



Region 1 IDN Semi Annual Report and  
Implementation Plans

July 31, 2017

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## DSRIP IDN Region 1 Project Plan Implementation (PPI)

### Soliciting Community Input:

Gaining community input has been foundational to all IDN-1 planning since the beginning of the 1115 Waiver program in Region 1. Leaders across IDN-1 recognize the importance of listening to key stakeholders to understand the complexities of the current system of care and of engaging these stakeholders to plan and implement the changes they would like to see. The following paragraphs define IDN-1's successful efforts to solicit community input.

**Comprehensive Behavioral Health Needs Assessment:** IDN-1 began project planning in 2016 with a comprehensive Behavioral Health Needs Assessment. The purpose of these community engagement efforts was to identify community health concerns and solicit input and advice on priorities and opportunities for community behavioral health care delivery system improvements. This comprehensive assessment included:

- A consumer survey of area residents targeted to high need locations and populations
- A survey of caregivers of people with behavioral health service and support needs
- A survey of providers including both direct service and community support providers broadly defined
- A series of nine discussion groups (6 consumer groups, 3 provider groups) to explore needs, gaps and improvement opportunities in more depth

Findings from the needs assessment have informed implementation planning efforts through the first half of 2017. (Note: Findings of the behavioral health needs assessment are described in the IDN-1 Project Plan that was approved by NH DHHS in December of 2016.)

**Community Members in Governance Roles:** IDN-1 made an explicit choice to engage community members in the formal governance structure of the IDN. Throughout the past year the IDN has benefited from the perspectives and inputs of Community Members on the Executive Committee, the Advisory Council, and on the Project Teams and Work Groups that act as committees to the Executive Committee.

**Community Members in Project Selection Roles:** IDN-1 engaged a Community Member as a key role within the Independent Review Board (IRB) that reviewed and selected proposals to fund for each IDN-1 project.

**Community Member input to Integration Design:** IDN-1 designed all projects to be member-centric and used the findings of the comprehensive behavioral health needs assessment to inform requirements. For example, community members were adamant that patients (and their caregivers) should decide goals for what it means to be well rather than providers. Based on this input, IDN-1 has developed workflows and supporting IT systems that solicit patient goals and feed these into the shared care planning process.

**Listening Tour:** The IDN-1 administrative team conducted a listening tour in the first quarter of 2017. During this tour the team met with leadership and key staff from 35 + throughout the region. The administrative team briefed each organization on the current state of the 1115 waiver and gathered input for planning.

## Network Development

To date, IDN-1 has been building a network of care providers and community supports to address the many needs of the Medicaid Members region 1. The process has been open and inclusive. The following paragraphs define the Network Development efforts to date, many of which will continue into the future:

**Commitment of Partners:** IDN-1 has provided information on the Waiver to all interested organizations. The IDN has requested letters of commitment to become formal IDN “Partners” throughout the planning phase. Committed Partners are provided with a governance seat on the Advisory Council and are included in IDN-1 formal communications and planning.

**Identification of Integrated Core Team Partners:** IDN-1 has used Medicaid Claims data to identify the providers that serve the current Medicaid population in region 1. The IDN-1 administrative team worked with DHHS this spring to confirm that the majority of Medicaid Member-serving providers are IDN-1 Partners and that the providers who see large numbers of Medicaid members are intimately engaged with the 1115 waiver program.

**RFA Process to Select and Deploy Projects:** IDN-1 has implemented a formal Request for Application Process to solicit applications from Partners to deploy a project. This process has helped formalize the network of providers that will work toward transformation of the delivery system.

**Contracts:** IDN-1 has drafted contracts to formalize participation in the projects selected through the RFA process.

**Community Supports Identification and Engagement:** IDN-1 projects have identified potential community supports providers, some of which have been involved with the waiver and some of which are new. Community supports partners are to be engaged through the projects.

## Addressing the Opioid Crisis

In fall of 2016, a systemic gap analysis was performed to determine the extent of the opioid crisis in the Region, existing SUD services, and both the need and the opportunities for expansion. Highest need areas identified in this assessment have addressed IDN-1 ongoing plan strategies to address screening; workforce requirements; barriers to accessing care; professional, institutional and community stigma; referral and coordination processes; documentation and confidentiality issues; multidisciplinary team approaches; levels of care; special needs populations; and shared care plans. Integral to the work in all of these areas is a robust plan for workforce development. Projects are planned for recruitment, retention, education and training. These initiatives are aligned with the statewide workforce plan, and will be coordinated with other IDNs. *See the A1 Implementation Plan section for additional information on these process milestones.*

IDN-1 has been involved in the ongoing coordination efforts across IDN providers to align various funding and projects addressing the opioid crisis. Some newly awarded funds are;

[REDACTED]

[REDACTED]

Other initiatives the IDN has been involved with over the last 6 months are;

[REDACTED]

Additionally, IDN-1 membership and staff have participated in MAT expansion training, met with staff from the Center for Technology in Behavioral Health, and worked to develop the Perinatal Addiction Treatment Program in the Region after determining the acuity of this need. *Please see the D3 Implementation Plan section for additional detail on the PATP expansion project.*

### Governance

IDN-1 formalized its governance structure in the late summer of 2016 and it has been in operation ever since. The governance structure is described in detail within the IDN-1 Project plan which was approved by DHHS in the fall of 2016. The following paragraphs define the Governance efforts to date, many of which will continue into the future:

**Executive Committee Periodic Meetings and Briefings:** The IDN-1 Executive Committee is the primary governance body of the IDN. The EC is comprised of 4 community members and 7 institutional members who represent the stakeholders of IDN-1. The EC met 9 times in the first half of 2017. The EC has taken a central role in the IDN-1 RFA process and has made its first round of project selections. The EC has been kept informed and apprised of IDN-1 activity through regular communications, a newsletter, and the IDN-1 website.

**Advisory Council Periodic Meetings and Briefings:** The IDN-1 Advisory Council is a broad inclusive body that has representation of all stakeholders and partners and that advises IDN-1. The AC met once for a half day work session in the first half of 2017. The Council has been kept informed and apprised of IDN-1 activity through regular communications, a newsletter, and the IDN-1 website.

**Data Governance:** IDN-1 launched a Data & IT Workgroup as a sub-committee of the Executive Committee. One function of the Workgroup is data governance. The workgroup has been working through issues of patient privacy including preparedness for information sharing between organizations that serve a single patient's needs.

## Budget

IDN-1 has continued through the project planning and capacity building stages of project development to invest in the learning infrastructure of our region. Supporting activities have been undertaken and funded to target supporting knowledge exchange activities and the dissemination of evidence based and best practices across IDN partners. Much of the last semi-annual period has been invested in planning and using data-driven decision making to successfully target and allocate funding across the project areas and statewide initiatives. A high proportion of funding across the last 6 month period was spent on IDN operational cost and supporting the HIT development across the region. As we enter into our first 6 month wave of implementations there will be considerable expenditures across the community and core competency projects in staffing and program support. Expense activities in the last six months;

**HIT:** The IDN continues to contract with [REDACTED] to support and lead our health information technology work across IDN 1 partners. In agreement with the other IDN's Region 1 has agreed to vendor contracts [REDACTED]. These contracts are underway and are funding the rollout of updates across our IDN providers facilitating greater connectivity in the EHR's and preparing Region partners for shared care plan implementation. See A2 Implementation Plan for additional details.

**Integration Assessment:** A contract was supported by the Region 1 Executive Committee to subcontract with the [REDACTED] to provide a tool for integration assessment across the B1 providers. The term of funding will cover 3 waves of assessment over the course of the next 18 months. This initial assessment will serve as the framework for the ongoing B1 rollout. Additionally, this subcontract will pay for quality improvement coach support across the B1 practices implementing in each wave. See B1 Implementation Plan section for additional details.

**Training:** IDN 1 has aligned support for [REDACTED] with 4 other regional IDN's to bring CTI training to the state of NH. Also, the IDN has participated in the Privacy Boot camps to many of the ongoing efforts and process milestones identified in the A1 Implementation Plan speak to the regional emphasis on offering IDN supported training and the value in collaboration statewide to facilitate more training availability.

The Region 1 IDN continues to follow the principles below to guide our distribution of funds where applicable:

1. Value =  $\frac{[(\text{Patient/client experience} \times \text{Quality of care})]}{\text{Cost}}$
2. Our work will be guided by evidence (when evidence exists)
3. Transparency amongst IDN partners
4. Efficient planning process: Use existing data and resources whenever possible, Leverage existing networks and relationships whenever possible
5. Include patients/clients/families as members of our planning team
6. Strive for consensus: Region 1's process, strategic priorities, programs, and broad fund allocations are established and approved by the Executive Committee within the guidelines developed by DHHS.

*Please see the Region 1 Implementation Plan sections for each project for additional detail on Budget activities in the July-December reporting period. At minimum the IDN-1 team will continue to support the activities listed below to continually support the IDN workforce development. Likely as project implementation develops and new initiatives are on-boarded there will need to be an expansion in activities to meet the needs of the network.*

| Project Plan Requirement   | Activity   |            |           |            |
|--|--|------------|-----------|------------|
|  | 6/30/2017  | 12/31/2017 | 6/30/2018 | 12/31/2018 |
| Soliciting Community Input   | • BH Needs Assessment  |            |           |            |
|  | • Community Members in Governance roles  |            |           |            |
|  | • Community Members in Project Selection Roles   |            |           |            |
|  | • Community Member input to Integration Design   |            |           |            |
|  | • Listening Tour   |            |           |            |
| Network Development  | • Commitment of Partners   |            |           |            |
|  | • Identification of Integrated Core Team Partners  |            |           |            |
|  | • RFA Process to Select and Deploy Projects  |            |           |            |
|  | • Contracts  |            |           |            |
|  | • Community Supports Identification and Engagement   |            |           |            |
|  | Expanded communication to IDN partner and Region 1 organizations through;  |            |           |            |
|  | • o Bi-weekly e-news   |            |           |            |
|  | • o Weekly website updates   |            |           |            |
|  | • IDN presentation at Upper Valley, Cheshire and Sullivan County Public Health Advisory Council Meetings   |            |           |            |
|  | • IDN Admin staff involvement across numerous organization meetings and committees   |            |           |            |
| • Continued outreach to Region 1 providers that fill gaps in the IDN network |  |            |           |            |
| Addressing the Opioid Crisis   | • MAT expansion training   |            |           |            |
|  | • Worked with the American Academy Addiction Psychiatry and the Foundation for Health Communities to develop a model MAT program at Alice Peck Day Memorial Hospital |            |           |            |
|  | • Networked with SUD providers through the All Together meetings in the Upper Valley   |            |           |            |
|  | • Participate in the Governor’s Opioid and Other Drugs Commission Healthcare Taskforce   |            |           |            |
|  | • Attend the meetings of the Governor’s Commission on Primary Care   |            |           |            |
|  | • Participate in the Insurance Department Advisory Board on Behavioral Health and Addiction  |            |           |            |
|  | • Met with staff from the Center for Technology in Behavioral Health addressing SUD in Region 1  |            |           |            |
|  | • Attended meetings of the Clinical Trials Network   |            |           |            |
|  | • Convened a Region-wide substance use Project team  |            |           |            |

|                        |  |  |  |  |
|------------------------|--|--|--|--|
|                        | <ul style="list-style-type: none"> <li>• Worked with the Center for Excellence on its NHB DAS contract to expand MAT</li> </ul> <p>Worked to develop the Perinatal Addiction Treatment Program in the Region after determining the acuity of this need, and shared resources with the Dartmouth-Hitchcock Substance Use Mental Health Integration initiative</p>   |  |  |  |
| Governance             | <ul style="list-style-type: none"> <li>• Monthly or Bi-monthly meetings held with the Region 1 Executive Committee</li> <li>• Bi-weekly Admin Leads meetings held with the Region 1 Administrative Lead staff</li> <li>• All IDN e-news sent bi-weekly to all IDN 1 Partners- inclusion of updates on governance and operating structure as applicable Data Governance</li> </ul>  |  |  |  |
| Budget                 | <ul style="list-style-type: none"> <li>• Continued operational expenditures as reported</li> <li>• New Subcontracts with: [REDACTED]</li> <li>• Project awards made for 6 months across B1, C1, D3, E5 totaling \$ [REDACTED]</li> <li>• Statewide training supported for privacy, B1 integration, CTI</li> <li>• Continued compensation for patient and family support across IDN meetings and project teams</li> </ul> |  |  |  |
| (Additional as needed) |  |  |  |  |



## A1: Workforce

### A1-1. IDN Participation in Statewide Behavioral Health Workforce Capacity Development Taskforce Strategic Plan Activity

| Statewide BH Workforce Capacity Taskforce Strategic Plan Activity                | Yes/No |
|--|--------|
| Participation in taskforce meetings - 1 BH representative                        | Y      |
| Participation in taskforce meetings - 1 SUD representative                       | Y      |
| Participation in assessment of current workforce gaps across the state           | Y      |
| Participation in the creation of the statewide gap analysis                      | Y      |
| Participation in the creation of the Statewide Workforce Capacity Strategic Plan | Y      |
| Completion of the Statewide Workforce Strategic Plan                             | Y      |

### A1-2. IDN-Level Workforce: Gap Analysis

Based on the survey of our Region 1 partners, our community health needs assessment, the Statewide Behavioral Health Workforce Capacity Development Strategic Plan, our current understanding of our evolving C1, D3 and E5 community-driven projects, and the overarching needs of our B1 integration partners the IDN- 1 team has synthesized this information and identified key gap areas that currently exist throughout the region. From this review we estimate the need for numerous new behavioral health clinicians entering the workforce in Region 1 over the next years of the DSRIP implementation. In addition, workforce aspirations include empowering patients and their families with education and self-management skills to manage chronic diseases.

Specifically, in response to the most prevalent gap areas we have identified needs in the following domains:

#### Recruitment

Our partners cite the following as critical barriers to recruitment:

- Lack of qualified MLADCs, MLCSWs, and numerous other BH positions
- Low initial rates of pay
- Limitations to capacity to provide clinical supervision of apprentice clinicians

The vast majority of the Primary Care and Behavioral Health practices and Community Service agencies in our Region are actively recruiting to fill existing vacancies for multiple roles, and will be expanding those efforts to meet the workforce needs of the IDN projects. There are no FQHCs in our Region, and only two of the primary care practices surveyed ( [REDACTED] ) have a co-located behavioral health clinician. A third ( [REDACTED] ) recently lost a psychiatric ARNP and is recruiting for a replacement. Both primary care practices and mental health centers have indicated that psychiatric ARNPs can manage medication and extend the capacities of collaborating psychiatrists. Both community mental health centers ( [REDACTED] ) have ongoing searches for psychiatrists and psychologists. Counseling Associates has expanded, opening a new office in the Upper Valley, and quickly filled their available appointment slots. They conservatively estimate the need for

another 2 clinicians/year for the next several years. MAPS is moving to a larger facility in Keene to accommodate more clinicians and clients in the Monadnock area, and anticipates the need for 2-4 new behavioral health clinicians, including MLADCs. The ED at DHMC has hired two Peer Recovery Support Workers, as part of a pilot program started in spring of 2017. Currently this project is paused pending current evaluation and redesign options. The EDs at the other 5 hospitals are expected to initiate similar programs. One of the free-standing MAT programs ( ) is expanding and anticipates the need for up to 4 more MLADCs in the next 2 years.

Across the IDN-1 partner group there are numerous shared barriers to hiring and onboarding BH staff. An additional barrier adding to this gap in the workforce is the lack of adequate screening in primary care practices for behavioral health issues and substance use disorders. In fact, one of the stated reasons for not screening is the lack of resources for referral when problems are identified. A signifier that the cyclical loop of referral to a small and chronically understaffed BH provider network is further causing barriers for patients.

Our intention is twofold, first to further address the BH capacity and staffing barriers with added positions attributed to the B1 Multi-Disciplinary Care Teams (MDCT) and second, is to use the B1 implementation process to further inform the exact needs to address this current gap. Once comprehensive screening is initiated, as required in the STCs for B-1, we will be able to adjust our estimates to data-driven levels of need. This data will come in waves as new B-1 practices are on-boarded. Also, as outlined in B1-8b, the populating of the MDCTs is to be determined specific to the needs of the individual practice; thus the determination of the CTC (e.g. RN, MSW, etc.) and the BHCs for the practices must also remain indefinite at this time.

Reflecting the statewide experience, recruitment in Region 1 has not been adequate in any of the categories listed in the BH Workforce Taskforce strategic plan. Barriers include an inadequate pool of qualified individuals, non-competitive salaries, onerous and lengthy licensing processes, lack of reasonable interstate reciprocity mechanisms, competition from other areas of the state and New England, stressful work environments, inability to provide required clinical supervision for new graduates, and the absence of a Region-wide coordinated recruitment effort. These additional factors serve to amplify the shortage of BH providers across specialties.

Several IDN organizations cited lack of employment options for spouses and partners of potential BH hires as a barrier to completing hiring. All agree that, in addition to raising salaries and reimbursement for licensed behavioral health personnel, coordinating recruitment efforts with regional employers might be helpful. Similarly, although impossible to quantify, the general perception of our behavioral health partners is that, given comparatively low salaries, a loan repayment program would help with recruitment. Another identified gap can be viewed as the imbalance between cost to train a BH clinician, expected salary and any existing workplace support programs to offset the difference. The feeling across providers is that the State has a limited loan repayment program, but it is currently limited due to the waitlist and funding status.

Finally, as noted in the Statewide PCBH Workforce Strategic Plan, there is a need for internship and graduate training experiences to get more behavioral health professionals into the pipeline. A problematic essential requirement contributing to the shortage gap is the lack of professional supervision. Not only are

potential training sites short on supervising clinicians; they cannot afford the financial losses associated with taking a clinician “off line” to supervise a non-reimbursable learner. All of our behavioral partners have indicated they would be enthusiastic about taking on graduate students if they could at least be compensated for the supervision.

### Retention

Turnover rates are high throughout the Region. Interviews with our IDN partners revealed a number of factors relating to the gaps in their ability to retain the workforce. Some being: chronic stress from the collision of increased demand for service with chronic understaffing; financially-challenged organizations unable to maintain or provide competitive salary and benefits; frustration with documentation requirements coupled with cumbersome IT systems; professional stigmatization; the uncertain national and state political environment; and competition between organizations for a limited pool of professionals.

### Education and Training

There is a distinct discrepancy between the number of behavioral health professionals in the educational pipeline and the need addressed throughout the State and Region, but there is some room for optimism. Several of our regional educational institutions, as well as UNH in Durham and New England College in Henniker, are working to ameliorate the education and training gaps. UNH has implemented a robust program to train psychiatric ARNPs. New England College has initiated an innovative partnership program with community mental health agencies to train LCMHCs. Keene State College, Antioch New England, Colby-Sawyer College, Franklin Pierce University, Dartmouth-Hitchcock Medical Center and River Valley Community College are training a variety of healthcare workers across different disciplines. There is continuing expansion of Peer Recovery educational opportunities and new coaches are being trained in several settings across NH. Unfortunately, as noted above, most agencies lack the financial cushion to be able to take revenue-producing professionals off line to do supervision for newly-minted psychologists and LCMHCs in training.

There is a significant need for training in the core competencies of integrated care among clinical and non-clinical staff in both primary care and behavioral health settings. There has been some effort to educate front-line primary care and behavioral health non-clinical staff in Mental Health First Aid, but such initiatives need to be significantly expanded. IDN-1 will train these non-direct care positions across the B1 required providers and offer support through web based training to all IDN partners. In addition, as we move toward further collaboration and ultimate integration, there is a need for training around stigma, cultural sensitivity and the culture of change to ultimately address the gaps to effective integrated care delivery.

### Staffing

*Based on our gap analysis and ongoing conversations with IDN partners we need:*

- *Up to 8 MLADC*
- *Up to 6 BHC*
- *Up to 4 Psychiatrists*

- Up to 2 Psychiatric APRN's
- Up to 4 Clinical Psychologists/Neuropsychologists
- Up to 6 Licensed Community Mental Health Workers/Licensed Social Workers
- Up to 10 Peer Recovery Coaches
- 6 AmeriCorps Community Mental Health Workers

Across the listed primary staff fields of Master Licensed Alcohol and Drug Counselors, Licensed Mental Health Professionals and Peer Recovery Coaches it has been assessed by the IDN-1 team that primary gaps in staffing are related to the systemic gaps addressed in recruitment, retention, education and training listed above. There are some unique needs across these fields (i.e. recovery coach academies for training and the hours required of supervision from MLADC's for certification) but overall the identified workforce gaps span these positions and many others contributing to a larger multi-dimensional issue across the region and state.

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

*\*Please see A1: Appendix A for Implementation Timeline*

The collaborative strategies to increase workforce capacity across the State and the Region are complex and challenging. By necessity they must address all of the domains discussed above: recruitment, retention, education and training. The first two domains are severely impacted by financial considerations, and part of our plan is to enhance the monetary incentives for behavioral health professionals to seek employment and training in our region, and then encourage practitioners to remain here to practice. The solution is not, however, just financial. We recognize the need for significant culture change, in professional practice and in the community, in order to make working in Region 1 more attractive. Our plan reflects that realization. We also will support state-wide efforts to create a friendlier behavioral healthcare environment, working at the policy and regulatory levels as well as enhancing the image of behavioral health in the community. Attracting new behavioral health professionals to the Region is important, but inadequate to fill the need. Our plan outlines strategies for getting new individuals into the educational pipeline, increasing the training of existing behavioral health workers, and ensuring that everyone is working at the top of her/his job qualifications. We will access our rich regional network of educational institutions and partner with the other IDNs when feasible. Finally, we seek to leverage the untapped resources of patients and families to advocate for themselves and self-manage chronic conditions with professional help, peer support services and additional training. With all of these efforts, the ultimate goal is a self-sustaining system of workforce development that persists long after the DSRIP initiative has ended.

#### Staffing

\* Please note: staffing as listed are targets determined by the information gathering and assessment of the Region 1 IDN team to date. It is anticipated as the projects progress, more information, and areas of need are highlighted these targets may change. Additionally, not all positions listed will be new FTE as the IDN will look to leverage existing staff supports and re- allocated percentage time where possible.

1. Up to 6 Behavioral Health Care Coordinators to do case management, facilitate in-house and interagency communication and follow-up, and organize regular case conferencing
2. Up to 8 MLADCs to provide individual and group SUD treatment in primary care settings as well as in community-based free-standing MAT programs, IOPs, and residential facilities
3. Up to 4 Psychiatrists to do consultations on referral from primary care healthcare providers and frontline behavioral health providers regarding diagnosis and medication for complex mental health issues; provide initial assessments to help develop treatment plans for patients with complicated neuropsychiatric problems; and do ongoing medication management where appropriate
4. Up to 2 psychiatric nurse practitioners to provide chronic medication management and psychotherapy in collaboration with psychiatrists and other treating providers
5. Up to 4 Psychologists to do neuropsychiatric evaluations, help develop treatment plans, and do ongoing psychotherapy for patients with complex behavioral health problems
6. Up to 6 Licensed Community Mental Health Counselors and/or licensed certified social workers to be integrated into primary care practices to do acute and chronic behavioral health counseling
7. Up to 10 Peer Recovery Coaches to provide emergency crisis counseling and on-going support in individual and group settings
8. 6 Community Mental Health Workers. The Region 1 IDN will be supported by 6 AmeriCorps CMHW's awarded through a new grant.

### Retention Activities and Process Milestones

By 12/31/17:

1. Beginning steps will be taken to develop a training to address the culture of change and the integration of the cultures of physical and behavioral health, with the goal of reducing the provider stress surrounding collaboration/integration efforts. Existing cultural change trainings will be leveraged to define the needs for this area.
2. Mental Health Training, IDN-1 aims to ask for input from the boards of the community mental health organizations and the local hospitals, as well as the NH Charitable Foundation to help outline the training and needs. Community forums will be scheduled in IDN-1, similar to the Mental Health Day program at DHMC in June 2017, to combat stigma and celebrate the successes of behavioral health clinicians in treating SUDs and other mental health problems. The goal is to provide more visibility and elevate the community standing of behavioral health clinicians.
3. Meetings will be held with the regional community mental health providers to determine the amount of additional supervision time required to reduce burn-out of existing BH clinicians and to support mentoring and supervision of trainees and to help career advancement of early career clinicians.
4. Meetings will be held with a minimum 2 of the HR directors of IDN 1 Partner BH provider organizations to determine the salary/benefit thresholds in our region below which trainees and recent graduates are likely to leave their positions.

5. We will explore synergy with other funding sources, including philanthropy, to provide financial incentives for retention.
6. Initial review of loan repayment program implementation and support across IDN-1 partners.  
*\*Funding will be withheld for the loan repayment program each semi-annual period commencing 7/1/17 to support readiness for program application as soon as possible*
7. Work with IDN partners to model a method for entry level position support (continuous throughout implementation)
8. Work with IDN partners to support expanded supervision capacity for BH positions (continuous throughout implementation)

By 6/30/18:

1. Offer culture of change trainings to the B1 partner agencies participating in the integration project work or as sub-regions (3) within IDN-1.
2. A community forum (as described above) will have taken place in each of the sub-regions.
3. A financial plan will be drafted to provide oversight on how IDN funds will be used to support BH supervision
4. A plan will be developed to provide financial support to upgrade the salary/benefits of entry-level staff to facilitate retention of recent trainees in partner agencies
5. Continued development of the Region wide loan repayment program and implementation
6. Work with IDN partners to model a method for entry level position support (continuous throughout implementation)
7. Work with IDN partners to support expanded supervision capacity for BH positions (continuous throughout implementation)

By 12/31/18:

1. Meetings will be convened in each of the B1 partner agencies to assess progress in the integration of behavioral and physical health cultures and facilitate further evolution.
2. Additional community forums will be held as needed, emphasizing specific topics in mental health care
3. Continued implementation and support to maintain regional loan repayment program
4. Work with IDN partners to model a method for entry level position support (continuous throughout implementation)
5. Work with IDN partners to support expanded supervision capacity for BH positions (continuous throughout implementation)

## Education Activities and Milestones

By 12/31/17:

1. Identify regional educational institutions interested in developing new, and enhancing existing, behavioral health training programs
2. Meet with NH AHEC to strategize about educating student health professionals in collaborative practice and team-based models of care
3. Meet with NH AHEC about developing a “road show” for middle and high schools to promote behavioral health careers
4. Meet with NH AHEC about how to encourage undeclared students in regional colleges to enter behavioral health fields
5. Meet with the Recovery Coach Academy, NH BDAS, and the Center for Excellence, and other IDNs to develop a strategy for expanding the pool of peer recovery coaches in the Region and across the state.
6. Meet with partner organizations to assess capacity to expand sites for student and trainee internships, preceptorships and electives.

By 6/30/18:

1. Meetings will be held with applicable faculty at Keene State, New England College, Antioch New England, Colby-Sawyer College, River Valley Community College and Franklin Pierce University regarding educational programs to meet regional workforce needs. \*As possible IDN-1 will look to coordinate these efforts statewide with other IDN’s
2. Meetings will be held with NH AHECs and other IDNs to discuss development of an inter-professional collaborative practice curriculum that can be utilized by NH professional schools. An interactive computer module will be explored.
3. A comprehensive list of student and trainee sites will be developed and shared throughout Region 1.

By 12/31/18:

1. Regional educational institutions will have identified, investigated the feasibility of, and begun to plan for, new and expanded workforce development programs.
2. An inter-professional collaborative practice curriculum will have been developed.
3. New student and trainee sites will be offered.

### Training Activities and Milestones

Region 1 has participated in the development of, and fully supports, the NH DSRIP Behavioral Health Workforce Capacity Strategic Plan. Training will address the core competencies outlined in the Plan (pages 16-23), utilizing many of the resources listed there, with our partners selecting those which are best suited to their unique practice settings and organizational structures. An overarching goal, underlying all of this training, is the development and enhancement of high functioning multidisciplinary teams. We will work to support expanded roles for non-MD healthcare workers in the primary care setting to work to the top of their licenses, and train beyond, to provide integrated care. SUD and other Part II providers will be trained in the 42 CFR Part 2 requirements. Providers will be trained in SBIRT using the tools in the Screen and Intervene NH SBIRT Playbook and Kognito Simulation. We will expand and implement self-care and chronic

disease management strategies in partner primary care practices. It is expected that much of this training will be conducted through the statewide DSRIP Learning Collaborative, supplemented by local initiatives as necessary. We will engage the [REDACTED] to explore further training modules for both staff and patients. C1 providers will participate in Critical Time Intervention training (see C1 Section 1 for additional details).

To reduce stigma and enhance the quality of care of patients with SMI and SUDs, the billing and reception staff of all B1 partners will be trained on primary content of mental health first aid (using a web-based curriculum) and in the psychological dynamics of addiction (through in-office sessions utilizing the “SUD 101” curriculum from the American Academy of Addiction Psychiatry). (More shared in the B1 Section)

To enhance utilization of existing SUD and behavioral health resources, and to enhance connection among those providers and primary care practices, several other training strategies will be employed.

B1 partners will report on their activities and capacities at quarterly Advisory Council meetings. They will all participate in monthly knowledge exchanges. All point of contact staff will be trained in the use of the pertinent NH online resources: NH Statewide Addiction Crisis Line, Headrest Crisis Line, Regional Access Point Services, NH Treatment Locator, and Partnership for Drug-Free Kids. MAT providers will participate in monthly meetings of the Statewide Community of Practice. Community forums will be held on an annual basis to inform and celebrate progress in mental health/SUD care.

By 12/31/17

1. Support IDN-1 primary care partners through training and ongoing knowledge exchange sessions to further understand information on SAMSHA levels of integrated healthcare, completion of Site Self-Assessment Tool, and understand where their practices fall in the continuum.
2. Assess with IDN partners- desired trainings, the number of staff to be trained on each training, existing in-house trainings and ability to expand them, and ability to create new trainings if resourced
3. Offer mental health training targeted for non-direct care staff positions to IDN partners through Knowledge Exchange Sessions
4. Offer SBIRT training to implementing provider practices as needed
5. Schedule trainings to expand MAT capability in partner primary care practices.
6. Offer Training on 42 CFR Pt II requirements for providers
7. Meet with The Center for Behavioral Health Technology to explore the use of telehealth models to expand treatment capacity and leverage behavioral health expertise.
8. Support C1: Care Transitions involved partners to participate in statewide CTI trainings
9. A monthly call-in/WebEx knowledge exchange will be established

By 6/30/18:

1. Schedule Region-wide training sessions in cultural competency (Specifics of training under development).
2. Schedule Region-wide training sessions in suicide prevention. (Model for training use under review)

3. Support new primary care partners in pursuing MAT.
4. Continuous involvement in CTI Statewide training and model dissemination initiatives.

By 12/31/18:

1. Continuous involvement in Statewide training platforms and projects where applicable to support IDN projects
2. Offer renewed training across a minimum of 3 core training areas
3. Assess need for and implement as needed additional Region-wide training sessions on cultural competency and suicide prevention.

### Evaluation Plan

The Region 1 Workforce Workgroup and Admin Team will continually work on refining and improving the method and process for tracking the IDN progress across the defined milestone areas. Additionally, through the support of the quality improvement coaches contracted by Citizens Health Initiative, the workgroup will use the continuous improvement efforts across project involved partners as a framework for the Workforce evaluation.

As the Workforce Taskforce Statewide continues to meet in 4 sub-committees the Region 1 IDN is committed to continued active participation and will adapt current defined strategies to align with the State-wide efforts where possible. It is anticipated that these areas will closely tie in across areas of policy advocacy, educational training creation, and licensure.

The Region 1 IDN team supported by the Workforce Workgroup and IDN partners has created a robust operational plan to support project efforts through the life of the Implementation in June, 2020. Much of this plan centers around the process milestones described above and listed on the A1: Implementation Plan Timeline. These steps are the central components of the Region 1 evaluation plan as the internal IDN team will continuously build and develop the ongoing workforce strategy following the listed process milestones. Each line item can be seen as a tollgate for the higher level efforts of the workforce strategy.

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

*Please note the fields numbered in progress towards target for 12/31/17, 6/30/18, 12/31/18 are projections based on current implementation planning and subject to change with evolving strategies statewide and regionally.*

| Performance Measure Name   | Target  | Progress Toward Target |               |                |
|--|---------|------------------------|---------------|----------------|
|  |         | As of 12/31/17         | As of 6/30/18 | As of 12/31/18 |
| New BH Clinicians recruited due to enhanced supervision capabilities | Up to 6 |                        |               | 1              |

|  |           |   |   |   |
|--|-----------|---|---|---|
| Participants in the annual job fair, expressing interest in Regional BH positions  | Up to 50  |   |   |   |
| Hits on the Website  | Up to 100 |   |   |   |
| Interviews with "Trailing Partners"  | Up to 10  | 1 | 1 | 1 |
| Applications for Loan Repayment  | Up to 20  |   | 2 | 2 |
| Culture Change/Integration education sessions                                      | 4         |   | 1 |   |
| Community forums held to celebrate progress in mental health/SUD care              | 2         |   | 1 | 2 |
| Educational institutions engaged in the workforce expansion project                | 3         |   | 2 | 1 |
| Meetings with IDN's and AHECs on statewide strategies                              | 2         | 1 |   | 1 |
| Collaborative practice curriculum for students implemented at professional schools | Up to 4   | 1 |   | 1 |

### A1-5. IDN-Level Workforce: Staffing Targets

\* Please note: staffing as listed are targets determined by the information gathering and assessment of the Region 1 IDN team to date. It is anticipated as the projects progress, more information, and areas of need are highlighted these targets may change.

| 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 |
| Master Licensed Alcohol and Drug Counselors | Up to 8              | 0  |                      |                     |                      |
| Behavioral Health Care Coordinators         | Up to 6              | 0  |                      |                     |                      |
| Psychiatrists                               | Up to 4              | 1 *Indicates shift in current staff time to support IDN project implementation |                      |                     |                      |
| Psychiatric APRN's                          | Up to 2              | 0  |                      |                     |                      |

|  |          |  |  |  |  |
|--|----------|--|--|--|--|
| Clinical Psychologists/Neuropsychologists                                  | Up to 4  | 0                                      |  |  |  |
| Licensed Community Mental Health Counselors and/or Licensed Social Workers | Up to 6  | 1                                      |  |  |  |
| Peer Recovery Coaches  | Up to 10 | 0                                      |  |  |  |
| AmeriCorps- Community Mental Health Workers                                | 6        | * Service Year begins in October, 2017 |  |  |  |

A1-5: Current Community Project Pilot Staffing

| Project Code | Provider Type                       | Projected Total Need | Baseline Staffing on 6/30/17   | Staffing on 12/31/17 | Staffing on 6/30/18 | Staffing on 12/31/18 |
|--------------|-------------------------------------|----------------------|--------------------------------|----------------------|---------------------|----------------------|
| D3           | <i>Masters Level clinician (BH)</i> | 1.5 FTE              | Recruit to Hire                | 1.5 FTE              | 1.5 FTE             | 1.5 FTE              |
|              | <i>Psychiatry (MD, ARNP)</i>        | .3 FTE               | Recruit to Hire                | .3 FTE               | .3 FTE              | .3 FTE               |
|              | <i>OB/GYN( ARNP, CNM)</i>           | .1 FTE               | Recruit to Hire                | .1 FTE               | .1 FTE              | .1 FTE               |
|              | <i>Pediatrician (MD, ARNP)</i>      | .1 FTE               | Recruit to Hire                | .1 FTE               | .1 FTE              | .1 FTE               |
|              | <i>Social Work Case Manager</i>     | .5 FTE               | Recruit to Hire                | .5 FTE               | .5 FTE              | .5 FTE               |
|              | <i>Recovery Coach</i>               | .5 FTE               | Recruit to Hire                | .5 FTE               | .5 FTE              | .5 FTE               |
|              | <i>Childcare Providers</i>          | .75 FTE              | Recruit to Hire                | .75 FTE              | .75 FTE             | .75 FTE              |
|              | <i>Administrative Support Staff</i> | .5 FTE               | Hired, Utilizing Current Staff | .5 FTE               | .5 FTE              | .5 FTE               |
|              | <i>Certified Medical Assistant</i>  | .5 FTE               | Hired, Utilizing Current Staff | .5 FTE               | .5 FTE              | .5 FTE               |

|    |                             |       |  |                                      |                                      |                                      |
|----|-----------------------------|-------|--|--------------------------------------|--------------------------------------|--------------------------------------|
| C1 | Care Transition Coordinator | 2 FTE | 0- In process to Recruit to hire             | 2 FTE                                | 2 FTE                                | 2 FTE                                |
|    | Enhanced Care Coordinators  | 2 FTE | 0- In process to Recruit to hire             | 2 FTE                                | 2 FTE                                | 2 FTE                                |
|    | Supervisor                  | 1 FTE | In process to reallocate Current Staff % FTE | 1 FTE                                | 1 FTE                                | 1 FTE                                |
| E5 | Community Case Manager      | 1 FTE | Recruit to Hire                              | 1 FTE                                | 1 FTE                                | 1 FTE                                |
|    | Supervisor                  | .1FTE | 0.1 FTE, Current Staff: Re-allocated         | 0.1 FTE, Current Staff: Re-allocated | 0.1 FTE, Current Staff: Re-allocated | 0.1 FTE, Current Staff: Re-allocated |

### A1-6. IDN-Level Workforce: Building Capacity Budget

The Region 1 IDN admin team and the Clinical/Workforce Workgroup worked throughout late winter and spring 2017 to formalize the Region 1 workforce plan and the required workforce steps to merge the regional initiatives with the directives of the statewide planning. With final decisions made on desired activities and review of the BH workforce taskforce plan complete the process for budget creation began. While high level funding brackets were proposed for each Workforce activity much was left open ended to accommodate for the community based project staffing needs. As shown on the budget table below for the B1, C1, D3, and E5 projects all direct staff costs are rolled into the workforce budget. This was done in an effort to allow for flexibility in the staffing and the opportunity for the IDN to support project hiring and training in alignment with the other workforce initiatives. Each project category in the budget below represents the total cost of staffing for all projects approved as of July 1, 2017 and an additional % of funding that will be reserved in State FY 18 for additional projects funded in subsequent RFA waves. Please note that due to the volume of B1 providers likely implementing in the next two waves the IDN has left the funding for Year 3 and 4 unconfirmed to allow for tailoring as necessary. It is anticipated that by the next semi-annual reporting period this will have been made clearer and will be updated.

Outside of allotments for project staffing the below budget reflects the proposed funding by year covering all of the process milestones referenced in the earlier sections of this plan. A significant emphasis has been placed on expanding loan repayment opportunities, entry level staff support and supervision. Many of the items on the budget have been level funded across the remaining implementation period of the DSRIP initiatives. However, the Region 1 IDN acknowledges that due to the evolving nature of system transformation work there may need to be revision to accommodate for new need areas or restructure the funding planning to meet IDN partner needs. Additionally, to further

support the activity milestones shared above there is broader flexibility within the funding categories to support funding where needed.

Please see table below for budget details.



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

| Organization Name  | Organization Type  | Associated with IDN Projects (A1, A2, B1, C, D, E) |
|--|--|--|
| <b>Alice Peck Day Memorial Hospital</b>                  | Hospital Facility  | A1, A2, B1   |
| <b>Cheshire County (includes :)</b>                      | County   | A1, A2   |
| <i>Behavioral Health Court Program (CCBHCP)</i>          | Other County Organization  | A1, A2   |
| <i>DOC</i>   | County Corrections   | A1, A2   |
| <i>Maplewood Nursing Home</i>                            | County Nursing Facility  | A1, A2   |
| <b>Cheshire Medical Center/DHK</b>                       | Hospital Facility  | A1, A2, B1, C1, E5                                 |
| <b>Child and Family Services</b>                         | Non CMHC Mental Health Provider                                    | A1, A2, B1   |
| <b>Community Volunteer Transportation Company (CVTC)</b> | Community Based Organization Providing Social and Support Services | A1, A2, C1, E5                                     |
| <b>Crotched Mountain (includes :)</b>                    | Community Based Organization Providing Social and Support Services | A1, A2, B1   |
| Adult Residential Services                               | Adult Residential Services   | A1, A2   |
| <i>ATECH Services</i>                                    | Assistive Technology Clinical Consultation                         | A1, A2   |
| <i>Community Care</i>                                    | Community Care Management  | A1, A2   |
| <i>Outpatient Services</i>                               | Specialty Outpatient Clinics                                       | A1, A2   |
| <i>Crotched Mountain School</i>                          | Residential Treatment  | A1, A2   |
| <b>Dartmouth-Hitchcock Primary Care-Lebanon</b>          | Primary Care Practice  | A1, A2, B1   |
| <b>Dartmouth-Hitchcock Psychiatric Associates</b>        | Non CMHC Mental Health Provider                                    | A1, A2, B1, D3                                     |
| <b>Easter Seals Farnum Center</b>                        | Substance Use Disorder (SUD) Provider                              | A1, A2, B1   |
| <b>Grafton County (includes :)</b>                       | County   | A1, A2   |
| <i>Senior Citizens Council</i>                           | Other County Organization  | A1, A2   |
| <b>Granite State Independent Living</b>                  | Home and Community Based Care Provider                             | A1, A2   |
| <b>Greater Monadnock Public Health Network</b>           | Public Health Organization   | A1, A2   |
| <b>Greater Sullivan County Public Health Network</b>     | Public Health Organization   | A1, A2   |
| <b>Headrest, Inc.</b>                                    | Substance Use Disorder (SUD) Provider                              | A1, A2   |
| <b>Home Healthcare Hospice and Community Services</b>    | Home and Community Based Care Provider                             | A1, A2, C1, E5                                     |
| <b>Hope for NH Recovery</b>                              | Other Organization Type  | A1, A2, E5   |
| <b>Keene Housing</b>                                     | Other Organization Type  | A1, A2, C1, E5                                     |
| <b>Ken Jue Consulting</b>                                | Other Organization Type  | A1, A2   |

|   |  |                    |
|---|--|--------------------|
| <b>Lake Sunapee VNA</b>                                       | Home and Community Based Care Provider                             | A1, A2             |
| <b>Lebanon Housing Authority</b>                              | Other Organization Type  | A1, A2             |
| <b>Life Coping Inc.</b>                                       | Non CMHC Mental Health Provider                                    | A1, A2             |
| <b>MAPS</b>   | Non CMHC Mental Health Provider                                    | A1, A2, B1         |
| <b>Mary Hitchcock Memorial Hospital</b>                       | Hospital Facility  | A1, A2             |
| <b>Mindful Balance Therapy Center PLLC</b>                    | Non CMHC Mental Health Provider                                    | A1, A2, B1         |
| <b>Monadnock Area Peer Support Agency</b>                     | Other Organization Type  | A1, A2, C1, E5     |
| <b>Monadnock Center for Violence Prevention</b>               | Community Based Organization Providing Social and Support Services | A1, A2             |
| <b>Monadnock Collaborative</b>                                | Other Organization Type  | A1, A2, C1, E5     |
| <b>Monadnock Community Hospital</b>                           | Hospital Facility  | A1, A2, B1         |
| <b>Monadnock Family Services</b>                              | Community Mental Health Center                                     | A1, A2, B1, C1, E5 |
| <b>Monadnock Region System of Care</b>                        | Non CMHC Mental Health Provider                                    | A1, A2, C1, E5     |
| <b>NAMI New Hampshire</b>                                     | Non CMHC Mental Health Provider                                    | A1, A2, B1         |
| <b>New London Hospital and Medical Group Practice</b>         | Hospital Facility  | A1, A2, B1         |
| <b>New London Pediatric Care Center Practice</b>              | Primary Care Practice  | A1, A2, B1         |
| <b>Newport Health Center Practice</b>                         | Primary Care Practice  | A1, A2, B1         |
| <b>Pathways of the River Valley</b>                           | Home and Community Based Care Provider                             | A1, A2             |
| <b>Phoenix House</b>  | Substance Use Disorder (SUD) Provider                              | A1, A2, B1         |
| <b>Planned Parenthood of Northern New England - Claremont</b> | Primary Care Practice  | A1, A2, B1         |
| <b>Planned Parenthood of Northern New England - Keene</b>     | Primary Care Practice  | A1, A2, B1         |
| <b>ServiceLink-Grafton County</b>                             | Other Organization Type  | A1, A2             |
| <b>ServiceLink - Monadnock</b>                                | Other Organization Type  | A1, A2, C1, E5     |
| <b>Southwestern Community Services, Inc.</b>                  | Community Based Organization Providing Social and Support Services | A1, A2, C1, E5     |
| <b>Sullivan County (includes :)</b>                           | County   | A1, A2             |
| <i>Dept. of Corrections</i>                                   | County Corrections   | A1, A2, E5         |
| <i>Maplewood Nursing Home</i>                                 | County Nursing Facility  | A1, A2             |
| <b>talc Family Resource Center</b>                            | Home and Community Based Care Provider                             | A1, A2, B1, E5     |
| <b>Twin Pines Housing Trust</b>                               | Other Organization Type  | A1, A2             |
| <b>Upper Valley Public Health Council</b>                     | Public Health Organization   | A1, A2             |

|   |  |                |
|---|--|----------------|
| <b>Valley Regional Hospital</b>                 | Hospital Facility                      | A1, A2, B1, E5 |
| <b>Visiting Nurse and Hospice for VT and NH</b> | Home and Community Based Care Provider | A1, A2         |
| <b>West Central Behavioral Health</b>           | Community Mental Health Center         | A1, A2, B1, E5 |

A1-8. Signed Attestation of IDN Review and Acceptance of the Statewide Workforce Capacity Development Strategic Plan

\*See A1: Appendix B

A1-9. Scoring Table (See DHHS SAR Template)

## A2: HIT

### A2-1 IDN Participation in Statewide HIT Taskforce

#### Introduction

To support the New Hampshire Department of Health and Human Services (DHHS) Delivery System Reform Incentive Payment (DSRIP) Building Capacity for Transformation, Section 1115 Medicaid demonstration waiver, IDN Region 1 is participating in two statewide projects as defined in the Special Terms and Conditions (STC).<sup>1</sup> The second of the two statewide projects, *A2. Health Information Technology (HIT) Infrastructure to Support Integration*, requires each IDN to develop HIT infrastructure required to support integrated, high-quality care throughout New Hampshire.

This HIT Implementation Plan includes IDN-specific plans and timelines that align with the HIT Task Force’s assessment and recommendations adopted on April 5, 2017. This HIT Implementation Plan is also based on the IDN’s current HIT capacity and IDN-specific community needs assessments.<sup>2</sup>

This document template was created by [REDACTED] in consultation with DHHS. It includes findings from the [REDACTED] environmental scan and gap analysis as well as summaries of the Statewide Task Force Process and consensus recommendations developed by the IT leadership of all IDNs.

#### Participation in Statewide HIT Task Force

In addition to the overall goals of the demonstration project, an HIT Task Force including representatives for each IDN was formed to support the statewide planning effort. All IDNs were required to participate in the monthly, in-person HIT Task Force meetings. Facilitated by [REDACTED], the HIT Task Force was charged with<sup>3</sup>:

- Assessing the current health IT infrastructure gaps across the state and IDN regions.
- Coming to consensus on statewide health IT implementation priorities given the demonstration objectives.
- Identifying the statewide and local IDN health IT infrastructure requirements to meet demonstration goals, including:
  - Minimum standards required of every IDN
  - “Desired” standards that are strongly encouraged but not required to be adopted by every IDN
  - A menu of optional requirements

In addition to the monthly HIT Task Force meetings, work sessions were established and conducted via WebEx and facilitated jointly by the elected Chairs of the HIT Task Force and [REDACTED]. These work sessions were scheduled to occur weekly (if necessary) with the exception of the weeks in which an in-person HIT Task Force meeting was held. IDN Region 1 participated in and contributed to all sessions.

**Figure 1: Table A2-1. IDN Participation in Statewide HIT Taskforce**

| Statewide HIT Taskforce Participation | Yes/No |
|---------------------------------------|--------|
|---------------------------------------|--------|

|  |     |
|--|-----|
| Participation in HIT Taskforce meetings  | Yes |
| Participation in current state assessment  | Yes |
| Completion of IDN member assessment of existing and scheduled HIT efforts and statewide report   | Yes |
| Participation in the review of pertinent State and Federal laws  | Yes |
| Participation in the creation of the gap analysis  | Yes |
| Participation on work to achieve consensus on a set of minimally required, desired, and optional IT HIE infrastructure projects for IDNs to pursue | Yes |

## A2-2. IDN HIT/HIE: Assessment and Gap Analysis

### Summary of Assessment and Gap Analysis

The IDN-1 Data & IT Workgroup developed project requirements in the fall of 2016 and then conducted a gap analysis against those requirements. The core requirements were those of the NH 1115 Waiver:

- Reduce unnecessary use of inpatient and ED services, hospital readmissions and wait times
- Promote the integration of primary care, behavioral providers (mental health and SUD providers) and community based organizations
- Support care transitions
- Support alternative payment models

The detailed requirements were derived from the projects selected by IDN-1.

In the Winter/Spring of 2017 DHHS engaged [REDACTED] to aid all IDNs in assessing gaps and defining base level services / standards that all IDNs could implement. The following narrative summarizes the assessment, gap analysis, and planning conducted through these two efforts.

### IDN-1 Data & IT Workgroup Requirements Development

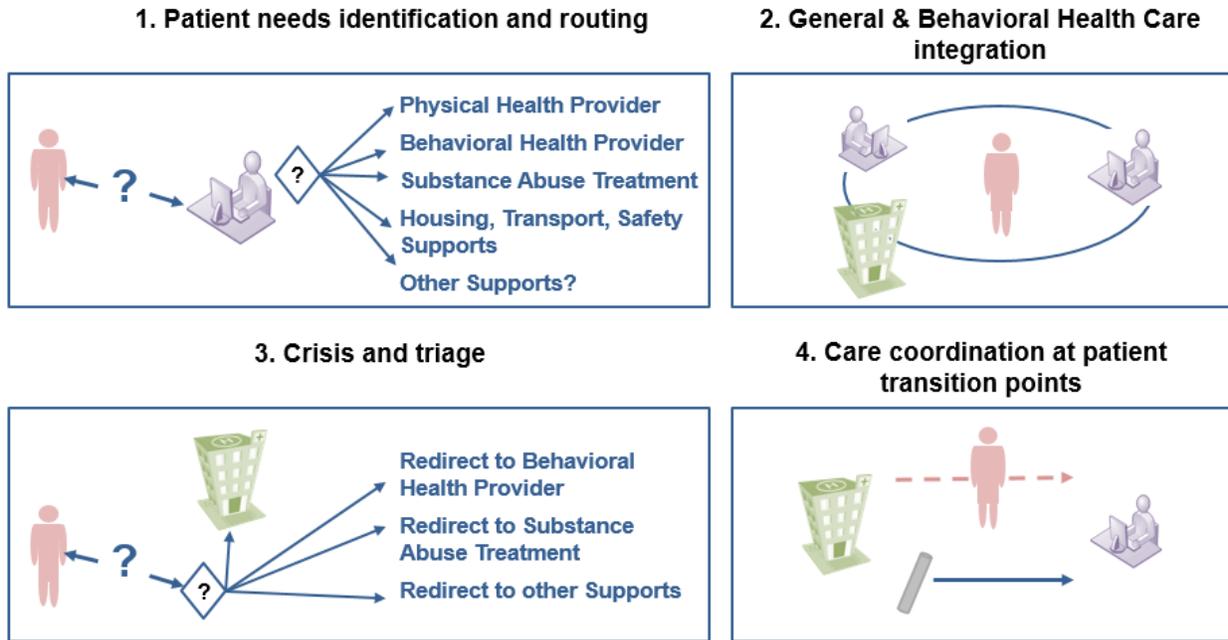
In the fall of 2016 the IDN-1 Data & IT Workgroup began to anticipate requirements for the NH 1115 waiver. The Workgroup began with agreement to a set of guiding principles suggested by [REDACTED] for IT support of the 1115 integration work in NH:

1. Make effective and efficient use of IT resources within the state by working across IDNs on technology.
2. Leverage existing tools and methodologies when possible.
3. Utilize common resources when possible (contractors, vendors).
4. Share project plans and technology plans.
5. Avoid making this an IT project; make it a care project that has a component of technology support.
6. Utilize the State HIT Task force as much as possible to coordinate and recommend solutions.

7. Business requirements (“what are we trying to accomplish and how”) drive the technology and data requirements.
8. Sometimes, simpler is better.

After review of the literature on behavioral health integration, four archetypes were developed to describe patient needs that impact information flow and IT.

**Figure 2: Care Coordination Archetypes**



High level use cases were developed for each of the archetypes to further refine the needs and requirements:

**Needs Identification and Routing for “No Wrong Door:”** Client’s needs are identified and Client / Caregivers are steered to appropriate supports.

**Figure 3: High Level Use Cases for Needs Identification and Routing for “No Wrong Door:”**

| From Whom                 | To Whom                          | Information Requirement   |
|---------------------------|----------------------------------|---|
| Primary Care              | Behavioral Health                | Summary of Care, Standard Screening Results (AUDIT, PHQ-9, GAD-7) |
| Behavioral Health         | Primary Care                     | Summary of Care, Standard Screening Results (AUDIT, PHQ-9, GAD-7) |
| Primary Care              | Substance Abuse Treatment        | Summary of Care, Standard Screening Results (AUDIT-C or AUDIT 10) |
| Behavioral Health         | Substance Abuse Treatment        | Summary of Care, Standard Screening Results (AUDIT-C or AUDIT 10) |
| Behavioral Health         | Housing support                  | Referral  |
| Behavioral Health         | Transport support                | Referral  |
| Behavioral Health         | Safety support                   | Referral  |
| Behavioral Health         | Peer support                     | Referral  |
| Primary Care              | Housing support                  | Referral  |
| Primary Care              | Transport support                | Referral  |
| Primary Care              | Safety support                   | Referral  |
| Primary Care              | Peer support                     | Referral  |
| Behavioral Health         | Finish high school - Support     | Referral  |
| Behavioral Health         | Enter college / Trade - Support  | Referral  |
| Behavioral Health         | Employment Support               | Referral  |
| Behavioral Health         | Wellness Programs - Support      | Referral  |
| Behavioral Health         | Individual goals - Support       | Referral  |
| Primary Care              | Behavioral Health Specialty Care | Referral, Navigation assistance, Follow-up, Bridged care          |
| Behavioral Health         | Behavioral Health Specialty Care | Referral, Navigation assistance, Follow-up, Bridged care          |
| Consumer/Patient          | Behavioral Health                | Self-referral   |
| BH Specialty Care         | Primary Care                     | Referral, Navigation assistance, Follow-up, Bridged care          |
| BH Specialty Care         | Behavioral Health                | Referral, Navigation assistance, Follow-up, Bridged care          |
| Substance Abuse Treatment | MAT (methadone, buprenorphine)   | Referral, Navigation assistance, Follow-up, Bridged care          |
| Substance Abuse Treatment | Intensive Outpatient Treatment   | Referral, Navigation assistance, Follow-up, Bridged care          |
| Substance Abuse Treatment | Inpatient treatment              | Referral, Navigation assistance, Follow-up, Bridged care          |
| Substance Abuse Treatment | Group Counseling                 | Referral, Navigation assistance, Follow-up, Bridged care          |
| Substance Abuse Treatment | Individual Counseling            | Referral, Navigation assistance, Follow-up, Bridged care          |
| Substance Abuse Treatment | Self-Help/12 Step Program        | Referral, Navigation assistance, Follow-up, Bridged care          |

**General & Behavioral Health Care integration:** Client is co-served by physical and behavioral health providers and care is coordinated

**Figure 4: High Level Use Cases for General & Behavioral Health Care integration**

| From Whom                    | To Whom                           | Information Requirement                              |
|------------------------------|-----------------------------------|--|
| Primary Care (bidirectional) | Behavioral Health (bidirectional) | Summary of Care                                      |
| Primary Care (bidirectional) | Behavioral Health (bidirectional) | Consultation   |
| Primary Care (bidirectional) | Behavioral Health (bidirectional) | SBIRT/AUDIT Screening Results (for substance abuse)  |
| Primary Care (bidirectional) | Behavioral Health (bidirectional) | PHQ-9 Screening Results (for severity of depression) |
| Primary Care (bidirectional) | Behavioral Health (bidirectional) | GAD-7 Screening Results (for severity of anxiety)    |

**Crisis Prevention and Triage:** In crisis, Client is redirected to the most appropriate care team / setting of care.

**Figure 5: High Level Use Cases for Crisis Prevention and Triage**

| From Whom            | To Whom                   | Information Requirement             |
|----------------------|---------------------------|-------------------------------------|
| Emergency Department | Behavioral Health         | Notification of Patient Disposition |
| Behavioral Health    | Emergency Department      | Summary of Care                     |
| Primary Care         | Emergency Department      | Summary of Care                     |
| Emergency Department | Emergency Department      | Summary of Care                     |
| Emergency Department | Behavioral Health         | "ED Diversion Referral of Care"     |
| Emergency Department | Substance Abuse Treatment | "ED Diversion Referral of Care"     |
| Emergency Department | Consumer/Patient          | "ED Diversion Care Plan"            |
| Crisis Support Line  | Behavioral Health         | "ED Diversion Referral of Care"     |
| Crisis Support Line  | Substance Abuse Treatment | "ED Diversion Referral of Care"     |
| Crisis Support Line  | Consumer/Patient          | "ED Diversion Care Plan"            |

**Care coordination at patient transition points:** Client moves from one care provider to another and care teams conduct formal hand offs

Figure 6: High Level Use Cases for Care Coordination at Patient Transition Points

| From Whom                        | To Whom                   | Information Requirement                            |
|----------------------------------|---------------------------|--|
| Primary Care                     | Substance Abuse Treatment | Referral, Summary of Care, SBIRT Screening Results |
| Primary Care                     | Behavioral Health         | Referral, Summary of Care                          |
| Behavioral Health                | Substance Abuse Treatment | Referral, Summary of Care, SBIRT Screening Results |
| Hospital                         | Behavioral Health         | Discharge Summary                                  |
| Primary Care                     | Consumer/Patient          | Summary of Care, Care Plan                         |
| Behavioral Health                | Consumer/Patient          | Summary of Care, Care Plan                         |
| Hospital                         | Consumer/Patient          | Discharge Instructions                             |
| Primary Care                     | Service Link              | Summary of Care, Care Plan                         |
| Behavioral Health                | Service Link              | Summary of Care, Care Plan                         |
| Hospital                         | Service Link              | Summary of Care, Care Plan                         |
| LTSS/HBCS/Independent Case Mgmt. | Primary Care              | Case management care plan                          |
| LTSS/HBCS/Independent Case Mgmt. | Behavioral Health         | Case management care plan                          |
| LTSS/HBCS/Independent Case Mgmt. | Hospital                  | Case management care plan                          |
| LTSS/HBCS/Independent Case Mgmt. | Substance Abuse Treatment | Case management care plan                          |

As the IDN-1 stakeholders completed project selection for the project plan, the IDN-1 Data & IT Workgroup was able to define overviews and requirements for the selected projects.

Figure 7: Project B1 Integrated Healthcare Overview

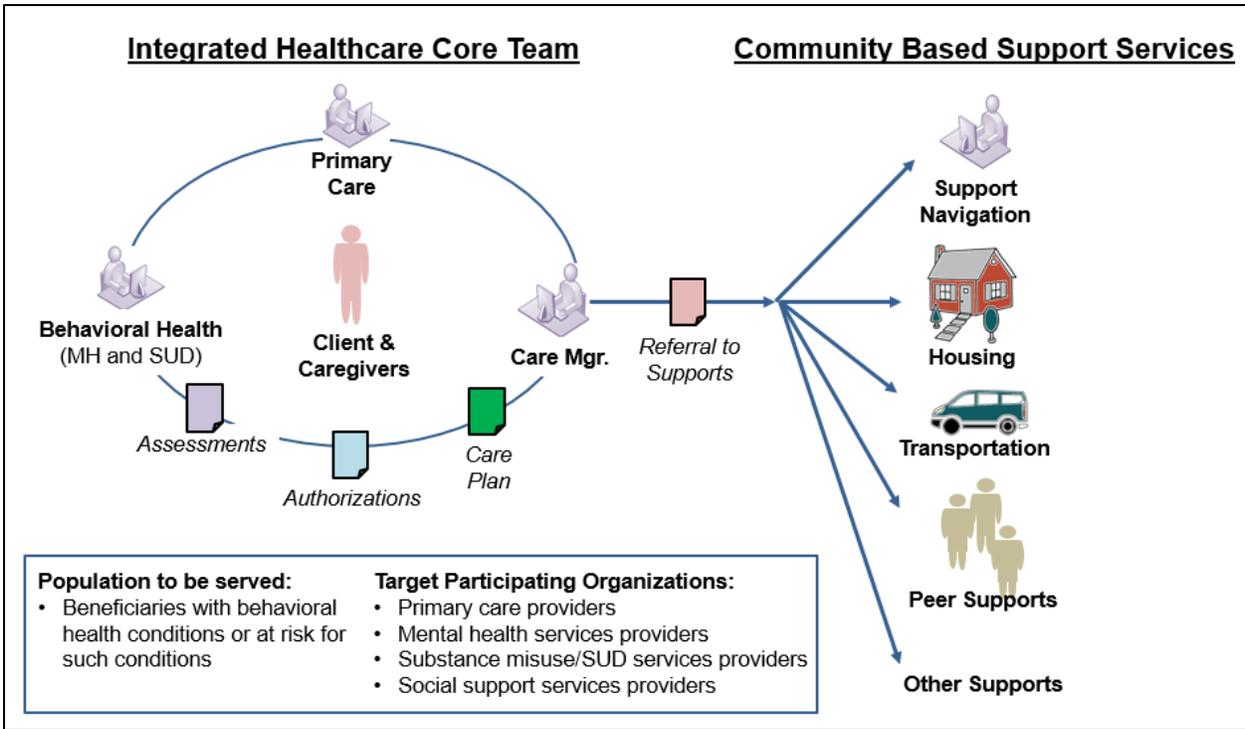


Figure 8: Project B1 Information Requirements

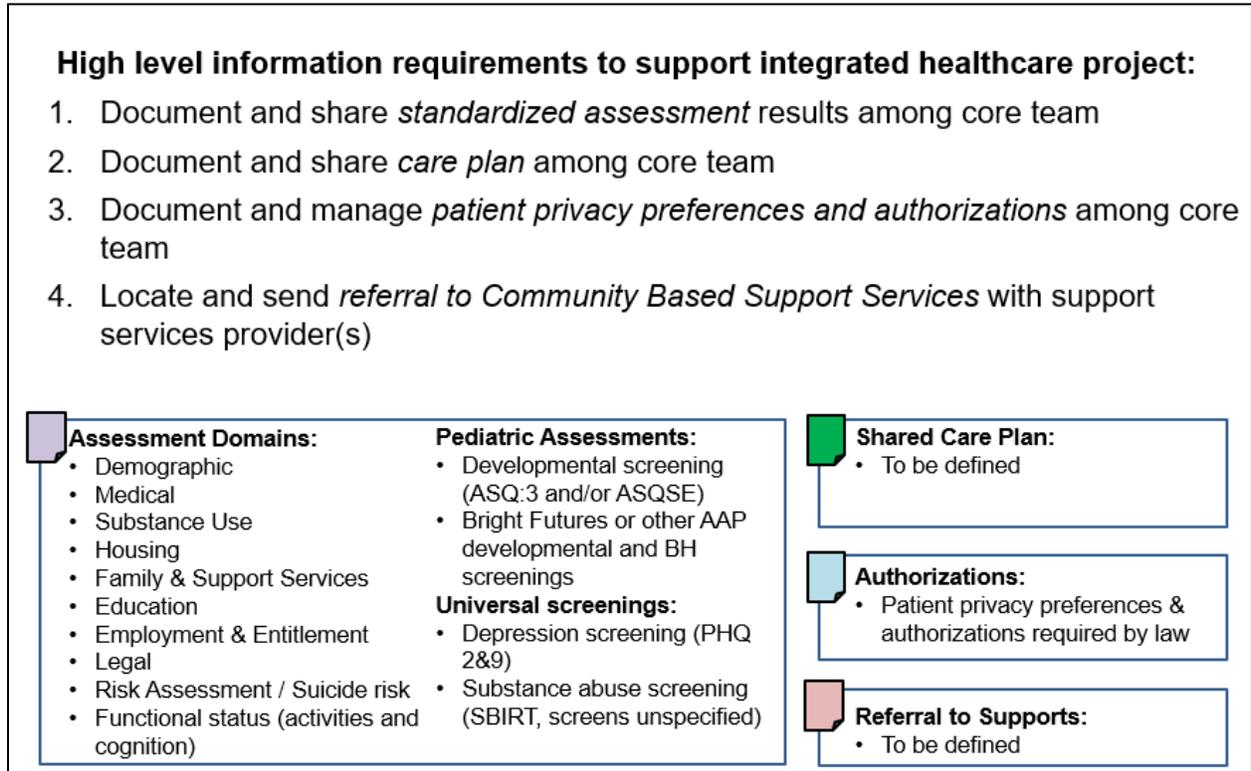


Figure 9: Project C1 Care Transitions Overview

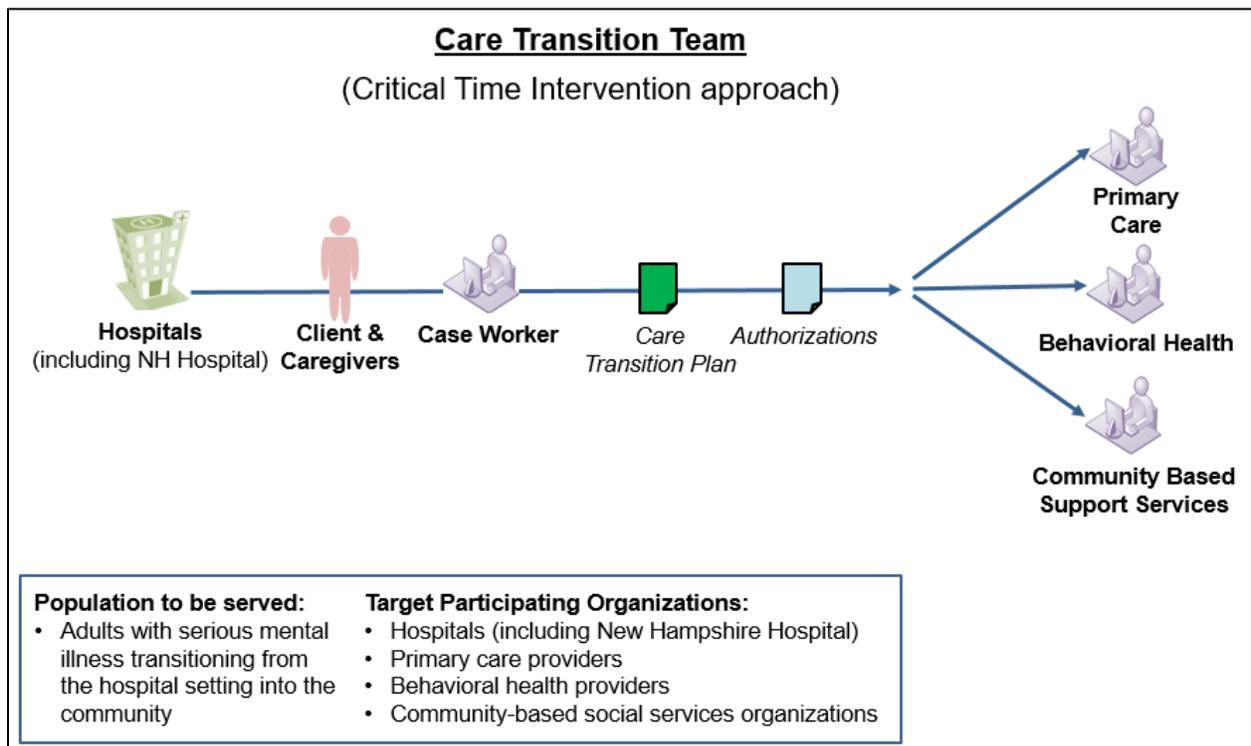


Figure 10: Project C1 Integration Requirements

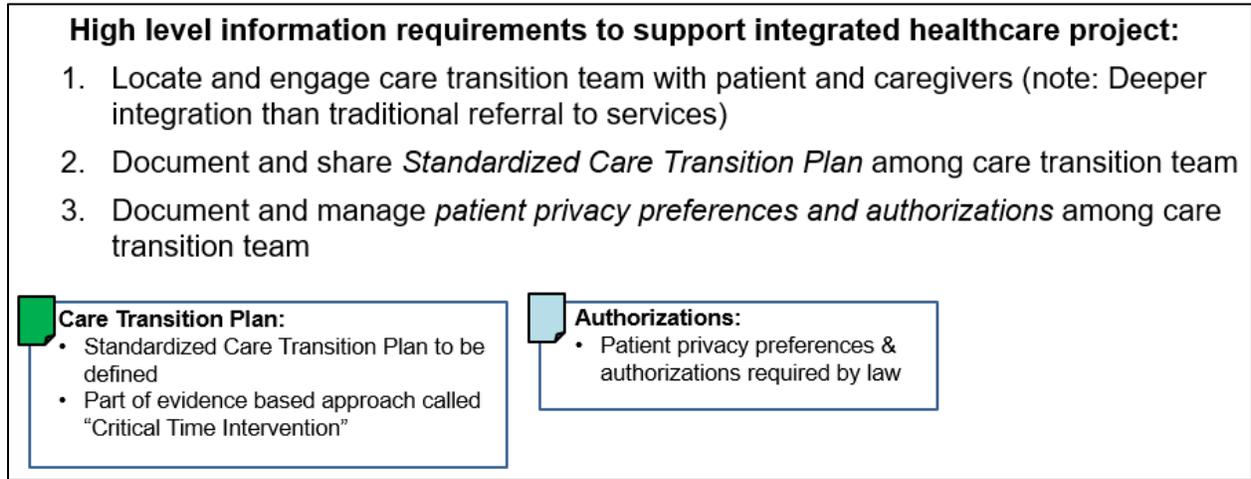


Figure 11: Project D3 Expansion of SUD Treatment Overview

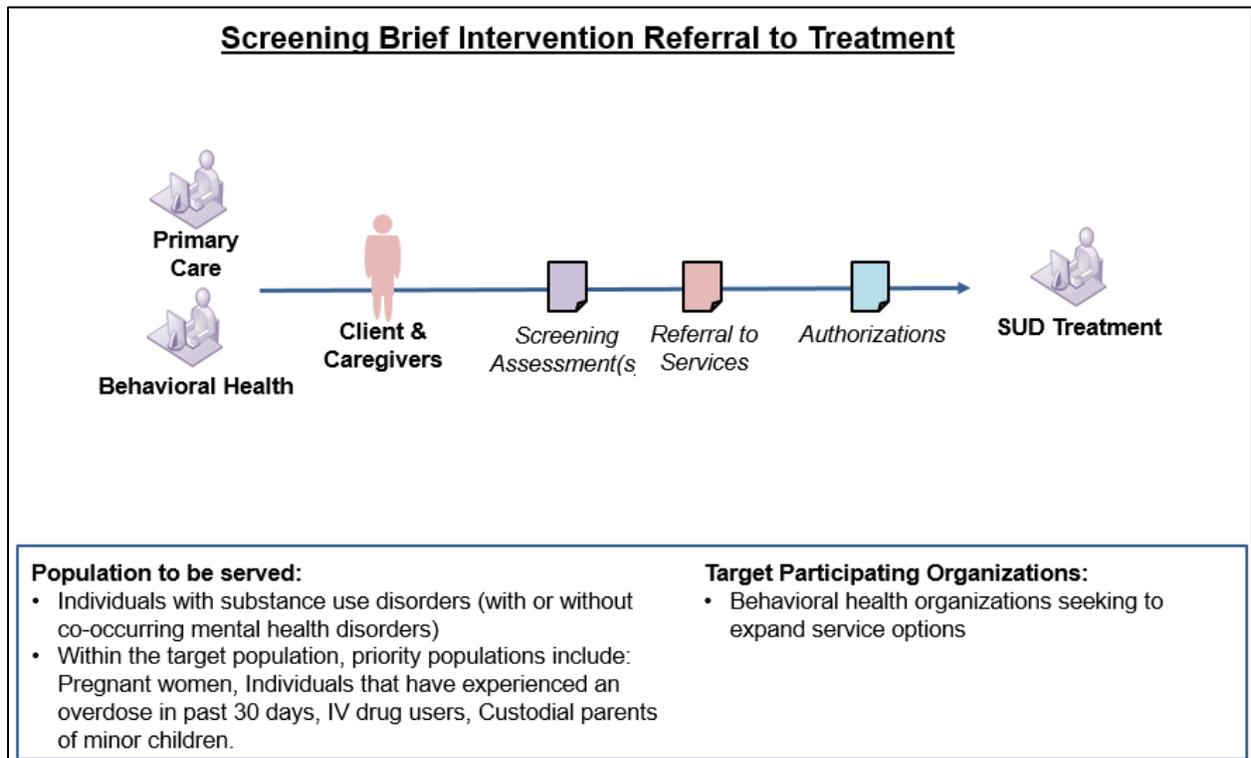


Figure 12: Project D3 Information Requirements

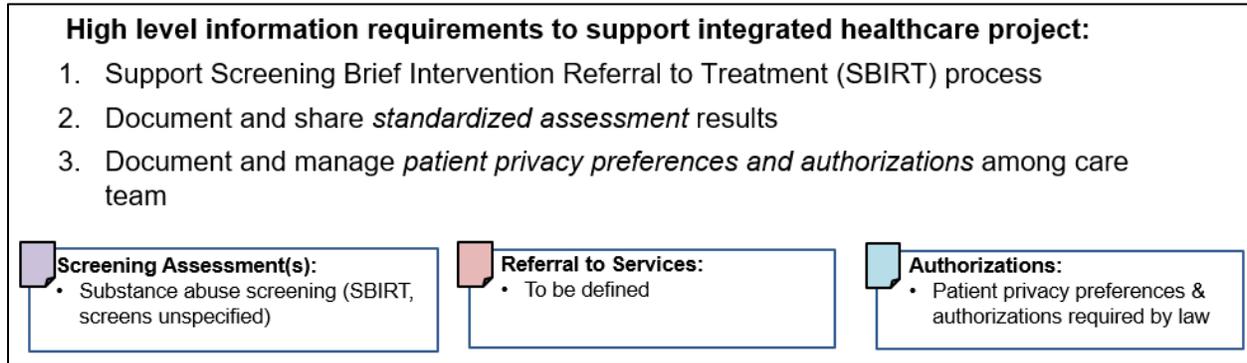
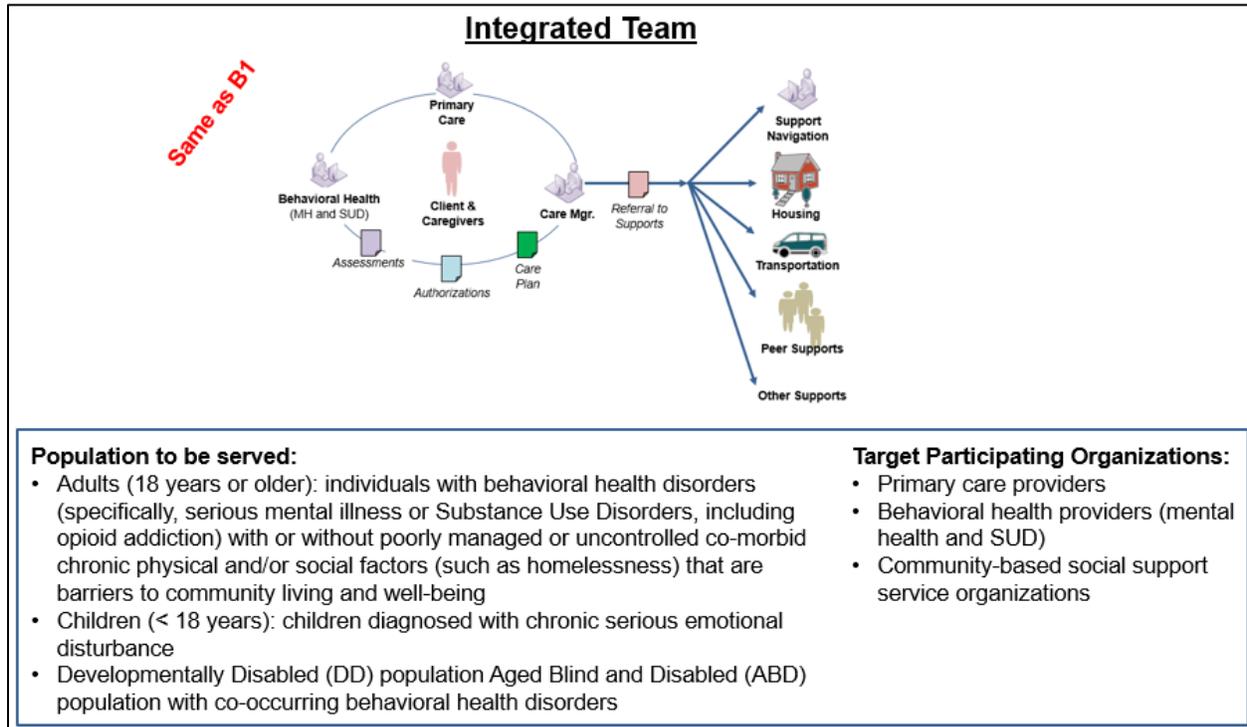


Figure 13: Project E5 Enhanced Care Coordination



IDN-1 Data & IT Workgroup Gap Analysis

Based on a detailed comprehension of the program requirements, the IDN-1 Data & IT Workgroup assessed current gaps. This was conducted through surveys and phone interviews with partner organizations. The result is an assessment of IDN-1 Partners individual Capabilities as well as an assessment of “open information pathways” between organizations:

Figure 14: IDN-1 Capabilities Analysis

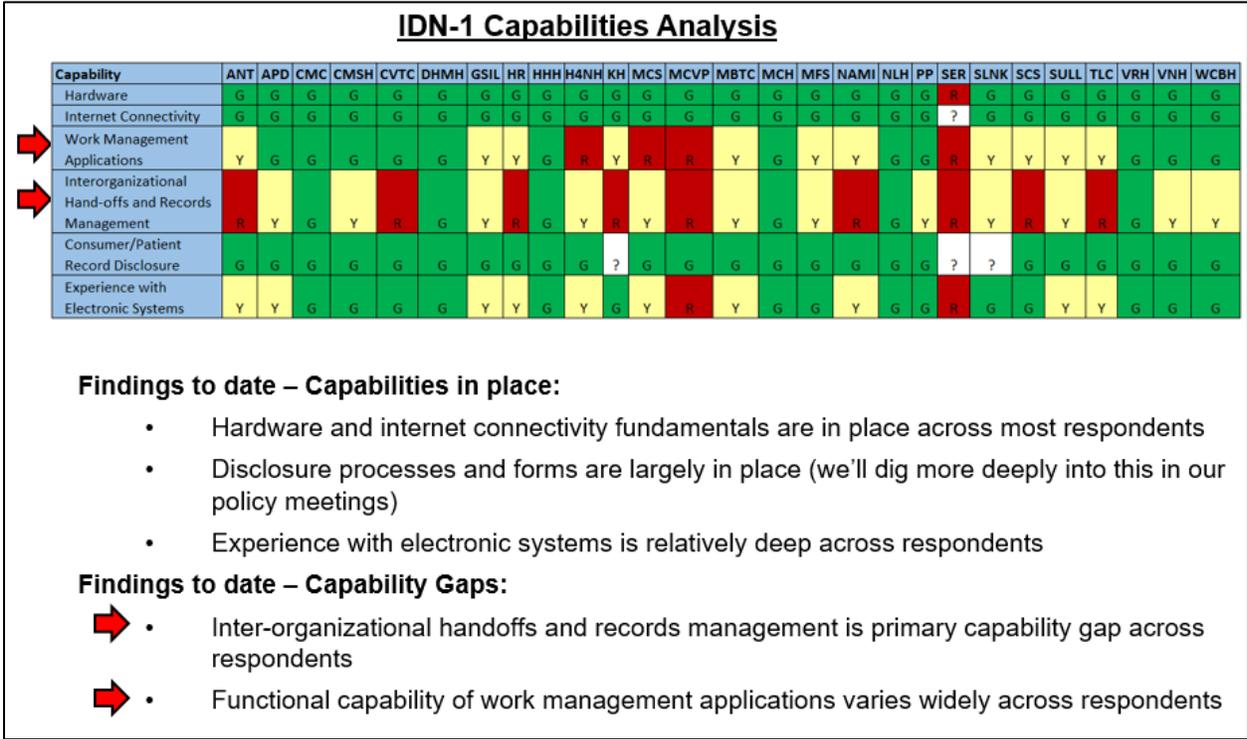


Figure 15: IDN-1 Open Pathways Analysis

## Recommendations from the IDN-1 Data & IT Workgroup

The Data & IT Workgroup concluded that the following solutions are required to support the IDN-1 projects:

**Figure 16: Recommended IT Solutions**

| Solutions (non-exclusive)                                 | Description  |
|---|--|
| <p>1<br/>Shore up EHRs and work applications</p>          | Set and meet capability thresholds for EHRs and work applications.   |
| <p>2<br/>Interconnect orgs. through multiple pathways</p> | Promote connection and active use of Direct Messaging, DH-Connect, and EHR vendor inter-vendor connectivity solutions. |
| <p>3<br/>Role out Shared Care Plan (with alerts)</p>      | Implement <i>Pre-Manage Community</i> solution which includes a shared care plan and event notification service.       |
| <p>4<br/>Actively use existing service locators</p>       | Promote active use of the data assets currently in place for location of services organizations.                       |
| <p>5<br/>Implement capacity management tools</p>          | Implement simple system(s) to support IDN-wide capacity transparency and management.                                   |

### Shore up Work Applications - Recommendations:

- Set capability thresholds (minimum, desired, optional) for IDN-1 organizations.
- Divide into two types of services organizations:
  - Primary Care, Behavioral Health, and Care Management Organizations that are central to IDN-1 projects (Project B1 and E5 “Integrated Core Teams,” Project C1 Hospitals and “Care Transition Case Workers,” Project D3 Behavioral Health organizations expanding intensive SUD treatment)
  - Organizations that provide Community Based Support Services for IDN-1 projects
- Provide technical support services to assess and address capability gaps.
- Provide capital to offset investments in HIT infrastructure
- (Note: 27 different work applications in use across IDN-1)

### Interconnect organizations through multiple pathways – Recommendations

- Promote connection and active use of interoperability solutions. Choose from the most viable available solutions based upon use case requirements, EHR vendor constraints, and trading partners. Remain flexible and evolve with the capabilities of the vendors.
- Inter-organizational solutions:
  - Direct Messaging services supported through a range of solutions vendors:
    - New Hampshire Health Information Organization (NHHIO)
    - Native EHR connection
    - DSM Connect Device - interface engine connection
    - Secure, Encrypted Webmail
    - EHR based Health Information Services Providers (HISPs)

[REDACTED]

[REDACTED]

[REDACTED]

- Secure texting service(s)

### Roll out Shared Care Plan and Event Notification System (ENS) – Recommendations

- Implement shared care plan and event notification services.
- Solution may be used for inter-organizational shared documentation/communication
  - Project B1: Shared Care Plan
  - Project C1: Care Transition Plan
- Solution provides event notifications including patient disposition and chief complaint.
- Solution provides statewide enterprise master patient index and patient matching.
- Solution is designed to solve common Emergency Department issues:
  - Provide critical information at ED to help ED staff redirect patients to a more appropriate care setting
  - Provide critical information to aid ED staff in appropriate treatment for individuals with history of substance abuse
- The service has been vetted at the state level through NHHIO.

### Actively use existing service locators – Recommendation

- Promote active use of the data assets currently in place for location of services organizations.
  - NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)
  - Refer Web - Servicelink Community Resource Directory (<http://www.referweb.net/nhsl/>)
  - NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)
  - NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)
  - 2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance
  - Monadnock Regional Council for Community Transportation (<http://monadnockrcc.weebly.com/need-a-ride.html>) (other regions <https://www.nh.gov/dot/programs/scc/rcc.htm>)
  - Coordinated access points

### Implement capacity management tools – Recommendations

- Implement simple system(s) to support IDN-wide capacity transparency and management. Specifically implement tools to track
  - Current capacity (e.g., Available beds for intensive SUD treatment)
  - Wait times
  - Patients waiting in ED for placement

### Introduction to the [REDACTED]

[REDACTED] was engaged to develop a Health IT Assessment tool to assess the current health IT environment of all IDNs. The HIT Assessment tool is an essential component in the design of the HIT infrastructure needed to support the health care integration project of New Hampshire’s DSRIP initiative. The assessment measured both the business and technical aspects of the HIT capabilities and gaps of providers, hospitals, and other consumer-focused entities. The results facilitated discussions on defining required, optional, and desired statewide HIT implementation priorities by the HIT Task Force and will inform the HIT Implementation Plan below.

[REDACTED] developed the HIT Assessment tool specifically designed to align with New Hampshire’s DSRIP objectives and informed by its HIT experience from similar engagements, research on other states and additional resources, including the Office of the National Coordinator for Health Information Technology’s (ONC) Interoperability Standards Advisory (ISA)<sup>4</sup> (and the Substance Abuse and Mental Health Services Administration’s (SAMHSA) behavioral and mental health screening tools.<sup>5</sup>

The HIT Assessment tool was divided into seven distinct sections that focused on different subject areas. Each section provided a unique set of questions that addressed the requirements of the DSRIP program requirements. The sections included:

1. **Base** – 12 questions: for the organization to provide basic contact information.
2. **Assessment** – 20 multiple choice questions: to assess HIT maturity and provide a corresponding score.
3. **Software** – 20 free response questions: to list EHR systems, consumer support systems, and other state systems.
4. **Patient Record** – 19 dropdown questions: to identify patient information captured and shared by organizations.
5. **Security** – 20 dropdown questions: to assess compliance with Health Insurance Portability and Accountability Act (HIPAA) standards.
6. **Behavioral** – 29 dropdown questions: to identify behavioral health assessments by provider organizations.
7. **HIT** – Four dropdown and three free response questions: to assess barriers, standards, and planned initiatives.

A final comprehensive statewide assessment report was completed in December 2016 based on the HIT Assessments submitted by member organizations. Individual HIT Data Supplements based on the HIT Assessments were provided to each IDN with the final version being received by our region in March 2017.

### Statewide Key Findings

Key areas of HIT maturity were analyzed for every IDN region and included Electronic Health Record (EHR) adoption, Health Information Exchange (HIE) adoption, patient access to their health information, and the ability to track patient consents electronically. While HIT adoption was high for many traditional providers such as hospitals, many community-based organizations had limited HIT infrastructure.

Key findings from the New Hampshire health IT assessment include:

1. **Electronic health data capture capabilities are not widespread among IDN members.** While New Hampshire benefits from a high number of providers having adopted electronic health records (EHRs) at 74% of IDN members, there are a several key provider types that have less than 60% adoption rate including SUD treatment organizations at 57%, community-based organizations at 48%, and public health organizations at only 33%.
2. **Limited capabilities for electronic health data sharing throughout the state, but IDN members use available option.** Despite the limitations in electronic health data sharing among New Hampshire’s providers, due in part to legislative restrictions, 48% of IDN member organizations are using or have plans to use Direct Secure Messaging (DSM) through New Hampshire Health Information Organization (NHHIO).
3. **Low rate of patient consents are captured electronically.** The ability to electronically capture patient consents still appears to be in its infancy among IDN members with only 21% of all responding organizations doing so. High adopters of health IT such as hospitals, community mental health centers,

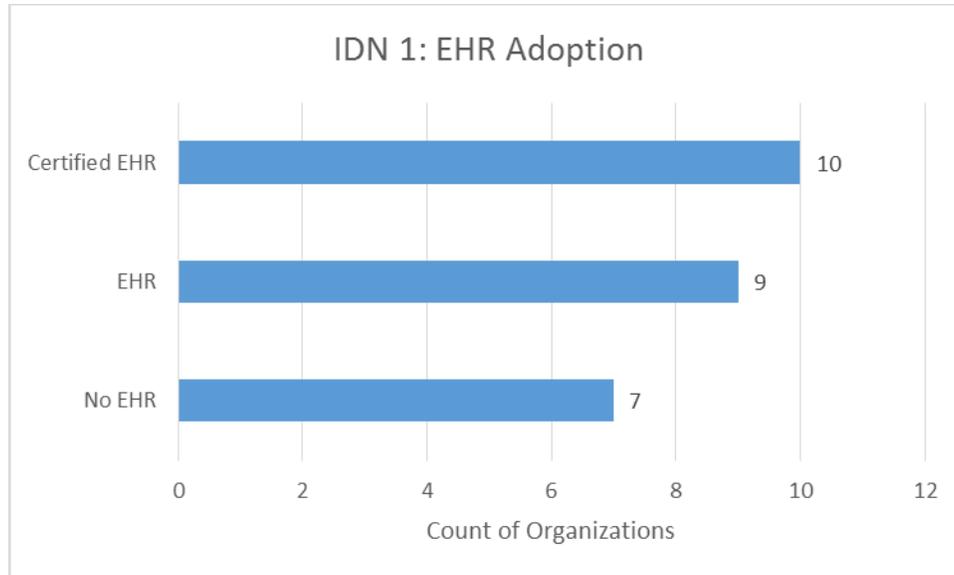
and federally qualified health centers (FQHCs) are all below 50% for collecting and storing patient consents by electronic means.

4. **Patient referrals are mostly manual processes.** Sixty-one percent of IDN members responding to the assessment stated that patient referrals are performed manually by either fax, U.S. mail, or telephone. Only a small percentage of organizations, just 15%, are using DSM for referrals.
5. **Patients have limited options to access their health information electronically.** Currently, only 28% of all IDN members responding to the Assessment Tool have a patient portal.
6. **A higher than expected number of IDN members capture at least one social determinant of health data element.** While collection of social determinants of health data is fragmented and inconsistent across the health care continuum<sup>6</sup>, 62% of all IDN member respondents electronically capture at least one area of social determinants of health such as economic stability, education, food, community, and social context.
7. **Funding is available to advance health IT in New Hampshire.** Several of the health IT-related needs identified by IDN members during the assessment and information gathering process may be funded through the [REDACTED] or other grant opportunities identified in this report.

IDN-1 Specific Findings

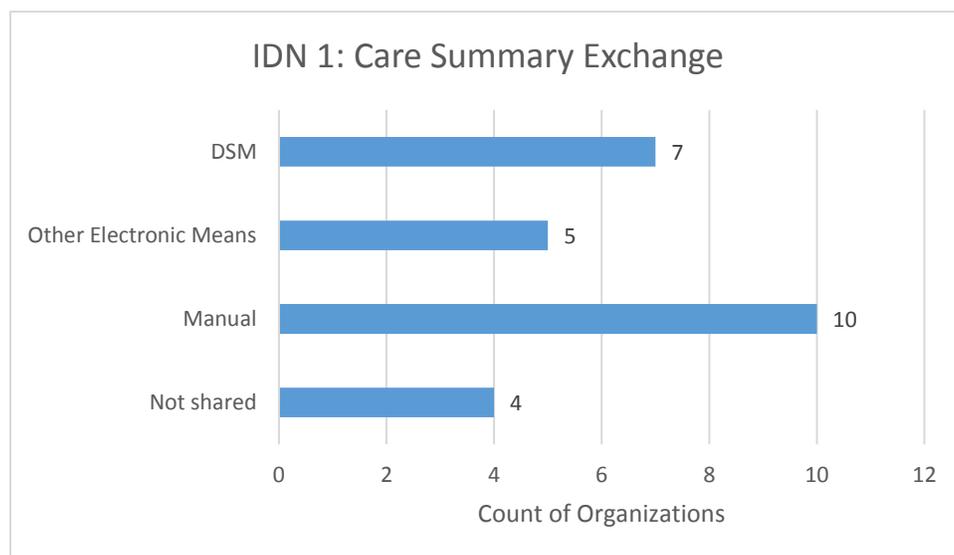
██████████ surveyed IDN-1 partners and relayed the following findings:

**Figure 1. EHR Adoption**



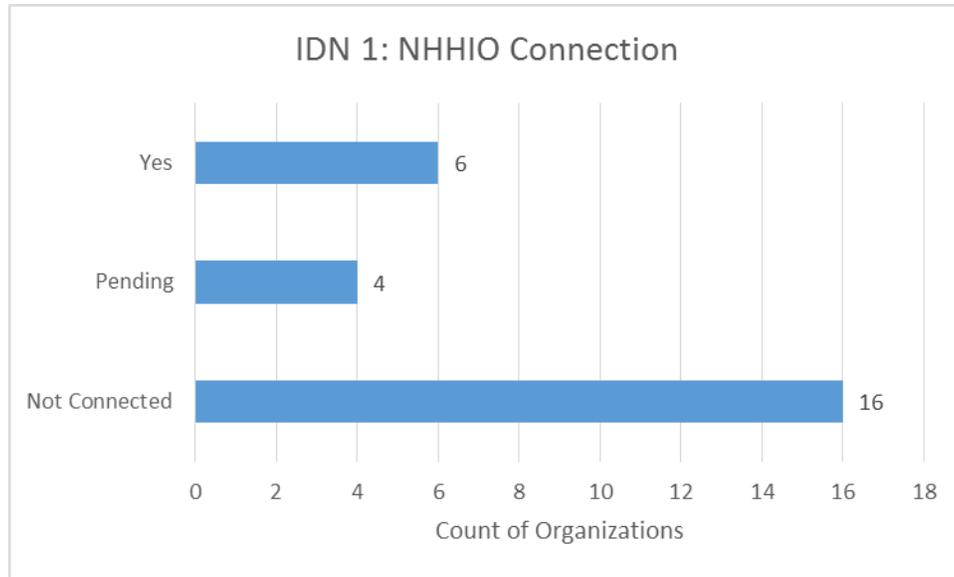
Based on the final version of the HIT Data Supplement for our region there was a total of twenty-six (n=26) organizations that completed the HIT Assessment tool. From the results, ten (n=10) organizations attested to having a certified EHR system and nine (n=9) organizations attested to having a non-certified EHR system. To be noted, seven (n=7) organizations stated that they had no EHR system at all. Organizations with no EHR systems are important to identify in order to determine what further assistance they need to meet the State’s DSRIP initiative objectives and our region’s goals.

**Figure 2. Direct Secure Messaging**



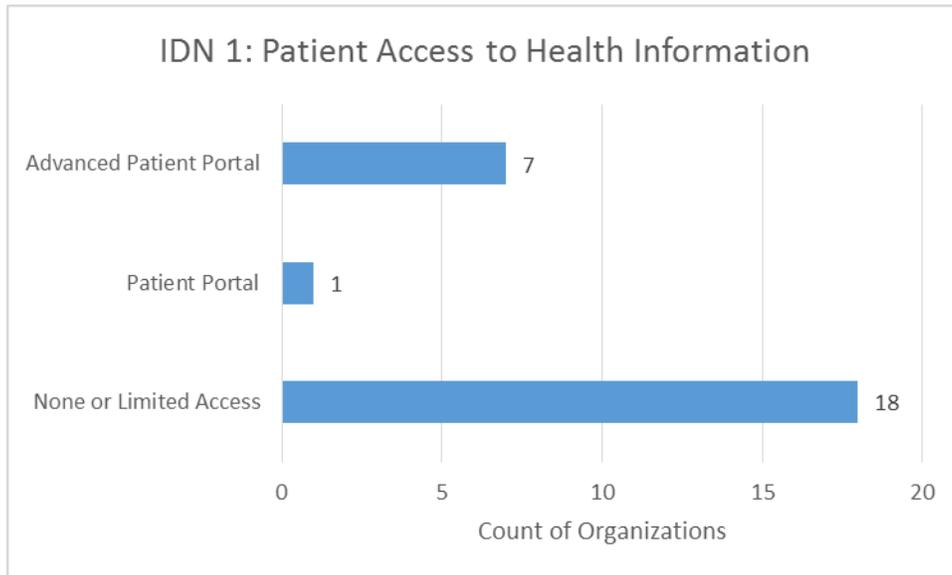
Limitations in electronic health data sharing among New Hampshire’s providers exists, due in part to legislative restrictions. Because of these limitations, Direct Secure Messaging (DSM) is used through the New Hampshire Health Information Organization (NHHIO). NHHIO serves as a Health Information Service Provider (HISP) with a statewide Healthcare Provider Directory (HPD) to support Transfers of Care. NHHIO provides a secure network option for small providers with fewer resources across the care continuum, such as community-based organizations.

**Figure 3. Electronic Health Data Sharing**



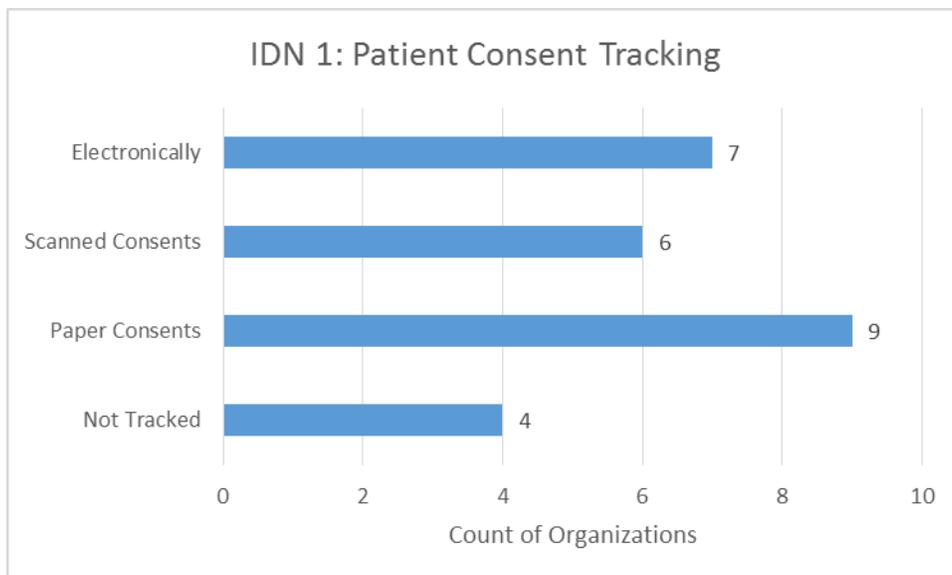
All organizations that completed the HIT Assessment tool were cross referenced with the NHHIO’s official list of organizations that are connected. In summary, for our region, six (n=6) organizations are connected to NHHIO with an additional four (n=4) organizations that are in the process of connecting. Sixteen (n=16) organizations are not connected or are not planning on connecting to NHHIO. While progressing through the DSRIP initiative, it will be important to ensure organizations that are not connected to NHHIO to adopt a basic sharing protocol like direct secure messaging.

**Figure 4. Patient Access to Health Information**



From the HIT Assessment results, a question was asked about patient access to health information. In general, most organizations do not provide easy access to their patient’s information. For our region, only seven (n=7) organizations provide an advanced patient portal with at least three of the following features: lab results, appointment scheduling, billing, links to health information websites, prescription refills, referrals, or secure messaging. This compares to eighteen (n=18) organizations that do not provide a patient portal at all and provide limited access to their patient’s information. It will be important to create infrastructure to allow the sensitive substance abuse patients access to their health information.

**Figure 5. Patient Consent Tracking**



Another critical area for the waiver program is how patient consents are tracked and processed. With patients being shared across multiple regions, it is imperative to define a standardized process. In our

region, seven (n=7) organizations capture patient consent information entirely electronically in an EHR system. Six (n=6) organizations scan paper consents into an electronic system while another nine (n=9) organizations only capture consents on paper. Four (n=4) organizations do not track patient consents at all. The HIT Taskforce determined that defining a statewide consent form and process should be a priority but it will require additional work outside the scope of HIT. If a statewide standard is defined it will be up to the HIT leads within each region to implement the infrastructure to make sharing easier.

### Defining Minimum, Desired, and Optional HIT Standards

IDN Region 1 collaborated with members of the Statewide HIT Taskforce Project to define and adopt minimum, desired, and optional health IT standards required for the demonstration project. For the purposes of enabling robust technology solutions to support care planning and management and information sharing among providers and community based social support service agencies as outlined in the STCs<sup>7</sup>, the identified statewide and local health IT standards are defined as either “Minimum,” “Desired,” or “Optional.”

**Minimum** – standards that apply to all IDN participants except where provider type is defined in the Minimum Standards Table

- Includes minimally-required technologies to ensure all participants are at a basic level in order to meet the overall HIT goals of the program.
- Minimally-required technologies required for meeting the requirements of the statewide initiative, project B1: Integrated Health Care.
- Each IDN will keep the HIT Task Force members informed on the progress for each minimum standard, along with required reporting to the state.

**Desired** – standards that apply to only some IDN participants.

- Includes more advanced technologies that may only apply to certain types of organizations
- Identifies standards that are strongly encouraged but not required to be adopted by every IDN in order to meet the overall HIT goals of the program.
- Applies, in some cases, to a statewide initiative or a regional initiative but will not arrest the advancement of the initiative, project B1: Integrated Health Care.
- Each IDN will keep the HIT Task Force members informed on the progress for each desired standard, along with required reporting to the state.

**Optional** – standards that apply to only some IDN participants

- Not required but could better enable IDN members' ability to support the demonstration project goals.
- Each IDN will keep the HIT Task Force members informed on the progress for each optional standard, along with required reporting to the state.

### Statewide HIT Standards Tables

The following tables outline the minimum, desired, and optional standards for the statewide and local health IT standards required for the demonstration projects, as agreed upon and adopted by the HIT Task

Force. As described above in the Process for Reaching Consensus section, each table had extensive input from each IDN. Consensus was achieved on April 5, 2017 via an official, in-person vote with a response collected from each IDN.

**Table 1. Minimum HIT Standards**

| New Hampshire Building Capacity for Transformation Waiver  |  |   |   |               |   |
|--|--|---|---|---------------|---|
| Health IT Minimum Standards  |  |   |   |               |   |
| Minimum Definition: Standards that apply to all IDN participants except where provider type is defined |  |   |   |               |   |
| Capability & Standard  | Description  | Provider Type   | Role of IDN   | DSRIP Project | Rationale for Standard Classification   |
| Data Extraction / Validation   | Using a single vendor is an option for all IDNs; reporting metrics is mandatory - the distinction will be made in the implementation plans | All   | Procurement and payment of a single collector for all IDNs. Assist organizations with transmitting data                   | All           | All IDNs are required to report metrics   |
| Internet Connectivity  | Securely connected to the internet   | All   | Determine if they have it, do they need it  | All           |   |
| Secured Data Storage   | Ability and knowledge to secure PHI through technology and training  | All   | Educate or assist organization with standards. Determine PHI at organization level  | All           | HIPAA regulations   |
| Electronic Data Capture  | Ability to capture and convert documents to an electronic format as a minimum.   | All   | Education of electronic data capture solutions including EHRs, certified EHRs, and other solutions. Assist in procurement | All           | Capturing discreet data is essential for sharing and analyzing data for population health, care coordination, etc.  |
| Direct Secure Messaging (DSM)  | Ability to use the protocol DSM to transmit patient information between providers.   | All   | Education of DSM to organizations including use cases, assist in procurement  | All           | DSM establishes standards and documentation to support pushing data from where it is to where it's needed, supporting more robust interoperability in the future.   |
| Shared Care Plan   | Ability to access and/or contribute to an electronic shared care plan for an individual patient  | Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment | Education of shared care plan to organizations including use cases, assist in procurement and payment                     | All           | A shared care plan is a patient-centered health record designed to facilitate communication and sharing data among members of the care team, including the patient. A shared plan of care combines physical and behavioral health aspects to encourage a team approach to care. |

| New Hampshire Building Capacity for Transformation Waiver  |   |   |  |                     |  |
|--|---|---|--|---------------------|--|
| Health IT Minimum Standards  |   |   |  |                     |  |
| Minimum Definition: Standards that apply to all IDN participants except where provider type is defined |   |   |  |                     |  |
| Capability & Standard  | Description   | Provider Type   | Role of IDN  | DSRIP Project       | Rationale for Standard Classification  |
| Event Notification Service   | Ability to receive notifications as a minimum for all organizations.  | Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment | Education of ENS to organizations including use cases, assist in procurement and payment | All, except B1 2017 | An automated service that provides timely alert messages when patients are discharged from a hospital or emergency department. Delivers alerts about a patient's medical services encounter to an authorized recipient with an existing relationship to the patient. |
| Transmit Event Notification Service  | Hospitals that have the ability to produce Admission, Discharge or Transfers (ADT) must transmit as a minimum | Hospital Facility   | Ensure that organizations that produce ADTs are transmitting                             | All, except B1 2017 | Leverage hospital generated ADT data elements for alerts to downstream clinical, behavioral and community providers  |

Table 2. Desired HIT Standards

| New Hampshire Building Capacity for Transformation Waiver |   |  |                     |
|---|---|--|---------------------|
| Health IT Desired Standards                               |   |  |                     |
| Desired Definition: Applies to only some IDN participants |   |  |                     |
| Capability & Standard                                     | Description   | Role of IDN  | DSRIP Project       |
| Discrete Electronic Data Capture                          | Ability to capture discrete data and/or usage of a Certified Electronic Health Record Technology (CEHRT) as desired       | Education of EHRs including certified EHRs, assist in procurement  | All                 |
| Integrated Direct Secure Messaging                        | Ability to use the protocol DSM to transmit patient information between providers. Integration in EHR system as a desired | Education of DSM to organizations including use cases, assist in procurement   | All                 |
| Query Based Exchange                                      | Ability to use Inter-Vendor capabilities to share data, query, and retrieve.  | Education of query-based exchange capabilities such as Carequality and Commonwell to organizations including use cases | B1 2018, D1, E4, E5 |

Table 3. Optional HIT Standards

| New Hampshire Building Capacity for Transformation Waiver  |  |   |                          |
|--|--|---|--------------------------|
| Health IT Optional Standards                               |  |   |                          |
| Optional Definition: Applies to only some IDN participants |  |   |                          |
| Capability & Standard                                      | Description  | Role of IDN                             | DSRIP Project(s)         |
| Closed Loop eReferrals                                     | Ability to send referrals electronically in a closed loop system                           | To be determined if standard is adopted | All                      |
| Secure Text  | Ability to use secure texting for patient to agency, agency to agency, or other use cases  | To be determined if standard is adopted | All, except D1           |
| Data Analysis / Validation                                 | Ability to analyze data to generate non-required organizational or IDN level reporting     | To be determined if standard is adopted | All                      |
| Population Health Tool                                     | Ability to identify high utilizers within populations at organizational or IDN level       | To be determined if standard is adopted | All                      |
| Capacity Management Tools                                  | Ability to see utilization and availability.   | To be determined if standard is adopted | All, except C2, D3       |
| Patient Engagement Technology                              | Ability to better engage patients which includes telemedicine, secure texting, and others. | To be determined if standard is adopted | B1 2017, B1 2018, D1, E5 |

### Implementing Standards in IDN-1

IDN-1 will provide technical assistance to its Partners and will support Partners with technology deployment for all technologies identified as “minimum” HIT standards. This will include:

- **Electronic Data Capture & Secured Data Storage:** A means to capture documents and data in computer applications such as electronic health records (EHRs) and to securely store personal health information (PHI).
- **Internet Connectivity & Direct Secure Messaging (DSM):** A means to securely transmit electronic documents and data among partner organizations.
- **Shared Care Plan:** A means to document a shared plan of care for a Medicaid member and to make such a plan available to other organizations involved in the member’s care.
- **Event Notification Service:** A means to alert a Medicaid Member’s care team at the time of an acute event such as a hospital admission, a transfer to another hospital (e.g., Escalation to NH Hospital), and discharge from a hospital.

- **Data Extraction / Validation:** A means to calculate and report clinical quality measures through aggregation of patient data from partners and by reporting to DHHS and to IDN partners to support clinical quality improvement efforts.

IDN-1 will provide technical assistance to some of its Partners for the technologies identified as “desired” HIT standards. Deployment of desired technologies is highly dependent upon the maturation of HIT vendor capabilities and standards for EHR interoperability. IDN-1 will support deployment of desired standards on a case by case basis when the vendors that provide the services have demonstrated sufficient market acceptance of their technologies and interoperability standards and these will be monitored for market readiness each year. This will include:

- **Discrete Electronic Data Capture:** A means to capture discrete data in computer applications such as EHRs. (note that this capability is currently mature in vendor systems that support acute and primary care providers, immature but maturing in vendor systems that support behavioral health and long term post-acute care providers, and immature in vendor systems supporting community support services.)
- **Integrated Direct Secure Messaging:** A means to securely send clinical information directly from EHRs where DSM is integrated with the workflow of the EHR (as opposed to using a separate DSM application and attaching information from an EHR to a secure message). (Note that this capability is currently immature in the market and varies significantly among vendors. Currently only a handful of vendors can reliably send and receive usable patient data. We will proceed with the partners that have capable vendors but will rely upon workaround portal solution for remaining partners.)
- **Query Based Exchange:** A means to securely locate, request, and receive clinical information from other organizations. (Note that this capability is currently immature but is rapidly maturing in the market. [REDACTED]. Inter-vendor query based exchange via [REDACTED] is expected to become available in some vendor systems beginning in 2018.)

IDN-1 will provide technical assistance to some of its Partners for the technologies identified as “optional” HIT standards. Deployment of optional technologies is highly dependent upon the maturation of HIT vendor capabilities and standards for EHR interoperability. IDN-1 will support deployment of optional standards on a case by case basis when the vendors that provide the services have demonstrated sufficient market acceptance of their technologies and interoperability standards and these will be monitored for market readiness each year. This will include:

- **Closed Loop eReferrals:** A means to engage another provider in a Member’s care with assurance of engagement. IDN-1 intends to pursue referrals using Direct Messaging and will remain flexible to other referral standards that emerge in the market.
- **Secure Text:** A means to informally communicate in real time among a care team. IDN-1 does not intend to purchase secure text systems for its Partners but will support/ incorporate its use should some Partners choose to use it.

- **Data Analysis / Population Health:** A means to understand the nuances of a particular population and to act on that information. IDN-1 intends to extend the use of the Data Aggregator in the out years to perform data analysis and population health functions. We also intend to use Pre-manage ED for data analysis of ED utilization.
- **Capacity Management Tools:** A means to assess capacity availability and/or wait times in real time to guide placement/transfer decisions. IDN-1 intends to look for simple capacity management tools in other industries that may be re-deployed to solve health delivery system problems.
- **Patient Engagement Technology:** A means to securely share information with Members as part of engaging them in their health management. IDN-1 will utilize existing patient portals for patient engagement. IDN-1 Partners have healthy adoption of patient portals and this provides the best available patient communication channel at this time.

### Summary of Results of IDN’s Analysis Relative to Waiver Objectives

IDN-1 will meet the core objectives of the NH 1115 Waiver and the requirements of the projects by deploying a set of technical services and vendor solutions to IDN-1 partners. The following table summarizes the technology solutions relative to the objectives:

Figure 17: NH 1115 Waiver Overall Objectives Cross-Walk to IT Solutions

| Objective   | Service/Solution  |
|---|---|
| Reduce unnecessary use of inpatient and ED services, hospital readmissions and wait times   | -Technical Support<br>-Shared Care Plan and Event Notification with ED team access [REDACTED]<br>-Data Aggregator and Clinical Quality Measurement Solution [REDACTED]  |
| Promote the integration of primary care, behavioral providers (mental health and SUD providers) and community based organizations | -Technical Support<br>-Shared Care Plan and Event Notification with Community team access [REDACTED]<br>-Closed Loop Referrals via Direct Secure Messaging<br>-Data Aggregator and Clinical Quality Measurement Solution [REDACTED] |
| Support care transitions  | -Closed Loop Referrals via Direct Secure Messaging<br>-Shared Care Plan and Event Notification  |
| Support alternative payment models  | -Data Aggregator and Clinical Quality Measurement Solution<br>-Financial Analytics solutions TBD in consultation with NH Medicaid and MCOs as Payment Reform plan is specified  |

## A2-3. IDN HIT/HIE Implementation Plan and Timeline

IDN-1 will provide technical assistance and will support technology purchase and deployment for all technologies identified as minimum HIT standards. The technical assistance will support Partners on their use of ONC Certified Technologies and functions and on their implementation of appropriate minimum standards. When the minimum HIT standards are deployed widely across the IDN and when the desired and/or optional standards are deemed sufficiently mature/market ready by the IDN-1 Data & IT Work Group, IDN-1 will offer technical assistance to help Partner organizations deploy selected desired and optional standards in continued support of the projects.

The IT deployment will be tightly coupled with each of the IDN-1 integration projects ensuring that the clinical and business needs of the organizations will drive the IT requirements and vendor product configurations [and not the other way around].

The Implementation Project Plan includes the following Work Streams:

- Work Stream 1: Support Partners in Waves
- Work Stream 2: Engage Technology Vendors
- Work Stream 3: Define Conventions for CCSA, Shared Care Plan, and Referrals
- Work Stream 4: Ensure Patient Privacy
- Work Stream 5: Roll Out Shared Technology with Partners
- Work Stream 6: Prepare for Shift to Value Based Payment
- Work Stream 7: Oversee Data & IT with Governance

### Work Stream 1: Support Partners in Waves

IDN-1 will directly support health information exchange (HIE) integration of IDN-1 Partner Organizations including hospitals, community mental health centers (CMHC), community mental health providers, primary care providers, substance use disorder (SUD) treatment providers, Designated Receiving Facility (DRF) participants, county agencies (nursing home, correction, justice/courts), and community support providers addressing social determinants of health. IDN-1 will also work to integrate with NH Hospital.

IDN-1 has put in place a wave-based proposal process to periodically identify, select, and fund Partner projects that are ready for deployment. This process is overseen by the multi-stakeholder Executive Committee and an Independent Review Panel to ensure fair allocation of resources across IDN-1 Partner organizations. Operationally, the proposal process results in up to three waves of project deployment that IDN-1 will support with technology deployment

The proposal process to select Wave 1 Partners concluded in June 2017 with the following projects identified for HIT deployment support:

- **Project B1: Integrated Healthcare:** [REDACTED]
- **Project C1: Care Transitions:** [REDACTED]
- **Project D3: Expansion of Intensive SUD Treatment Options** [REDACTED]
- **Project E5: Enhanced Care Coordination:** [REDACTED]

Each project selection wave encompasses two groups of organizations to support:

1. “Core Partners” are those organizations that require tight integration of people and process to form the “core” of each project centered on the Medicaid Members.
2. “Supporting Partners” are community supports organization that wrap around the core partners and support the social determinants of health of the Medicaid Members.

This grouping is required for deployment sequencing. “Core Partners” will go first in each wave to establish the people, process, technology integration, and patient privacy protections among a contained group of organizations. “Supporting Partners” will then be linked to the “Core Partners” one at a time based on once three pre-requisites are met:

- Supporting Partner services are identified as being of high value to the Medicaid Members to meet their goals for wellness. (This will be based on gathering patient goals of Medicaid Members as part of each project.)

- Patient Privacy processes and forms are in place to accommodate sensitive information disclosure with community support organizations.
- Technology vendors are configured to support community support organizations. (Note that the shared care plan vendor [REDACTED] will not integrate community support organizations until at least Spring 2018)

Wave 1 will include the following Core Partners. Each project has identified a list of potential supporting partners to pursue

Figure 18: Wave 1 Partners

| Project | Core Partners | Potential Supporting Partners                   |
|---------|---------------|---|
| B1      | [REDACTED]    | 16 potential Supporting Participants Identified |
| C1      | [REDACTED]    | 5 potential Supporting Participants Identified  |
| D3      | [REDACTED]    | 12 potential Supporting Participants Identified |
| E5      | [REDACTED]    | 8 potential Supporting Participants Identified  |

An additional proposal process is underway to solicit greater participation in Wave 1 for project B1. Wave 2 and Wave 3 proposal processes are scheduled with details in the project plan.

The following is the detailed project plan with activities and milestones:

Figure 19: Project Plan Detail - Work Stream 1

| Deliverable/Milestone  | Jan-Jun '17 | Jul '17 | Aug | Sep | Oct | Nov | Dec | Jan '18 | Feb | Mar | Apr | May | Jun | Jul '18 | Aug | Sep | Oct | Nov | Dec | Status      |
|--|-------------|---------|-----|-----|-----|-----|-----|---------|-----|-----|-----|-----|-----|---------|-----|-----|-----|-----|-----|-------------|
| <b>Work Stream 1: Support Partners in Waves</b>  |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| <b>Identify Partners to Support with HIT - Wave 1</b>                                      |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| Conduct RFA Process to consider, vet, and select wave 1 projects                           |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     | Completed   |
| Identify Wave 1 Core Partners and Potential Supporting Partners                            |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     | Completed   |
| <b>Milestone: List of Core Partners and Potential Supporting Partners - Wave 1</b>         |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     | Completed   |
| Conduct second RFA Process to solicit additional B1 Projects                               |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     | In Progress |
| Update Wave 1 Core Partners and Potential Supporting Partners                              |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| <b>Milestone: Updated List of Core Partners and Potential Supporting Partners - Wave 1</b> |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| <b>Identify Partners to Support with HIT - Wave 2</b>                                      |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| Conduct RFA Process to consider, vet, and select wave 2 projects                           |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| Identify Wave 2 Core Partners and Potential Supporting Partners                            |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| <b>Milestone: List of Core Partners and Potential Supporting Partners - Wave 2</b>         |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| <b>Identify Partners to Support with HIT - Wave 3</b>                                      |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| Conduct RFA Process to consider, vet, and select wave 3 projects                           |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| Identify Wave 3 Core Partners and Potential Supporting Partners                            |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |
| <b>Milestone: List of Core Partners and Potential Supporting Partners - Wave 3</b>         |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |             |

### Work Stream 2: Engage Technology Vendors

IDN-1 is engaging with several vendors to deploy, train, and support health information systems with IDN-1 Partners. In the first 18 months IDN-1 will focus on broad deployment of systems identified as “minimum” HIT standards by the statewide HIT task force.

IDN1 has engaged the [REDACTED] to provide technical support to IDN-1 Partners and to orchestrate the deployment of vendor systems. [REDACTED] will help Partners confirm or establish the basics of secure document/data storage, connectivity, and use of electronic health records (EHRs). Where Partners do not have an EHR or where systems are sub-par, [REDACTED] will encourage organizations to select and implement Certified Electronic Health Record Technologies (CEHRTs). The technical assistance will support Partners on their use of ONC Certified Technologies and functions adhering to the ONC’s 2016 Interoperability Standards Advisory and subsequent guidance. (Note that IDN-1 does not intend to fund EHR purchase and instead will advise organizations on EHR investments and use.) EHR integration activity will be conducted in collaboration with the multiple EHR vendors (there are currently 26) and several Health Information Services Providers (HISPs) that support IDN-1 Partners.

IDN-1 will provide technical support to Partners to ensure that Direct Secure Messaging services are in place and ready to support project requirements. In many cases this will be a validation and testing of services already available through Certified EHR Technologies (CEHRTs). Where Direct Secure Messaging is not available, IDN-1 will pay for and support deployment of a webmail solution provided by the vendor Kno-2. This is the vendor selected by the New Hampshire Health Information Organization.

IDN-1 will contract with [REDACTED] to deploy systems in support of the Shared Care Plan and an Event Notification Service (ENS). This is the vendor selected by the Statewide HIT Task Force.

IDN-1 will continue to work with the Statewide HIT Task Force to select a vendor for data aggregation and quality reporting. For all vendors, IDN-1 will facilitate execution of contracts with embedded Business Associate Agreements (BAAs). The following is the detailed project plan with activities and milestones:



### Work Stream 3: Define Conventions for CCSA, Shared Care Plan, and Referrals

The NH 1115 Waiver brings with it 5 novel workflows that are not well standardized. There is “pioneering” work to be done to define the workflows, information flows, and configuration requirements for the vendors. Conventions will be determined by the clinicians and staff that will follow them and will be supported by the technology. This will be done as part of the wave 1 projects. Conventions will be required to support:

1. Comprehensive Core Standardized Assessment
2. Shared Care Plan
3. Referrals (Intra-Integrated Core Team Referrals, Referrals to Supports)
4. Notifications of Medicaid Member Hospitalization Status
5. Measurement of Clinical Quality per NH 1115 measure set

In concert with defining these conventions, IDN-1 will work with Partners and technology vendors to configure their systems.

- The CCSA convention will first be developed in document form. Some Partners will proceed to codify some individual assessment instruments within their EHR systems (e.g., PHQ-2, PHQ9). CCSA completion tracking will be configured in the Quality Reporting system
- The Shared Care Plan convention will be configured in the [REDACTED]
- Referrals will be configured in the EHRs and with the HISPs. Those without an EHR or with an immature EHR will require some configuration of [REDACTED] for referrals.
- Notification will be configured in the [REDACTED]
- The NH 1115 Measure Specification will be configured in the Quality Reporting system

For all workflows, an “initial” convention will be established. This will be revisited periodically with a debrief and continuous improvement process.

The following is the detailed project plan with activities and milestones:







### Work Stream 6: Prepare for Shift to Value Based Payment

The IDN-1 technology implementation serves two purposes. The immediate purpose is to support successful execution of the projects. This immediate work is concentrated in the period July 2017 – Dec 2018 with continued operation of the implemented systems through the end of the waiver and beyond. The longer range purpose is to implement foundational systems to support the IDN and its partners in the State Government to shift to a Value Based Payment.

The component parts required to support Value Based Payment will be set up through the first half of the Waiver and refined in the out years:

1. Partners will have modern technology in place for managing the clinical and business/financial sides of their organizations.
2. Partners will deliver care as an “Integrated Delivery System” formed around Medicaid Members and will share key clinical information with one another to support safe, timely, effective, efficient, patient-centered care.
3. Patient Goals for wellness will be gathered for a new definition of what successful care provision comprises.
4. Partners will have analytics capabilities in place to identify high complexity / high risk Members.
5. Partners will have Care Coordination capabilities in place for Medicaid population management.
6. Partners will have a system wide view of Medicaid Members including where they are presenting and the teams that serve them.
7. Clinical Quality Reporting systems will be in place to provide checks and balances for a simpler payment model.
8. Community Support Providers will be part of the integrated delivery system.

There is an open question among all IDNs regarding the financial analytics systems and their inputs and outputs that will support the shift to Alternative Payment Models. Determining requirements, technical solutions, and implementation plans for financial analytics will first require development of clear and specific plans for rollout of alternative payment models by NH Medicaid and/or the ACOs. Prior to the specifics of payment reform being defined by NH DHHS, IDN-1 has begun to engage with the resources and organizations that will need to work together to implement a successful payment model transition. These include:

1. IDN Partners – Regardless of payment methodology, the IDN Partner Organizations will require the following fundamental information: a) Acceptance/declaration of accountability for an attributed Medicaid member; b) Budgets for attributed members; and, c) Quality indicators
2. Data Aggregators – In addition to DHHS, there are three points of region wide/statewide data aggregation that are beginning to work together to determine roles and interdependencies:





Figure 26: Project Plan Detail - Work Stream 7

| Deliverable/Milestone   | Jan-Jun '17 | Jul '17 | Aug | Sep | Oct | Nov | Dec | Jan '18 | Feb | Mar | Apr | May | Jun | Jul '18 | Aug | Sep | Oct | Nov | Dec | Status    |
|---|-------------|---------|-----|-----|-----|-----|-----|---------|-----|-----|-----|-----|-----|---------|-----|-----|-----|-----|-----|-----------|
| <b>Work Stream 7: Oversee Data &amp; IT with Governance</b>           |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| <b>Support Frequent Meetings of the IDN-1 Data &amp; IT Workgroup</b> |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Jan - June 2017          |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     | Completed |
| Milestone: Data & IT Work Group Meeting(s) - July 2017                |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     | Completed |
| Milestone: Data & IT Work Group Meeting(s) - Aug 2017                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Sep 2017                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Oct 2017                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Nov 2017                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Dec 2017                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Jan 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Feb 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Mar 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Apr 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - May 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Jun 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - July 2018                |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Aug 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Sep 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Oct 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Nov 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |
| Milestone: Data & IT Work Group Meeting(s) - Dec 2018                 |             |         |     |     |     |     |     |         |     |     |     |     |     |         |     |     |     |     |     |           |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

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

The 1115 Waiver program has multiple layers of evaluation. Quality measures are comprehensive and encompass reporting of clinical quality measures, process measures around use of the Comprehensive Core Standardized Assessment (CCSA) and Shared Care Plan, Physical and Mental Health HEDIS measure, and patient experience of care measures. The HIT evaluation targets do not duplicate these measures. Instead IDN-1 has selected process measures that indicate deployment and use of the most critical technologies supporting the care integration goals of the NH 1115 Waiver.

The following table outlines the HIT evaluation measures and targets and will be periodically updated with progress metrics.

Figure 27: Table A2-4. IDN HIT Evaluation Project Targets

| Performance Measure Name  | Target | Progress Toward Target |               |                |
|---|--------|------------------------|---------------|----------------|
|   |        | As of 12/31/17         | As of 6/30/18 | As of 12/31/18 |
| # Partners Connected to Shared Care Plans                                     | 21     |                        |               |                |
| # Partners Actively Working with Shared Care Plans                            | 21     |                        |               |                |
| # Partners Receiving Event Notifications                                      | 21     |                        |               |                |
| # of Partners Submitting Data for Quality Reporting (data feed and/or portal) | 21     |                        |               |                |
| # of Project B1 Partners Capable of exchanging Direct Messages                | 21     |                        |               |                |
| # of Community Partners Capable of exchanging Direct Messages                 | 9      |                        |               |                |
| [REDACTED]  | 4      |                        |               |                |
| [REDACTED]  | 3      |                        |               |                |
| [REDACTED]  | 2      |                        |               |                |

Notes:

- 21 organizations are participating in project B1 and expected to achieve ‘coordinated care’ designation by 12/31/18. These 21 organizations make up the target for the first five measures.
- Initial target of 9 community supports organizations enabled with Direct Secure Messaging capability to receive ‘referrals to supports.’
- Initial target of 4 of 6 hospitals sending registration (ADT) feeds to the event notification service. Two hospitals have low Medicaid volume and have not committed to implementing the [REDACTED].

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- Use of [REDACTED] within the hospital is not a minimum requirement but a stretch goal for the IDN. We hope to see 3 hospitals connected and 2 using the system by 12/31/18.
- Partners are defined as organizations. In cases where a single legal entity is made up of more than one distinct entity (e.g., A Hospital and a hospital employed practice) the distinct entities are targeted and counted separately.
- Actively Working with Shared Care Plans is contributing to and/or accessing plans.
- Actively Working with [REDACTED] is contributing to and/or accessing plans.

### A2-5. IDN HIT: Workforce Staffing

IDN-1 conducted a survey of partner organizations in the fall of 2016 followed by phone interviews and site visits. Part of this assessment was to determine partner organization experience with supporting health information technology.

Survey respondents were asked to respond to the question: *Please explain/characterize your organization's experience level and sophistication with using information technology to do your daily work. (e.g., "we implemented IT systems 18 months ago but are still figuring out clinical workflow and inter-organizational communications.")*

56% (15 of 27) of the organizations that responded to the survey provided answers that indicated an advanced level of experience with HIT systems. 37% (10 of 27) of the organizations that responded to the survey provided answers that indicated that the organization was using some electronic systems and/or that the implementations of electronic systems was relatively recent. 7% (2 of 27) of the organizations that responded to the survey provided answers that indicated the organization was using very little information technology and/or that the organization was new to using electronic systems.

The IDN-1 Data & IT Work Group concluded that the region would benefit from Technical Assistance deployed centrally from the IDN. Technical Assistance needs to prepare IDN-1 participants to implement the selected integration projects while improving the IT capabilities and know-how among the region's IT leadership and staff. This recommendation was accepted by the IDN-1 Executive Committee and included in the project plan and budget in the fall of 2016.

The Data & IT Work Group also concluded that IDN-1 Partners would benefit from cross-sharing among organizations throughout the waiver period. The Data & IT Work Group, which was originally convened for planning purposes, will continue as an information sharing forum among the partner organizations that are implementing or about to implement the projects and related IT components.

Figure 28: Table A2-5. IDN HIT Work Force Staffing

| Staff Type                               | Projected Total Need | IDN Workforce (FTEs)      |                |               |                |
|--|----------------------|---------------------------|----------------|---------------|----------------|
|  |                      | Baseline Staffing 6/30/17 | As of 12/31/17 | As of 6/30/18 | As of 12/31/18 |
| Data & IT Workgroup Co-Chair (Volunteer) | .10 FTE              | .1 FTE                    |                |               |                |
| Data & IT Workgroup Co-Chair (Volunteer) | .05 FTE              | .05 FTE                   |                |               |                |

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|  |         |         |  |  |  |
|--|---------|---------|--|--|--|
| Director of Data & IT (IDN Contracted)     | .85 FTE | .85 FTE |  |  |  |
| Implementation Specialist (IDN Contracted) | .35 FTE | .35 FTE |  |  |  |

### A2-6. IDN HIT: Budget

IDN-1 will support its partners with both technical assistance and software system investment as described throughout this implementation plan. IDN-1 has budgeted costs in two categories: Consultants and Software.

The Consultant costs cover the following:

- Engagement of the [REDACTED] as the IDN-1 advisor and subject matter expert in health information exchange.
- Engagement of the [REDACTED] as the IDN-1 technical services support vendor.
- Engagement of Legal Services to support ongoing patient privacy planning.

The Software costs cover the following:

- Engagement of [REDACTED] to provide webmail for Direct Secure Messaging.
- Engagement of [REDACTED] to provide the event notification service and [REDACTED].
- Engagement of [REDACTED] to provide the Shared Care Plan.
- Engagement of a vendor (pending selection by Statewide HIT Taskforce) to provide data aggregation and quality reporting services.
- Contingency to cover actual Data Aggregator cost (unknown), additional licenses, and unforeseen costs associated with software deployment.

The following is a detailed HIT budget followed by the DHHS budget forms for each 6-month program period.

*Figure 29: IDN-1 IT Solutions Budget*

|              | Jul-Dec '16    | Jan-Jun '17    | Jul-Dec '17    | Jan-Jun '18    | Jul-Dec '18    | Jan-Jun '19    | Jul-Dec '19    | Jan-Jun '20    | Jul-Dec '20    | Total            |
|--------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|------------------|
| Consultants  | 125,445        | 207,000        | 235,000        | 235,000        | 210,000        | 66,500         | 66,500         | 50,500         | 38,055         | 1,234,000        |
| Software     | -              | -              | 188,295        | 124,020        | 92,819         | 95,939         | 99,059         | 99,059         | 99,059         | 798,250          |
| <b>Total</b> | <b>125,445</b> | <b>207,000</b> | <b>423,295</b> | <b>359,020</b> | <b>302,819</b> | <b>162,439</b> | <b>165,559</b> | <b>149,559</b> | <b>137,114</b> | <b>2,032,250</b> |









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|  |                                |
|--|--------------------------------|
| Lake Sunapee VNA                           | Home Health                    |
| Lebanon Housing Authority                  | Community Support Provider     |
| Life Coping Inc.                           | Mental Health Provider         |
| MAPS                                       | Mental Health Provider         |
| Mary Hitchcock Memorial Hospital           | Hospital                       |
| Mindful Balance Therapy Center PLLC        | Mental Health Provider         |
| Monadnock Area Peer Support Agency         | Mental Health Provider         |
| Monadnock Center for Violence Prevention   | Community Support Provider     |
| Monadnock Collaborative                    | Community Support Provider     |
| Monadnock Community Hospital               | Hospital                       |
| Monadnock Family Services                  | Community Mental Health Center |
| Monadnock Region System of Care            | Care Management                |
| NAMI New Hampshire                         | Community Support Provider     |
| New London Hospital                        | Hospital, Primary Care         |
| Pathways of the River Valley               | Community Support Provider     |
| Phoenix House                              | SUD Treatment                  |
| Planned Parenthood of Northern New England | Primary Care                   |
| Serenity Center                            | Community Support Provider     |
| ServiceLink Monadnock                      | Care Management                |
| Southwestern Community Services            | Mental Health Provider         |
| Sullivan County - Nursing Home             | Long Term Care                 |
| TLC Family Resource Center                 | Mental Health Provider         |
| Twin Pines Housing Trust                   | Community Support Provider     |
| Valley Regional Hospital                   | Hospital                       |
| Visiting Nurse & Hospice of VT/NH          | Home Health                    |
| West Central Behavioral Health             | Community Mental Health Center |

## A2-8. IDN HIT. Data Agreement

*Figure 38: A2-8. IDN HIT. Data Agreement*

| Organization Name | Data Sharing Agreement Signed? |
|-------------------|--------------------------------|
| [REDACTED]        | Yes                            |



A2-9. Project Scoring: IDN HIT Process Milestones

**Figure 39: Project Scoring: IDN HIT Process Milestones**

| Process Milestone Number | Process Detail                                       | Submission Format                                   | Results (Met/Not Met) |          |         |          |
|--------------------------|--|---|-----------------------|----------|---------|----------|
|                          |  |   | 6/30/17               | 12/31/17 | 6/30/18 | 12/31/18 |
| A2-1                     | IDN Participation in Statewide HIT Taskforce         | Table   |                       |          |         |          |
| A2-2                     | IDN HIT/HIE Assessment and Gap Analysis              | Narrative   |                       |          |         |          |
| A2-3                     | IDN HIT/HIE Implementation Plan and Timeline         | 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   |                       |          |         |          |

# Integrated Delivery Network Region 1: *Partnership for Integrated Care*

## B1: Integrated Healthcare

### B1-1. IDN Integrated Healthcare: Assessment of Current State of Practice against SAMHSA Framework\* for Integrated Levels of Care and Gap Analysis

Region 1 contracted with the [REDACTED] to administer a validated survey tool to measure primary care and behavioral health providers' current state of practice against the SAMHSA requirements. This is highly correlated with the Special Terms and Conditions definitions of Coordinated Care Practice and Integrated Care Practice. The site self-assessment tool used was [REDACTED]. This tool was developed in 2006 and has been used across the country including two years of use as part of [REDACTED]. The tool provides quantitative and qualitative assessments to create an in-depth analysis of inter- and intra-practice integration. These analyses inform practices of their strengths and weaknesses and will be used to measure progress toward goals over time.

The survey was delivered to sites in May through early June 2017. Instructions were provided to site leaders in writing and all site leaders were instructed to watch a video which provided detailed instructions on survey distribution within a practice. Multiple roles within a practice were asked to complete the survey and site leaders captured numerical responses to produce an aggregate score for each practice.

The [REDACTED] crosswalks to the SAMHSA levels of integration as described in the figure below:

## SAMHSA/SSA Crosswalk

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

Blount A. Integrated primary care: organizing the evidence. Families, Systems, & Health. 2009; 21 (2):121-133. doi: 10.1097/F001-7527.21.2.121.  
Health B, Wiley Romero P, Reynolds K, Washington, D.C. SAMHSA-IRISA Center for Integrated Health Solutions. A review and proposed standard framework for levels of integrated healthcare. Published March 2015.  
Mettre Health Access Foundation. Site Self-Assessment. Updated 2016.  
Hurlins CM. Building Integrated Care in North Carolina. [Webinar Lecture] Behavioral Health Integration Learning Collaborative Learning Webinar Series Center for Excellence for Integrated Care. A Program for Health Leadership and Innovation; January 26, 2016

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Practices are scored in two domains and these two scores are combined to produce a total score. The domains of assessment are:

- Integrated services and patient and family centeredness
- Practice/Organization

Analyses are done at the practice level and the IDN level. The site level analyses provide information about specific strengths and weaknesses at that site and provide benchmarking information to allow the practice to compare their performance to the other practices in the IDN. The IDN “roll up” report aggregates scores in the domains across all practices and shows the variation in scores between the practices. Detailed analyses of each survey element create a prioritized set of improvement opportunities, ranked by aggregate score.

Surveys were completed and analyzed in June 2017; roughly half of eligible IDN-1 practices responded to this first round of surveys. Repeated attempts were made to encourage practices to complete the survey including individualized communications with site leads. Due to the lack of completion by all eligible B1 providers the IDN-1 team will work with [REDACTED] to assess the best time for a re-opening of SSA submissions across missing providers. It is anticipated this will occur in late Fall 2017. Through this re-opening process the IDN team will ask for confirmation or intent to submit. If this is not received by a provider the IDN-1 lead team will schedule time for supported SSA submission with the provider teams as needed to establish a full cohort baseline in 2017. Next steps:

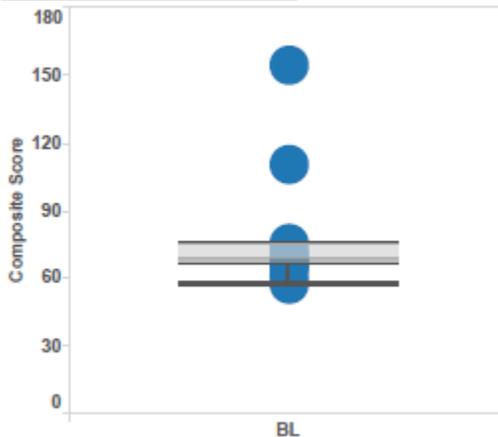
- 1) Re-open SSA survey fall 2017
- 2) Phone calls and in-person outreach to non-completing sites
- 3) Those sites not completing will be asked to confirm interest in participation in IDN and if still interested, assisted to complete the survey
- 4) If not interested in IDN work, addressing other potential options for support and then if necessary removal from the IDN network

Going forward, the site self-assessment will be administered every 6 months for the first 18 months of implementation. Allowing for an 18+ month change in integration through B1 implementation to be captured between the baseline and last survey. As integration activities increase and an increased number of practices are engaged in care model redesign, we anticipate survey completion rates to improve.

Overall, the Region 1 aggregate total score was 80 out of a total of 180 possible points. This score corresponds to a SAMHSA level III, basic onsite collaboration. Scores across the 9 respondents ranged from the highest score of 155 and the lowest score of 58. Most organizations clustered around a score of 67 with two positive outliers at 111 and 155. (See below).

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**Composite Score Distribution**



**Composite Scores by Practice**

| Practice | SSA No. |
|----------|---------|
| 1-106    | 111     |
| 1-110    | 155     |
| 1-111    | 58      |
| 1-112    | 62      |
| 1-114    | 76      |
| 1-116    | 71      |
| 1-117    | 71      |
| 1-120    | 67      |
| 1-121    | 67      |
| 1-122    | 66      |

The survey provides a comprehensive gap assessment and partial baseline for the IDN and the individual practices and helps target improvement opportunities across the Region. As referenced above through secondary SSA submission the IDN expects to have a comprehensive baseline established by late fall 2017. The summary of these prioritized gap areas for the IDN are listed in the table below:

**Domain One Improvement Opportunities (Average Scores by Question Shown in Ascending Order)**

| SSA No. | 6. Communication with patients about integrated care | 8. Social support (for patients to implement recommended treatment) | 3. Treatment plan(s) for primary care and behavioral/mental health care | 4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care | 1. Level of integration: primary care and mental/behavioral health care | 9. Linking to community resources | 7. Follow-Up of assessments, tests, treatment, referrals and other services | 2. Screening and assessment for emotional/behavioral health needs (e. g. stress, depression, anxiety, substance abuse) | 5. Patient/family involvement in care plan |
|---------|--|---|---|---|---|-----------------------------------|---|--|--|
| BL      | 3.9  | 4.1   | 4.2   | 4.2   | 4.3   | 5.0                               | 5.7   | 5.8  | 5.9  |

**Domain Two Improvement Opportunities (Average Scores by Question Shown in Ascending Order)**

| SSA No. | 9. Funding sources/resources | