, E5	25	Lamprey Health Care, Newmarket
Cultural Competency	4/26/18	A1, B1, C1, D3, E5	29	Lamprey Health Care, Raymond
Harm Reduction 201	5/11/18	A1, B1, C1, D3, E5	120	Dozens of Agencies
Trauma Informed Care	6/1/18	A1, B1, C1, D3, E5	60	SOS Peer Recovery Center; Wentworth Douglass Hospital; Strafford County Community Action; Community Partners; Cross Roads House; Seacoast Mental Health Center; Goodwin Community Health; Tri-City Consumers' Alliance Cooperative; R6 IDN; Wentworth Health Partners; Strafford County Community Corrections; Strafford County Public Health Network
Trauma Informed Care	6/2/18	A1, B1, C1, D3, E5	37	

Training provided	Date	Project Relevance	Total Attendance	Agencies attending
Core Standardized Assessment	6/7/18	A1, B1, C1, D3, E5	30	Rockingham Community Action; Strafford County CAP; Grtr Seacoast Homeless Coalition; Portsmouth Regional Hospital; Manchester Community MH Center; Frisbie Memorial Hospital; Rochester Public Housing Authority; NH Healthy Families; Community Partners; Strafford County Public Health Netwk; Cornerstone VNA; Cross Roads House; Wentworth Douglass Hospital; Portsmouth Welfare Dept; Somersworth Welfare Dept;
Cultural Competency	6/7/18	A1, B1, C1, D3, E5	30	Dover Welfare Dept; NH BEAS; WellSense; R6 IDN; Rochester Welfare Dept; Portsmouth Housing Authority
NH Policy Environment Training and Planning	6/7/18	A1, B1, C1, D3, E5	30	
Clinical Integration	6/14-15/2018	B1	40	CORE Physicians; Families First; Frisbie Memorial Hospital; Addiction Recovery Services; Goodwin Community Health; Region 6 IDN; Lamprey Health Care; Seacoast Mental Health Center; Southeastern NH Services; Wentworth Douglass Hospital
Motivational Interviewing	6/19/18	A1, B1, C1, D3, E5	16	Lamprey Health Care; Wentworth Douglass Hospital; Wentworth Health Partners; Easter Seals; Community Partners; Rockingham VNA & Hospice; Lovering Health Center; Region 6 IDN CTI Staff
Shared Care Plan	6/20/18	B1, C1, D3, E5	15	R6 IDN Clinical Advisory Team: Addiction Recovery Services, Families First, Southeastern NH Services, Lamprey Health Care, CORE Physicians, Wentworth Health Partners, Seacoast Mental Health Center, SAU 16,

Training provided	Date	Project Relevance	Total Attendance	Agencies attending
Motivational Interviewing	6/26/18	A1, B1, C1, D3, E5	16	Frisbie Memorial Hospital; Lamprey Health Care; Southern NH Services; CORE Physicians; Granite Pathways; Exeter Health Resources; Rockingham Community Action; Seacoast Mental Health Center; Exeter Hospital; Rockingham VNA & Hospice; Seacoast Pathways
** When available				

B1-8e: The Wentworth Health Partners B1 Team met weekly for initiative development and case conferences. Core team case conferences for patients with significant behavioral health conditions or chronic conditions were also conducted by both the Seacoast and Strafford County Community Care Teams during the reporting period. The CCTs met at least twice monthly and occasionally more frequently if case load or acuity indicated a need for increased frequency. See attachment B1-8e for CCT partner details.

Att_B1.8e

<u>COMMUNITY CARE TEAM</u>	2018					
	January	Feb	March	April	May	June
Seacoast County Portsmouth Regional Hospital Classroom 3 or 4 2nd Monday of each month 10:30 to 11:30 AM	Jan 15	Feb 5 Feb 19	Mar 5 Mar 19	April 2 April 16	May 7 May 21	June 4 June 18
Strafford County Frisbie Memorial Hospital Belknap Room, Education & Conference Center 3rd Monday of each month 9:00-10:30 AM	Jan 8	Feb 12	Mar 12	April 9	May 14	June 11

Seacoast CCT Members

- Amedisys Home Care
- Beacon Health Strategies
- Community Action Partnership of Strafford County
- Child & Family Services
- Cornerstone VNA
- Cross Roads House
- Crotched Mountain Community Care
- Exeter Health Resources
- Families First of the Greater Seacoast
- Granite State Independent Living
- Greater Seacoast Coalition to End Homelessness
- Haven

Strafford County CCT Members

- Beacon Health Strategies
- Child & Family Services
- Community Action Partnership of Strafford County
- Community Partners
- Cornerstone VNA
- Cross Roads House
- Dover Housing Authority
- Families First of the Greater Seacoast
- Frisbie Memorial Hospital
- Goodwin Community Health
- Granite State Independent Living
- Greater Seacoast Coalition to End Homelessness

Hope on Haven Hill
NH DHHS Bureau of Elderly and Adult Services
NH Healthy Families MCO
One Sky Community Services
Portsmouth Housing Authority
Portsmouth Regional Hospital
Region 6 Integrated Delivery Network
Rockingham Community Action
Rockingham VNA
Safe Harbor Recovery Center
Salvation Army, Portsmouth
Seacoast Mental Health Center
Seacoast Pathways (Granite Pathways)
ServiceLink of Rockingham County
St. Vincent dePaul Society
Veterans, Inc.
Welfare Department, City of Portsmouth
WellSense Healthplan

Haven
Homeless Center for Strafford County
Hope on Haven Hill
The Homemakers Services
My Friend's Place
NH DHHS Bureau of Elderly and Adult Services
NH Healthy Families MCO
Region 6 Integrated Delivery Network
Rochester Community Recovery Center
Rochester Housing Authority
ServiceLink of Strafford County
Somersworth Housing Authority
SOS Recovery Community Organization
Southeastern NH Services
Tri-City Consumers' Action Co-operative
Veterans, Inc.
Welfare Department, City of
Dover
Welfare Department, City of Rochester
Welfare Department, City of Somersworth
WellSense
Healthplan
Wentworth-Douglass Hospital
Wentworth Home Care and Hospice - Amedisys

B1-8f:

NOT MET - B1-8f - – Identify any progress made during this reporting period. Specifically, Direct Secure Messaging contract execution.

a. Pg. 70 - DHHS appreciates the discussion being facilitated among your partners.

However, payment is tied to selection and implementation. Funds for B1-8f will be carried over to the subsequent reporting period.

The IDN Team made progress on B1-8f through the completed assessments of all core clinical partner agencies for current capacity and interest in a Direct Secure Messaging solution, and by funding Seacoast Community Mental Health Center to change their HISP (Health Information Service Provider) vendor. Every partner agency indicated that they already have capacity that is adequate to their needs and no interest in adopting a new or replacement technology during this reporting period. The IDN Team indicated that we would revisit subsequent demand for a DSM solution in Q4 2018 after our other HIT solutions are in place (data aggregator and shared care plan).

In addition to the Direct Secure Messaging solution mentioned above and availability identified in Attachment B1.8f below, additional potential secure message strategies will evolve through implementation planning for Allscripts (Care Director), the Region 6 vendor selected to meet the minimum standard requirements for Shared Care Plan, scheduled to commence during the next Reporting Period in Q3/Q4 2018.

ATTACHMENT B1.8f: Secure Messaging Status

Partner Provider							Data	Dir
	A1	A2	B1	C1	D3	E5	Agreement	
Appledore Primary Care Practices/(*select practices - Portsmouth Hospital)							NO	
Community Partners							Pending	EH
CORE Primary Care Practices (*select practices - Exeter Hospital)							Pending	EH
Exeter Hospital							Pending	
Families First Health & Support Center							Y	EH
Frisbie Hospital Primary Care Practices (selected)							Pending	EH
Frisbie Memorial Hospital							Y	EH
Goodwin Health Center							Y	EH
Hope On Haven Hill							NO	EH
Lamprey Health Care							Pending	EH
Portsmouth Regional Hospital							NO	
ROAD to Recovery							NO	
Seacoast Mental Health Center							Y	EH
Southeastern NH Services							NO	
Wentworth Douglass Hospital							Pending	EH
Wentworth Douglass Hospital Primary Care Practices (selected)							Pending	EH

B1-8g: During this reporting period, the Region 6 IDN continued the assessment of current referral practices in use among regional partners for Wave 1 partners during the initial Collaborative Integrated Design phase of the B1 Core Integration project.

During the current reporting period, the following B1 partners reported using (primarily)

[REDACTED]

- [REDACTED]
- [REDACTED]

[REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

[REDACTED]

Referral gaps, pathways, processes and protocols were also assessed via guided exercises at 2 regional All Partner meetings. For those partners who do use electronic means to conduct closed loop referrals, the technology is not a barrier. The internal work processes and workflows are not consistent within or across agencies with regard to patient population or types of referrals that are included in closed loop consideration. For those partner agencies who express willingness to dialogue with the Region 6 IDN regarding the development of closed loop protocols, the IDN Operations team has provided recommendations. Although closed loop referrals are an optional DSRIP standard, Region 6 IDN believes they are a good indication of a maturing care coordination system. Further development of this standard will only enhance the function and effectiveness of the electronic Shared Care Plan solution (Allscripts Care Director) that the Region plans to implement during the next Reporting Period in 2018.

B1-8h:

NOT MET - B1-8h - Submit all workflows developed during this reporting period. Update timeline detailing milestones toward achievement in each remaining reporting period through December 2018. Identify any progress made during this reporting period.

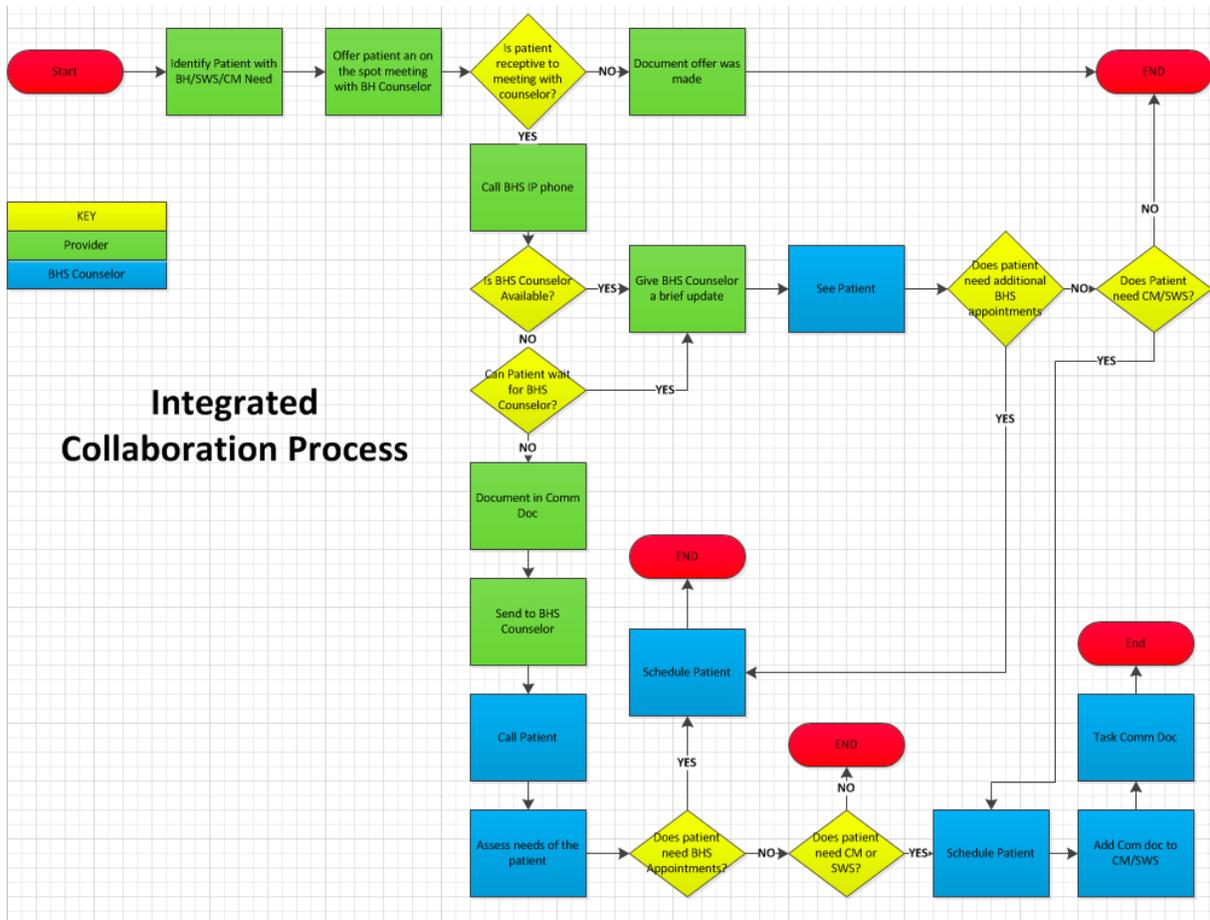
- a. Pg. 71 – Thank you for your response that workflows will be provided upon completion which is anticipated by the end of the next reporting period. B1-8h funds will be carried over to the subsequent reporting period.

The IDN Team has met this requirement by crafting and submitting the first fully developed Workflow

[REDACTED]

The IDN Team continues to find tremendous variability and fluid boundaries around categorizations, definitions, approaches and the solutions being contemplated among Wave One partners. Our approach is to continue to focus on the development of work flows, including procedures, authorizations and communication streams that will be required for partners to meet their Wave One Objectives. Work flows in every Wave One partner [REDACTED] have been in tremendous flux due to factors like EMR implementation; agency mergers; agency re-structuring, and general agency restraint in an unstable market environment.

[REDACTED]



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	<p>All of the following domains must be included in the CCSA:</p> <ul style="list-style-type: none"> ● Demographic information ● Physical health review ● Substance use review ● Housing assessment ● Family and support services ● Educational attainment ● Employment or entitlement ● Access to legal services ● Suicide risk assessment ● Functional status 	<p>CCSAs (Submit all that are in use)</p> <p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				

	<p>assessment</p> <ul style="list-style-type: none"> • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT 					
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> • 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 	<p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
B1-8b	<p>List of multi-disciplinary core team members that includes, at minimum:</p> <ul style="list-style-type: none"> • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker 	<p>Table listing names of individuals or positions within each provider practice by core team</p>				
B1-8c	<p>Multi-disciplinary core team training for service providers on topics that includes, at minimum:</p> <ul style="list-style-type: none"> • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple) 	<p>Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting</p>				

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

B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> ● Interactions between providers and community based organizations ● Timely communication ● Privacy, including limitations on information for communications with treating provider and community based organizations ● Coordination among case managers (internal and external to IDN) ● Safe transitions from institutional settings back to primary care, behavioral health and social support service providers ● Intake procedures that include systematically soliciting patient consent to confidentially share information among providers ● Adherence to NH Board of Medicine guidelines on opioid prescribing 	<p>Work flows and/or Protocols (submit all in use)</p>				
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B1-9. Additional Documentation as Requested in B1-9a - 9d

- a. Achievement of all the requirements of a Coordinated Care Practice
- b. Adoption of both of the following evidence-based interventions:
 - Medication Assisted Treatment

- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through the use of IMPACT or other evidence-supported model
- c. Use of Technology to identify, at a minimum:
 - At Risk Patients
 - Plan Care
 - Monitor/Manage Patient progress toward goals
 - Ensure Closed Loop Referral
- d. Documented Workflows including at a minimum: Joint service protocols and Communication channels

B1-9a: Assessments conducted with partners in Wave 1 of the B1 Core Integration project included self-surveys of practice or agency integration. The initial phase of the B1 Collaborative Integrated Design process included review of each participant's self-survey in Wave 1. As a result of those reviews and ongoing discussion, the Region 6 IDN has assessed that all 5 participants in Wave 1 of the B1 Core Integration project met or exceeded Level 2 on the SAMHSA Model of Coordinated/Integrated Care (in Attachment_B1.9a). Characteristics of Level 2, or 'Basic Collaboration at a Distance' include:

- Behavioral health and primary care providers maintain separate facilities and separate systems.
- Providers view each other as resources and communicate periodically about shared patients.
- Most communications are typically driven by specific issues. (*i.e., a primary care physician may request a copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis.*)
- Behavioral health is most often viewed as specialty care.

While some Wave 1 participants demonstrate elements of more robust integration, additional assessment is required to confirm that any partners are meaningfully and consistently performing above a Level 2 at the practice, agency, or institutional level.

Remaining partner practices/agencies will be assessed for integration status in subsequent Waves of the B1 Core integration process or as part of community project participation. The Region 1 IDN will work with current Wave 1 and future Wave Partners to assess interest and appropriateness for IDN supported pursuit of Integrated Practice designation.

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> » Have separate systems » Communicate about cases only rarely and under compelling circumstances » Communicate, driven by provider need » May never meet in person » Have limited understanding of each other's roles 	<ul style="list-style-type: none"> » Have separate systems » Communicate periodically about shared patients » Communicate, driven by specific patient issues » May meet as part of larger community » Appreciate each other's roles as resources 	<ul style="list-style-type: none"> » Have separate systems » Communicate regularly about shared patients, by phone or e-mail » Collaborate, driven by need for each other's services and more reliable referral » Meet occasionally to discuss cases due to close proximity » Feel part of a larger yet non-formal team 	<ul style="list-style-type: none"> » Share some systems, like scheduling or medical records » Communicate in person as needed » Collaborate, driven by need for consultation and coordinated plans for difficult patients » Have regular face-to-face interactions about some patients » Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> » Actively seek system solutions together or develop work-a-rounds » Communicate frequently in person » Collaborate, driven by desire to be a member of the care team » Have regular team meetings to discuss overall patient care and specific patient issues » Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> » Have resolved most or all system issues, functioning as one integrated system » Communicate consistently at the system, team and individual levels » Collaborate, driven by shared concept of team care » Have formal and informal meetings to support integrated model of care » Have roles and cultures that blur or blend

B1-9b:

NOT MET - B1-9b - In B1-2, provide a detailed narrative outlining the activities, milestones, and timeframes throughout the demonstration period indicating measurable progress to be achieved on integration practice designation.

- a. B1-9b does not provide a detailed narrative describing when and how you will meet this designation or submit required protocols. B1-9b funds will be carried over to the subsequent reporting period.

The IDN Team has met this requirement by providing the following detailed narrative for each of our Wave One and a subset of our Wave Two partners:

[REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

- [REDACTED]
- [REDACTED]

- [Redacted]

[Redacted]

- [Redacted]
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- [Redacted]
- [Redacted]

[Redacted]

- [Redacted]
- [Redacted]

[Redacted]

- [Redacted]
- [Redacted]
- [Redacted]

B1-9c:

NOT MET - – Attachment B1-9c – Note: these are to be achieved by December 2018. Table is not clear. Reformat table to indicate technology across the columns with progress made for each provider partner in this reporting period with in the table. Example: contract executed with xxx? Also, indicate contractor for each solution and date contract was executed. Add B1 providers to the table (attachment B1.9c). Provide a narrative to describe progress made during this reporting period.

- a. Pg. 86 - B1-9c - The table does not reflect progress made. Funds will be carried over to the subsequent reporting period

The IDN Team has met this requirement by providing a reformatted table that indicates progress made across HIT categories with each B1 Partner See Attachment B1.9c for additional information on the R6 IDN plan to monitor partner use of technology to identify at risk clients, plan care, monitor and manage patient care goals, and ensure closed loop referral as solution implementation continues. Partner agencies in the B1 project have identified capacity to identify at-risk clients. Those methods are reported as proprietary. With observation and analysis, the Region 6 team has observed elements of those methods to include electronic notification of patient Emergency Department visits, risk-scoring based on confidential agency-specific criteria and algorithms, and reports run by the agency on HEDIS measures and/or provided, in few instances, by an MCO for a panel of clients. All but one partner agency (ROAD) reports the capacity to plan care and monitor progress for clinical care via the use of EHR notes, patient and provider dashboards, and reports. While partners continue to develop the ability to assess social determinants and consider that assessment in care plan development through implementation of the CCSA domains, agency-wide ability to consistently monitor progress for social determinant interventions is still emerging. This capability will be improved when agencies begin implementation of Care Director, the Allscripts Shared Care Plan solution, during the next reporting period. Care Director will provide staff at all B1 partner agencies access to social determinant assessments and progress on interventions driven by those interventions.

Attachment B1.9c

Partner Provider	Data Agreement	Data Aggregator engagement	B1-9c ID At Risk Patients	B1-9c Plan Care/ Monitor Progress	Plan Care Progress -
Appledore Primary Care Practices/(*select practices - Portsmouth Hospital)	NO	NO	Electronic	Electronic - EHR	U
Community Partners	Pending	YES	Electronic	Electronic - EHR	Care
CORE Primary Care Practices (*select practices - Exeter Hospital)	Pending	NO	Electronic	Electronic - EHR	Care
Exeter Hospital	Pending	NO	Electronic	Electronic - EHR	U
Families First Health & Support Center	Y	YES	Electronic	Electronic - EHR	Care
Frisbie Hospital Primary Care Practices (selected)	Pending	YES	Electronic	Electronic - EHR	Care
Frisbie Memorial Hospital	Y	YES	Electronic	Electronic - EHR	Care
Goodwin Health Center	Y	YES	Electronic	Electronic - EHR	Care
Hope On Haven Hill	NO	NO	Electronic	Electronic - EHR	U
Lamprey Health Care	Pending	NO	Electronic	Electronic - EHR	Care
Portsmouth Regional Hospital	NO	NO	Electronic	Electronic - EHR	Care
ROAD to Recovery	NO	NO	Electronic	UNK	U
Seacoast Mental Health Center	Y	YES	Electronic	Electronic - EHR	Care
Southeastern NH Services	NO	NO	Electronic	Electronic - EHR	
Wentworth Douglass Hospital	Pending	YES	Electronic	Electronic - EHR	Care
Wentworth Douglass Hospital Primary Care Practices (selected)	Pending	YES	Electronic	Electronic - EHR	Care

B1-9d: The most robust Work Flow for Community-based Social Support Providers in Region 6 occurs through our Community Care Team. We found few formalized, documented work flows with community based social support service providers among our Wave One partners during this reporting period. We are mapping related screening, assessment, referral, and follow-up in several clinical and non-clinical domains among several diverse coordinated care practices in our efforts to advance a Core Standardized Assessment and Shared Care Plan. While we work from an Ideal-Type Work Flow (Figure 1, below), we have found this clinician and EMR-centric approach to be limited in comparison to the processing, management and follow-up (loop closure) of referrals made through the CCT, where multiple agencies who may benefit from or contribute to the appropriateness and ultimate success of a referral are collaborating in real-time. A more ideal representation of the Community Care Team referral loops and Multidisciplinary Care Coordination is presented in Figure 2.

Figure 1.

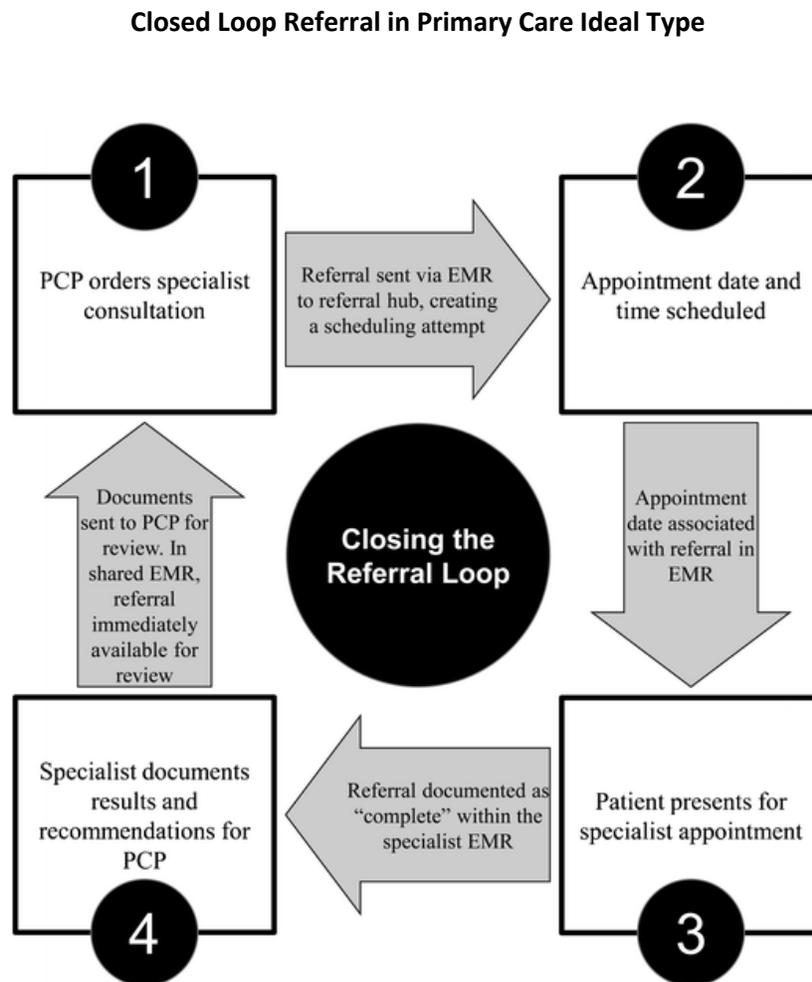
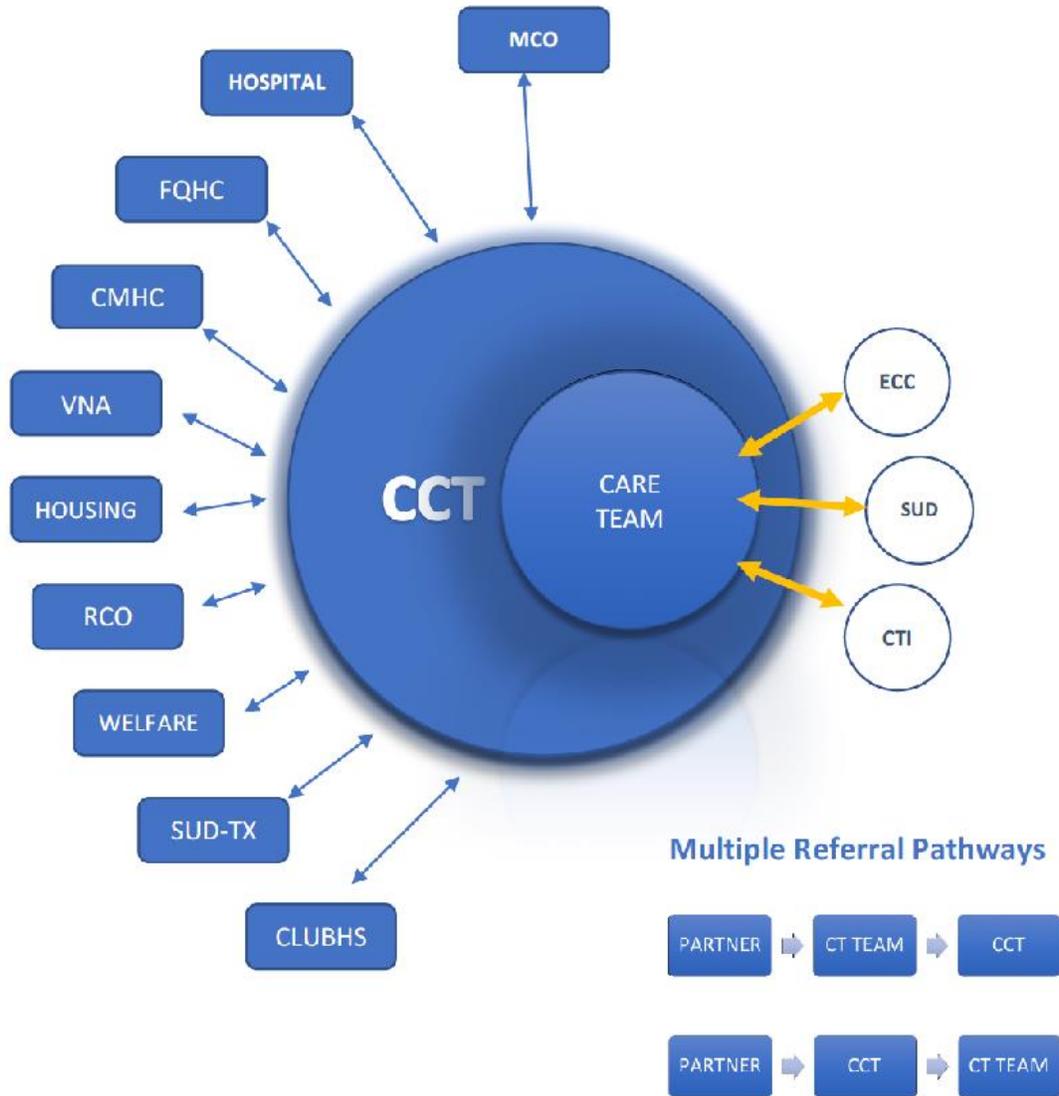


Figure 2.

Community Care Team Referral Loops and Multidisciplinary Care Coordination



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

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

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

		minimum: <ul style="list-style-type: none"> ● Joint service protocols ● Communication channels 					
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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.

	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	14	0	5	11	
Integrated Care Practice	3	0	0	0	

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

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	██████████ ██████████ ██████████	2	2	
	██████████ ██████████ ██████████	2	2	
	██████████ ██████████ ██████████ ██████████	2	3	
	████████████████████	1	1	
	████████████████	1	1	
	██████████████		1	
	██████████		1	

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	Under Assessment			

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.

The IDN-6 C1 Care Transitions project implementation continues to progress the most quickly among the three community projects. This is due, in part, to the fact that the staffing of this project is internal to the IDN/Strafford County organizational structure, and does not require outside contractual agreements. Summary of Progress on Objectives in Work Plan:

Objective: Recruit and Hire New Staff

After losing one Case Manager the IDN was fortunate to recruit, hire and onboard three qualified Case Managers (one each in March, May and June 2018).

Objective: Training for CTI Staff

The new staff member hired in March as well as several IDN Partners participated in trainings delivered by the Center for the Advancement of Critical Time Intervention (CACTI). CTI Team members have also attended regional trainings. For additional description of training activities, see Section C-9.

Objective: Establish Project Specific Metrics

These efforts remain in progress. Absent Medicaid case data availability from DHHS or NH MCOs, we are currently reliant on partner agency level data to determine baseline measures to be used for progress. Emergency Department claims data from Frisbie Memorial Hospital were somewhat instructive, however these data are now almost two years old and since FMH has undergone a complete conversion of the HER, we have been unable to source similar claims data. Efforts to source these data continue as we are working through organizational-level requirements for authorization of data definitions and transfer.

Objective: Refine Data Collection Instruments

Screening and assessment tools have undergone considerable development and are now in use. The IDN Ops and CTI Teams adapted established and approved CTI tools in use in North Carolina in relation to several tools that are already in use in our region (i.e. Coordinated Entry, Recovery Outreach, FQHCs, etc.).

Objective: Develop Service Definition and Standards for Reimbursement

This is a long-term objective for which we have begun formative efforts by reviewing the service definitions, program components, utilization tracking methods and fidelity monitoring practices that are currently approved and in use in North Carolina, as we develop our own protocols and standards.

Objective: Execute Contracts and Agreements

The initial project budget was formally approved by the IDN-6 Executive Committee. The Community Care Team Release of Information serves as a universal referral mechanism for the CTI Team. We completed and executed a Business Associates Agreement with Frisbie Memorial Hospital. Since we have no fiscal relationship built into the Care Transitions Project with any of our partners, all other Case Management services are currently facilitated through partner agency releases as needed.

Objective: Formal Launch of Project

The IDN Team concluded that a formal kick-off event was unnecessary for this project as implementation is closely integrated with existing efforts in our Community Care Team where there is very high awareness and participation.

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:

NOT MET - C-2 – Provide performance measures which show progress made in this reporting period. Provide a timeframe for determining baselines. Based upon progress identified in C-1, add performance measures to identify progress.

a. Pg. 90 - Although we appreciate the meeting attendance and case reviews, those are process milestones under C-1 incentive payment. There is no noted progress in the table of Evaluation Progress Targets. Funds will be carried over to the subsequent reporting period.

- Number of individuals served (during reporting period and cumulative)

The IDN Team has met this requirement since the Care Transitions Team commenced receiving referrals directly from an Emergency Warming Center operation in Rochester at the very end of the last reporting period. Since then the CT Team has received additional referrals through the Community Care Team and directly from partner agencies. The CT Team has served the following

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# clients referred to CT Team		0	133	
# clients Screened		0	133	
# clients in Pre-CTI phase		0	10	
# clients enrolled in CTI		0	15	

Referrals		Service Status	
Warming Center	64	Pre-CTI	10
Frisbie Hospital CCT	24	CTI (Phase 1&2)	15
Crossroads House	12	Enhanced Care Coordination	7
Tri-City Co-Op	10	Ongoing Contact	38
SOS Dover/Rochester	9	Not Eligible/Declined	15
Portsmouth Hospital CCT	5	Disengaged	32
Other	9	Left AMA	4
		Deceased	2
TOTAL REFERRALS	133		133

As reported earlier, in the absence of Medicaid case data availability from DHHS or NH MCO's, we are currently reliant on partner agency level data to determine baseline measures to be used for progress. Efforts to source these data continue as we are working through organizational-level requirements for authorization of data definitions and transfer. Absent claims-based systems data, the challenges, limitations and inefficiencies of this approach remain significant and will continue as we add more referral sources. Baselines for the population will be calculated by aggregating enrollee case data. Targets will be determined upon baseline calculations.

A total of 133 clients have been engaged and served by the Care Transitions Team. We have set targets for performance measures. At the time of reporting, clients were in many various stages of screening, assessment, referral and enrollment in a range of service types (the minority are eligible candidates for CTI). Case-based data are being procured and aggregated through multiple sources, demonstrating significant progress.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Total # clients served	70 per CTI team	0 – See Above	133	
ED Admissions	Reduce by 10%	N/A	Data Pending	
ED Utilization for PC treatable conditions	Reduce by 10%	N/A	Data Pending	
Hospitalization Frequency & Duration	Reduce by 10%	N/A	Data Pending	
Psych Hospitalization Freq. & Duration	Reduce by 10%	N/A	Data Pending	
Incarceration Nights	Reduce by 10%	N/A	Data Pending	
Increase enrollment for eligible benefits	Increase 10%	N/A	Data Pending	
Reduce Crisis Response Services	Reduce by 10%	N/A	Data Pending	

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.

After losing one Case Manager the IDN was fortunate to recruit, hire and onboard three qualified Case Managers (one each in March, May and June 2018).

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
Team Leader (Masters Level)	2	0	1	1	
CTI Worker (Case Manager)	6	0	2	4	

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.

As of June 30, current spending, as indicated in Attachment C4.1 for the C1 project, totaled \$91,519.03. Spending is currently on track with initial projections.

Attachment C4.1: C1 Project Actual Expenses

C4 Actual Expenditures-CTI						
CARE TRANSITIONS TEAM		2016	Q1-Q2 2017	Q3-Q4 2017	Q1-Q2 2018	ACTUAL TO 6/30/18
26.7400.001	CTI - SUPERVISOR	\$ -	\$ -	\$ -		
26.7400.002	CTI - CASE MANAGERS	\$ -	\$ -	\$ -		
26.7400.102	CIT - ACCRUED BENEFITS EXPENSE	\$ -	\$ -	\$ -		
26.7400.103	CTI - SOCIAL SECURITY	\$ -	\$ -	\$ -		
26.7400.104	CTI - DENTAL INSURANCE	\$ -	\$ -	\$ -		
26.7400.105	CTI - HEALTH, LIFE & DISABILITY	\$ -	\$ -	\$ -		
26.7400.106	CTI - RETIREMENT	\$ -	\$ -	\$ -		
26.7400.107	CTI - WORKERS COMPENSATION	\$ -	\$ -	\$ -		
26.7400.108	CTI - UNEMPLOYMENT	\$ -	\$ -	\$ -		
26.7400.229	CTI - FEES & OUTSIDE SERVICES	\$ -	\$ -	\$ -		
26.7400.236	CTI - OFFICE SUPPLIES	\$ -	\$ -	\$ -	\$ -	\$ -
26.7400.239	CTI - GENERAL SUPPLIES	\$ -	\$ -	\$ -	\$ 3,943.82	\$ 3,943.82
26.7400.268	CTI - TELEPHONE	\$ -	\$ -	\$ -	\$ 1,287.53	\$ 1,287.53
26.7400.270	CTI - TRAVEL	\$ -	\$ -	\$ 136.96	\$ 2,185.62	\$ 2,322.58
26.7400.273	CTI - RENT	\$ -	\$ -	\$ -	\$ 2,200.00	\$ 2,200.00
26.7400.297	CTI - NEW EQUIPMENT	\$ -	\$ -	\$ 4,799.97	\$ 1,981.00	\$ 6,780.97
	Total	\$ -	\$ -	\$ 7,586.02	\$ 83,933.01	\$ 91,519.03

It is worth noting in the projected budget in Attachment C4.2 that the budget for this Community Project is more detailed than D3 and E5 budgets because the C1 Team is housed at the IDN

and are employees of Strafford County and is considered the most likely to scale in scope across the region the most quickly. Totals include consideration of expenses to date.

Attachment C4.2: C1 Project Projected Budget

Attachment_C4.2	Q3- Q4 2018	2019	2020	2021	TOTAL
C1 Workforce Expenses					
Recruitment (with bonuses)	10,000	10,000	10,000	-	45,000
Retention	10,000	20,000	20,000	10,000	75,000
Training/Education	15,000	10,000	10,000	15,000	70,000
Workforce Staffing					
LCMHC (2)					
CTI Case Managers (6) growing to 8					
Workforce SS/WC/UI					
Workforce Benefits					
Section Subtotal	454,000	826,000	962,000	1,035,000	3,537,000
C1 Project Infrastructure					
Lease: Office	4,500	18,000	18,000	18,000	67,500
Furniture	4,000	-	-	-	8,000
Supplies; Technology; Equip	15,000	20,000	20,000	15,000	80,000
Travel	6,000	15,000	15,000	15,000	56,000
Enabling Technology	20,000	30,000	30,000	30,000	130,000
Section Subtotal	49,500	83,000	83,000	78,000	341,500
TOTALS	503,500	909,000	1,045,000	1,113,000	3,878,500

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.

The Community Care Team (which includes all key partner agencies) Release of Information serves as a universal referral mechanism for the CTI Team. We completed and executed a Business Associates Agreement with Frisbie Memorial Hospital. Since we have no fiscal relationship built into the Care Transitions Project with any of our partners, all other Case Management services are currently facilitated through partner agency releases as needed.

Organization/Provider	Agreement Executed (Y/N)
Frisbie Memorial Hospital, Rochester, NH (*host org)	Yes - BAA submitted and approved
Crossroads House Shelter, Portsmouth, NH (*host org)	Yes - ROI under CCT
Community Partners CMHC, Rochester, NH	Yes - ROI under CCT
Seacoast Mental Health - CMHC	Yes - ROI under CCT
Goodwin Community Health (FQHC)	Yes - ROI under CCT
Families First (FQHC)	Yes - ROI under CCT
Cornerstone VNA	Yes - ROI under CCT

SOS Recovery Community Organization	Yes - ROI under CCT
Rochester Community Recovery	Yes - ROI under CCT
Safe Harbor Recovery Center	Yes - ROI under CCT
Tri-City Consumers' Action Cooperative	Yes - ROI under CCT

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.

Screening, assessment tools and management tools were deployed, piloted and are undergoing continued refinement while in use. The Team is also evaluating overlap and/or synergy with other tools under development through the IDN, including the Core Standardized Assessment and Enhanced Care Coordination screen.

Standard Assessment Tool Name	Brief Description
Pre-CTI Screening (attachment C-6a)	Domains assessed to determine appropriate disposition/next step
CTI Assessment and Resource Tree (attachment C-6b)	Domains assessed to craft initial care coordination plan
Phase Template (attachment C-6c)	CTI-eligible cases initiated into 3-phase tracking plan

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.

The Critical Time Intervention is not a clinical care protocol, but rather is focused on supporting clients to align clinical and non-clinical care and support services on their own behalf. The Community Care Team Release of Information serves as a universal referral mechanism for the CTI Team. The CTI Team conducts Pre-CTI Screening to determine appropriate case disposition; a Full CTI Assessment, including Contact Sheet, for clients who consent; and case planning that may include formal CTI enrollment (triggering Participation Agreement), Pre-CTI supportive services, and/or Referrals to IDN services partners for priority needs. All clients' status is tracked. Those enrolled in

CTI are tracked in Phases, along with Progress notes as appropriate.

Protocol Name	Brief Description	Use (Current/Under development)
Screening Protocol	For use in each setting to determine initial eligibility and disposition	In use
CTI Assessment	For use in each setting to determine confirm eligibility and initiate care planning	In use
Referral Protocol	For Referrals to CT Team as well as referrals of clients to partner services	In use
Case Utilization Management	To establish evidence base for case rate and model fidelity	In use and development
CTI Self-Assessment Tool	For assessment of CTI Model Fidelity	Currently being deployed

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]	[REDACTED]

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

The new staff member hired in March as well as several IDN Partners participated in the two-day training delivered by the Center for the Advancement of Critical Time Intervention (CACTI). CTI Team members have also attended regional trainings.

Core and supplemental trainings have been scheduled in alignment with other projects and organization demands. The Care Transitions Team members participated in a number of trainings that are identified in the table below.

Ongoing training and capacity building for the development of the Care Transitions Team services (including but not limited to CTI) is accomplished in the context of the Community Care Team,

and the CT Team has met twice with members of the Care Management and Social Work and Staff at Frisbie Memorial Hospital to continue to develop protocols and work flows.

C.1 Training Schedule	6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
CACTI Delivered								
One Day F2F CTI Training for Supervisors		Nov 30			Apr 30		Apr 30	
Two Day F2F CTI Training - All CTI Staff		Nov 30			Apr 30		Apr 30	
CTI Train-the-Trainer				Aug 23				
Ongoing Coaching & Imp Support		Begins Nov and ongoing through 2020						
Web-based: Program Fidelity Assmt				Sep 12				
Core Trainings								
Trauma-Informed Care			Jun 1	Dec 31		Dec 31		Dec 31
Core Standardized Assessment			Jun 7	Dec 31		Dec 31		Dec 31
Integration in Practice			Jun 14	Dec 31		Dec 31		Dec 31
Supplemental Trainings								
Human Trafficking			Mar 29					
Mental Health First Aid				Sep 30	Mar 30		Mar 30	
Cultural Competence			Apr 24		Mar 30		Mar 30	
Motivational Interviewing			Jun 19		Mar 30		Mar 30	

Project Scoring: IDN Community Project Process Milestones

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

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

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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.

This Community Project has undergone slight modifications in Design and Objectives as several of our organization partners have shifted their internal primary care strategies, administrative teams, and other related strategic plans since the D3 Workgroup crafted the original design. This shifting landscape has required additional planning meetings, alterations in plans, and delayed readiness of key partners to embark on the implementation of these new initiatives.

First, the implementation of D3 was delayed considerably due to staffing shortages being experienced in the Seacoast Region. The SUD Team was not on-boarded until mid-May. In the meantime the priorities of our IDN key partners shifted from an interest in Withdrawal Management in Primary Care settings to capacity to serve patients in Emergency Department and Inpatient Hospital settings, including delivery of comfort medication, withdrawal management, MAT induction as indicated, comprehensive SUD assessment, and the navigation of patients experiencing SUD-associated challenges to the most clinically appropriate and available clinical and non-clinical treatment and supports.

To build regional network capacity for serving the most vulnerable people throughout our attributed population, the staff of the D3 project have begun working very closely with our Care Transitions Team and supporting people who have been referred through the Community Care Team. As a larger partnership, two members of the IDN6 Operations Team also serve leadership roles for Hand-Up Health Services, the Syringe Services Program of the New Hampshire Harm Reduction Coalition in Region.

Program design, training and support of Hand-Up volunteers has resulted in numerous referrals of Hand-Up clients to SUD treatment.

Objective: Recruit and Hire New Staff

Two new staff were recruited and hired, one MLADC Navigator and one Case Manager. The MLADC position was hired twice as the candidate who was initially hired resigned within a week, so the search needed to be re-opened and was not successfully filled until May 15. The Case Manager position could not be filled until the MLADC position was filled. Per our plans, staff are employees of Southeastern New Hampshire Services. As part of our B1 effort with Lamprey Health Care the IDN also agreed to support the addition of a Full Time Nurse Practitioner in their Fellowship Program who has obtained her x-waiver and will be key to expanding Medication Assisted Treatment capacity in their agency and to patients in that underserved part of our region.

Objective: Training for SUD Staff

For description of training activities, see Section D-9.

Objective: Training for PCP Staff

For description of training activities, see Section D-9.

Objective: Establish Project Specific Metrics

These efforts remain in progress. Absent Medicaid case data availability from DHHS or NH MCOs', we are currently reliant on partner agency level data to determine baseline measures to be used for progress. Efforts to source these data continue as we are working through organizational-level requirements for authorization of data definitions and transfer, especially sluggish due to concerns about 42-CFR Part Two regulations.

Objective: Refine Data Collection Instruments

Ongoing efforts to develop the Core Standardized Assessment have been sensitive to the tools that are already contemplated for use in D3.

Objective: Develop Service Definition and Standards for Reimbursement

This is a long-term objective for which we have begun formative efforts by reviewing the service definitions, program components, utilization tracking methods and fidelity monitoring practices as we develop our own protocols and standards.

Objective: Execute Contracts and Agreements

The initial project budget was formally approved by the IDN-6 Executive Committee. The Qualified Service Organization Agreement between SENHS and Strafford County was executed. The Community Care Team Release of Information serves as a universal referral mechanism for the CT Team, of which the D3 staff are members. Since we have no fiscal relationship built into the D3 Project with any of our partners, all other Navigation and Case Management services are currently facilitated through partner agency releases as needed.

Objective: Formal Launch of Project

The IDN-6 began outreach back to partners and providers who expressed interest to participate in the initial design of the project. We found that partner priorities had shifted from services that would be based in their Primary Care practices to meeting the needs of people with SUD in hospital settings, both inpatient and emergency departments.

The D3 Team did formally begin their services in conjunction with the Community Care Team in June. Recent planning meetings with key Wentworth Douglass and Frisbie Memorial Hospital staff have resulted in alterations to the scope and design of the project. Relevant protocols are under development and clinician training and support has been secured.

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.

NOT MET - D-2 – Identify progress made during reporting period

a. Pg. 111 - There is no noted progress in the table of Evaluation Progress Targets. Funds will be carried over to the subsequent reporting period.

The IDN Team has met this requirement by since the start dates on these performance measures were pushed back slightly due to the challenges in identifying, hiring and onboarding qualified staff in our region, and the shifting interested away from Primary Care partners to Hospital-based settings.

The project will offer the same basic set of services including delivery of comfort medication, withdrawal management, MAT induction as indicated, comprehensive SUD assessment, and the navigation of patients experiencing SUD-associated challenges to the most clinically appropriate and available clinical and non-clinical treatment and supports. The referral sources, however, have been altered to include Hospital-based settings (inpatient and ED), as well as community-based (from the Community Care Team and Hand-Up Health Services).

The SUD staff were not on-boarded until nearly the end of the reporting period. We have set targets for performance measures. At the time of reporting, clients were in many various stages of screening, assessment, referral and enrollment in a range of service types. Case-based data are being procured and aggregated through multiple sources, demonstrating significant progress.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# patients engaged with Navigator	30 by 12/31/18	0	11	
# referrals made and completed	20 by 12/31/18	0	5	
# clients who complete a defined treatment program	15 by 12/31/18	0	TBD	
# clients who leave treatment in the first 7 days	<50%	0	TBD	
# clients in supportive services 30 days after completion	>50%	0	TBD	

# Providers trained in SBIRT	20 by 12/31/18	0	0	
# Providers employing SBIRT	10 by 12/31/18	N/A	N/A	

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 IDN-6 Team secured an agreement with Southeastern New Hampshire Services (SENHS) to employ and provide clinical supervision to the D3 Services Team. Two new staff were recruited and hired, one MLADC Navigator and one Case Manager. The MLADC position was hired twice as the candidate who was initially hired resigned within a week, so the search needed to be re-opened and was not successfully filled until May 15. The Case Manager position could not be filled until the MLADC position was filled.

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
MLADC Navigator	2	0	0	1	
Case Manager	6	0	0	1	

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.

As reflected in Attachment D4.1, current spending as of June 30 was a total of \$158,122.49.

Attachment D4.1: D3 Project Actual Expenses

D3 - SUD		2016	Q1-Q2 2017	Q3-Q4 2017	Q1-Q2 2018	Actual to 6/30/18
27.7400.217	SUD - TRAINING	\$ -	\$ -	\$ -		
	SUD - SENH - FEES & OUTSIDE					
27.7500.229	SERVICES	\$ -	\$ -	\$ -		
27.7500.268	SUD - SENH - TELEPHONE	\$ -	\$ -	\$ -		
27.7500.297	SUD - SENH - NEW EQUIPMENT	\$ -	\$ -	\$ -		
	Total Actual Expenditures SUD	\$ -	\$ -	\$ -		

Spending is slightly behind projections, indicated in Attachment D4.2 – Budget Projections, for reasons noted in the narrative. It is worth noting that this D3 Project budget is less detailed than the C1 Team since that team is housed at the IDN and are employees of Strafford County. Totals include consideration of expenses to date.

Attachment D4.2: D3 Project Budget Projections

Attachment_D4.2	Q3- Q4 2018	2019	2020	2021	TOTAL
D3 Workforce Expenses					
Recruitment (with bonuses)	10,000	10,000	10,000	5,000	40,000
Retention	5,000	25,000	25,000	25,000	60,000
Training/Education	5,000	15,000	15,000	10,000	45,000
Workforce Staffing (Contracts)				-	
MLADC (2)					
Case Managers					
Clinical Supervision					
Administrative Support					
Workforce SS/UI/WC					
Workforce Employee Benefits					
Section Subtotal	293,600	412,400	412,400	402,400	1,241,400
D3 Project Expenses					
Lease: Office	6,000	12,000	12,000	12,000	33,000
Supplies; Technology; Equip	15,000	10,000	15,000	10,000	45,000
Travel	6,000	15,000	15,000	15,000	39,000
Enabling Technology	20,000	30,000	40,000	30,000	110,000
Section Subtotal	47,000	67,000	82,000	67,000	227,000
TOTALS	340,600	479,400	494,400	469,400	1,468,400

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

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

The primary organizational partner and hub for the D3 project is Southeastern New Hampshire Services (SENHS), the largest and most comprehensive SUD treatment provider in Region Six. SENHS offers a full range of low to high intensity clinically managed outpatient and inpatient residential SUD services, including specialty programs for women, Drug Court, Impaired Driver Care Management, and Community Access to Recovery Program.

The IDN Team and SENHS is working closely with key partners (Wentworth Douglass Hospital, Frisbie Memorial Hospital, Exeter Hospital and Lamprey Health Care) to formalize referral protocols from inpatient and ED, as well as working with agencies and organizations that are included and covered by the Release of Information Agreement in the Community Care Team.

Organization/Provider	Agreement Executed (Y/N)
Southeastern New Hampshire Services (host agency)	Yes - QSOA
Goodwin Community Health	Yes - ROI under CCT
Families First Health & Support Center	Yes - ROI under CCT
Seacoast Mental Health Center	Yes - ROI under CCT
Wentworth Douglass Hospital	Yes - ROI under CCT
Frisbie Memorial Hospital	Yes - ROI under CCT
Portsmouth Regional Hospital	Yes - ROI under CCT
Exeter Hospital	Yes - ROI under CCT
Hope on Haven Hill	Yes - ROI under CCT
SOS Recovery Community Organization	Yes - ROI under CCT
Safe Harbor Recovery Community Organization	Yes - ROI under CCT
Tri-City Co-Op	Yes - ROI under CCT

D-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
Core Standardized Assessment	Via B1.a1 (Attachment B1.aAZ-SSM)
Comprehensive SUD Assessment	Addiction Severity Index (Attachment A-6a)
Case Management Program	TBD in conjunction with HIT platform

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.

As the IDN Team collected and assessed existing protocols for Assessment, Treatment, Management and Referrals already being employed by key partners in the Region, we confirmed that large scale shifts happening in the region are having significant impact on existing and emerging protocols. The significant reorganization of hospital practices and their behavioral health partnerships, as well as the merger between FQHCs Goodwin Community Health and Families First, have required the IDN to delay and/or revisit original implementation plans.

Protocol Name	Brief Description	Use (Current/Under Development)
SBIRT	Standard in Field	Several providers employ
SUD Comprehensive Assessment	Protocol under development	Drawing from Existing
Referral, Counseling, PRSS	Numerous Existing Protocols	Drawing from Existing

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]	[REDACTED]

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

Trainings of services delivery staff and affiliated network partner staff must be aligned with staff onboarding, which did not occur until May, 2018. Core and supplemental trainings have been scheduled in alignment with other projects and organization demands. D3 partners have been invited to join Care Transitions Team members in a number of trainings that are identified in the table below.

Ongoing training and capacity building for the development of the Care Transitions Team to include D3 staff and services is accomplished in the context of the Community Care Team. To facilitate close coordination, the D3 Team joins the CT Team in our office space located in Dover that is dedicated to the staff of all community projects and community-based services.

D.3 Training Plan Schedule	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
<u>Core Trainings - Project Staff</u>							
Trauma Informed Care		Jun 1	Dec 31		Dec 31		Dec 31
Core Standardized Assessment		Jun 7	Dec 31		Dec 31		Dec 31
Integration in Practice		Jun 14	Dec 31		Dec 31		Dec 31
Mental Health First Aid		ToT Apr 23-27	Dec 31		Dec 31		Dec 31
SBIRT			Dec 31		Dec 31		Dec 31
Cultural Competence		Apr 24	Dec 31		Dec 31		Dec 31
Withdrawal Management			Dec 31		Dec 31		Dec 31
Motivational Interviewing		Jun 19	Ongoing		Ongoing	Ongoing	Ongoing

Project Scoring: IDN Community Project Process Milestones

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

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

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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.

The onboarding and implementation of the E5 Enhanced Care Coordination Project has been sluggish due to several factors. Our key Primary Care partner (CORE/Exeter) did not sign an agreement to become a formal partner in or network until May 2018. Likewise, the project plan includes participation and partnering with schools, primarily SAU-16. The development of protocols and agreements in this area has been slow, due to stringent privacy concerns. To help advance progress we have included key SAU-16 staff members on our IDN Clinical Advisory Team, and have contracted the services of a therapeutic mental health provider who has partnered with schools and related providers in the region for many years.

Objective: Recruit and Hire New Staff

Job descriptions are completed and positions were posted by Seacoast Community Mental Health. Several applicants have been screened and interviewed over a three-month period. Three offers were made and not accepted. One offer is pending response at the writing of this report.

As the IDN has continually assessed need and opportunities in our region, we also made the decision to add and on-board an additional adult-focused ECC Case Manager. This job was approved and filled in June 2018. This ECC staff was a member of our Care Transitions Team, is

working in close collaboration with the CT Team and the CCT, and is currently serving Adults who were referred to the CCT but whose needs were too complex and acute to be enrolled in the CTI protocol.

Objective: Training for ECC Staff

For description of training activities, see Section E-9.

Objective: Training for Partner Staff

For description of training activities, see Section E-9.

Objective: Establish Project Specific Metrics

These efforts remain in progress. Absent Medicaid case data availability from DHHS or NH MCOs', we are currently reliant on partner agency level data to determine baseline measures to be used for progress. Efforts to source these data continue as we are working through organizational-level requirements for authorization of data definitions and transfer.

Objective: Refine Data Collection Instruments

Screening and assessment tools are under continued development. The IDN Ops Team is assessing opportunities to adapt established and approved tools in the field, as well as in relation to several tools that are already in use in our region (i.e. Coordinated Entry, Recovery Outreach, FQHCs, etc.). The Team is also evaluating overlap and/or synergy with other tools under development through the IDN, including the Core Standardized Assessment.

Objective: Develop Service Definition and Standards for Reimbursement

This is a long-term objective for which we have begun formative efforts by reviewing the service definitions, program components, utilization tracking methods and fidelity monitoring practices that are currently approved and in use in similar projects/protocols as we develop our own protocols and standards.

Objective: Execute Contracts and Agreements

The initial project budget was formally approved by the IDN-6 Executive Committee. A Business Associate Agreement between Seacoast Community Mental Health and Strafford County was executed. The Community Care Team Release of Information serves as a universal referral mechanism for the CT Team, of which the Adult ECC staff is a participating member. Since we have no current fiscal relationship built into the Enhanced Care Coordination Project with any of our partners, all other Care Coordination services are currently facilitated through partner agency releases as needed.

Objective: Formal Launch of Project

ECC for Adults launched in June 2018

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.

NOT MET - E-2 - Please provide a timeline for completion. Please identify any progress made during this reporting period. Indicate targets for each performance measure and include in timeline when targets will be achieved. Document any progress made toward targets.

a. There is no noted progress in the table of Evaluation Progress Targets. Your identified progress is reflected in your E1 incentive payments. Funds will be carried over to the subsequent reporting period.

The IDN Team has met this requirement since the start dates on these performance measures were pushed back slightly due to the challenges in identifying, hiring and onboarding qualified staff in our region. As the Transition-Aged Youth-focused ECC hiring has been extremely sluggish, with several offers resulting in no new staff at SCMC, the IDN Team made the decision to add and on-board an additional adult-focused ECC Case Manager. This job was approved and filled in June 2018. This ECC staff was a member of our Care Transitions Team, is working in close collaboration with the CT Team and the CCT, and is currently serving Adults who were referred to the CCT but whose needs were too complex and acute to be enrolled in the CTI protocol. Our Adult ECC Case Manager has enrolled and is serving 7 clients, although the case management window is currently too short to report out other Performance Measures, which are currently under revision.

Established initial performance measures. Will enroll at least 20 individuals through 2018. Based on demand and several additional factors this number will be calibrated and expanded for 2019. Additional baseline data are currently being collected/established as active enrollees are early in program. Performance measures on subset of initial enrollees will be reportable by 12/31/18, as all are longitudinal and require establishment of baselines.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Individuals served	20 by 12/31/18	N/A	7	
Continued participation in care	60% 6+months	N/A	Ongoing	
Client generated achievable goals met	50% met	N/A	Ongoing	
Improved Functional status	50% enrolled	N/A	Ongoing	
Reduced Crisis services utilization	15% reduction	N/A	Ongoing	
Reduced School attendance/truancy	10% reduction	N/A	Ongoing	

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.

The IDN-6 Team secured an agreement with Seacoast Community Mental Health Center (SCMHC) to employ and provide clinical supervision to the E5 Services Team. Positions were posted by Seacoast Community Mental Health. Several applicants have been screened and interviewed over a three-month period. Three offers were made and not accepted. One offer is pending response at the writing of this report.

As the IDN has continually assessed need and opportunities in our region, we also made the decision to add and on-board an additional adult-focused ECC Case Manager. This job was approved and filled in June 2018. This ECC staff was a member of our Care Transitions Team, is working in close collaboration with the CT Team and the CCT, and is currently serving Adults who were referred to the CCT but whose needs were too complex and acute to be enrolled in the CTI protocol.

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 Care Coordinator	6	0	0	1	
Clinical Supervision (3 hrs/week per CCC)	Up to .5FTE	0	ready	0.2	

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.

Current spending for this project, detailed in Attachment E4.1 through June 30, was a total of \$132.02 for reasons identified in the narrative.

Attachment E4.1: E4 Project Actual Expenses

TOTAL ACTUAL EXPENDITURES-E5	2016	Q1-Q2 2017	Q3-Q4 2017	Q1-Q2 2018	ACTUAL TO 6/30/18
ENHANCED CARE - FEES/OUTSIDE SERVICES	\$0	\$0	\$0		
	\$0	\$0	\$0		
TOTAL ACTUAL EXPENDITURES - ECC	\$0	\$0	\$0		

As noted in Attachment E4.2, Project Projected Budget, spending is behind initial projections for reasons noted in the narrative. It is worth noting that this E5 Project budget is less detailed than the C1

Team since that is housed at the IDN and are employees of Strafford County. Totals include consideration of expenses to date.

Attachment E4.2: E5 Project Projected Budget

Attachment_E4.2	E.5 Enhanced	Q3- Q4 2018	2019	2020	2021	TOTAL
Care Coordination						
E5 Workforce Expenses						
Recruitment (with bonuses)						
Retention						
Training/Education						
Workforce Staffing						
	Clinical Care Coordinators (8)					
	Clinical Supervision					
	Workforce SS/WC/UI					
	Workforce Benefits					
	Section Subtotal	349,000	698,000	703,000	703,000	2,592,440
E5 Project Expenses						
Lease: Office		6,000	15,000	15,000	15,000	54,000
Supplies; Technology; Equip		15,000	20,000	20,000	20,000	80,000
Travel		6,000	15,000	15,000	15,000	54,000
Enabling Technology		20,000	50,000	30,000	25,000	125,000
	Section Subtotal	47,000	100,000	80,000	75,000	313,000
	TOTALS	396,000	798,000	783,000	778,000	2,905,440

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.

Met with 40 representatives (counselors, nurses, etc.) of SAU-16 (Exeter School system)

Organization/Provider	Agreement Executed (Y/N)
CORE Pediatrics via Exeter Health Resources	Yes - ROI under CCT
SAU-16	In Process – Expected by Mar 15
Families First Health and Support Center	Yes - ROI under CCT
OneSky Services	Yes - ROI under CCT
Seacoast Community Mental Health	Yes - ROI under CCT
Chase Home for Children	Pending Verbal Commitment
Winnacunnet High School	Pending Verbal Commitment
Seacoast Youth Services	Pending Verbal Commitment
Division of Children, Youth and Families, NH DHHS	Pending Verbal Commitment
Bureau of Juvenile Justice Services, DCYF, NH DHHS	Pending Verbal Commitment
Beacon Well Sense	Yes - ROI under CCT
Portsmouth Regional Hospital	Yes - ROI under CCT

Community Partners	Yes - ROI under CCT
Lamprey Health	Yes - ROI under CCT
Goodwin Community Health	Yes - ROI under CCT
Wentworth Douglass Hospital and Partners	Yes - ROI under CCT
Hope on Haven Hill	Yes - ROI under CCT
SOS Recovery Community Organization	Yes - ROI under CCT
Safe Harbor Recovery Community Organization	Yes - ROI under CCT
Tri-City Co-Op	Yes - ROI under CCT

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

NOT MET - E-6 - Please provide copies of assessment tools.

The IDN Team has met this requirement by selecting the screening and assessment tools below, while the RENEW protocol is still being adapted (RENEW can be considered a tool and a protocol). The ECC Work Group supports the use of the CANS (Child and Adolescent Needs and Strengths) assessment tool for Youth. The ECC Work Group supports the use of the Arizona Self-Sufficiency Matrix as an initial assessment tool for Adults, to be reconciled with the Care Transitions Tool and the Core Standardized Assessment being deployed in B1.

Standard Assessment Tool Name	Brief Description
CANS (Child and Adolescent Needs and Strengths) (attachment B1-8a5)	Standard BH Functional Assessment for CMHCs
Arizona Self Sufficiency Matrix (attachment B1-8a1)	Multi-domain Evidence-based Tool
RENEW (checklist attachment E-6b)	Being Adapted for ECC

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.

NOT MET - E-7 Did not report protocols.

- a. Pg. 129 - E-7 Funds will be set aside for submission of IDN completed protocols. DHHS would expect the IDN to seek the necessary permission to provide the protocols as required.

The IDN Team has met this requirement. Enhanced Care Coordination in IDN 6 is not contemplated to serve as a clinical care protocol, but rather is focused on supporting clients to align clinical and non-clinical care and support services on their own behalf. The Community Care Team Release of Information serves as a universal referral mechanism for the Adult ECC. For Adult referrals from the CCT to ECC, the CTI Team conducts Pre-CTI Screening to determine appropriate case disposition; a Full CTI Assessment, including Contact Sheet, for clients who consent; and case planning that may include formal CTI enrollment (triggering Participation Agreement), Pre-CTI supportive services, and Referrals to the Adult ECC for those clients deemed to be appropriate candidates. All clients' status is tracked. Those enrolled in CTI are tracked along with Progress notes as appropriate. For protocol for Youth referrals is to be adapted to the RENEW protocol Attachment E7, below.

Protocol Name	Brief Description	Use (Current/Under Development)
RENEW (Attachment E7)	Strengths-based strategies for setting and obtaining life goals	In use by SMHC
Community Care Team (checklist attachment B1-9d)	Referral Protocol for Adults, includes multiple Referral Sources	In use

Attachment E7: Renew Process Checklist

RENEW Process Checklist

I. Student Engagement: Introductory Meeting (~20 to 30 min)		
Task	Steps/evidence	Check if Completed
Orientation <ul style="list-style-type: none"> Discuss RENEW goals & purpose & how they may be related to the students interests & needs (refer to youth & families brochure) Futures' planning process & how it works 	Student agrees to proceed	
Explain Facilitator & student roles	Student completes Roles and Responsibilities Agreement	
Identify key people, school support contact, probation contact person etc.	Individuals Identified	
Complete releases or letters of support	Release completed	
Establish schedule of next meetings	Student given appointment schedule	
II. Post-Orientation		
Task	Step/evidence	Check if Completed
Obtain and Review at risk checklist or	Obtained	

screening		
Contact and orient special education case manager, counselor, when indicated	Notification received	
Request school information	School information obtained: <ul style="list-style-type: none"> ● FBA ● Discipline data ● Attendance ● transcripts 	
Create Student Progress Tracker form for student	Student record entered	
Enter student in facilitator Track and Outcome forms	Student entered on Tracker and outcome forms	
III. MAPPING (Refer to Facilitator Skills Checklist)		
Task	Step/evidence	Check if Completed
Begin mapping within 3 weeks: <ul style="list-style-type: none"> ● History Map ● Who you are today ● Strengths & Accomplishments ● Relationship & Resource Map ● Preferences: What Works/Doesn't Work ● Dreams ● Fears/Concerns/Barriers to Dreams ● Goals (Target: complete the maps within 30 days)	All items completed	
Update Student Progress Tracker with goals (when maps are done)	Entered	
List Next Steps and create an Action Plan (when maps are done)	Action Plan completed and copy given to youth, and key team members	
IV. Form Core Team (within 30 days)		
Task	Step/Evidence	Check if Completed
Ensure involvement of: <ul style="list-style-type: none"> ● Parent/guardian ● Key individuals in school and community 		
Work with youth to: <ul style="list-style-type: none"> ● Identify team members. ● Identify MAPS to be shared ● Create a list of ground rules ● Decide who will invite each person to the first meeting ● Agenda for first team meeting 	List of people, ground rules, and agenda. People are invited	

██████████	██████████
██████████	██████████

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

Trainings were offered through the reporting period and attended by Adult ECC services delivery staff and affiliated network partner staff.

E.5 Training Schedule	6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
Core Trainings - Project Staff								
Core Standardized Assessment		Nov 30	Jun 7	Dec 31		Dec 31		Dec 31
Integration in Practice		Dec 31	Jun 14	Dec 31		Dec 31		Dec 31
Mental Health First Aid		Dec 31	ToT Apr 23-27	Dec 31		Dec 31		Dec 31
Cultural Competence			Apr 24	Dec 31	Jun30	Dec 31	Jun30	Dec 31
Motivational Interviewing		Dec 31	Jun 19	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Trauma Informed Care		Dec 31	Jun 1	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

DHHS Project Scoring: IDN Community Project Process Milestones

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

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

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

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

Provide a brief narrative describing the current use of APMs among partners.

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.

The Region 6 IDN participated in development of a statewide APM roadmap during the reporting period. Participation included the provision of design and development guidance to Myers & Stauffer to inform the agenda for an APM focused Learning Collaborative and the promotion of that learning opportunity to regional partners, some of whom did attend with Region 6 Operations Team representatives. The Region 6 IDN has consistently provided leadership level representation to statewide workgroups and stakeholder meetings on APM. During the reporting period, that representation was informed by IDN Executive Director led consultations with partner Agency CEOs (including hospital systems) regarding the impact of historical and future APMs on their efforts. In addition, a Special Executive Committee Meeting was convened to focus on improving partner readiness for APM planning. That session also informed Region 6 participation on statewide efforts. Partners continue to struggle to identify use cases of APM in practice.

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		IDN 6 ED attended 4 meetings	
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		premature	
Develop the financial, clinical and legal infrastructure required to support APMs		premature	
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		premature	

DSRIP Outcome Measures for Years 2 and 3

Each IDN may earn up to 10% of the total IDN performance funding in Year 2 (CY 2017) and 25% of the total performance funding in Year 3 (CY 2018). The Table below, provided for information only, includes the DSRIP Outcome Measures that will be used for incentive payments for Years 2 and 3. For Years 2 and 3, use the current DSRIP Outcome Measures that must be reported as indicated in the Table below; cross reference to the final DSRIP Outcomes Measures documentation, located in eStudio. For additional information regarding Years 2-5 incentive payment mechanics, see the STCs, Attachment D, located in eStudio.

For Years 4 and 5, CY 2019 and 2020, 100% of the performance funding will be based on the DSRIP Outcomes Measures. See the DSRIP Outcomes Measures, available on the DSRIP website, for more information.

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
Use of Comprehensive Core Standardized Assessment by Medicaid Billing IDN Providers	Recommended U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by IDN Providers (reporting)	Physical Health-Focused HEDIS Measures for BH Population: Summary Score (reporting)
Appropriate Follow-Up by Medicaid Billing IDN Providers for Positive Screenings for Potential Substance Use Disorder and/or Depression	Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by Medicaid Billing IDN Providers (reporting)	Experience of Care Survey: Summary Score
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners	Timely Transmission of Transition Record After Hospital Discharge (reporting)	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Develop an IDN-specific roadmap for using APMs	Potentially Avoidable Emergency Department Visits
		Follow-up After Emergency Department Visit for Mental Illness Within 30 Days
		Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days
		Follow-up After Hospitalization for Mental Illness Within 7 Days
		Follow-up After Hospitalization for Mental Illness Within 30 Days
		Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose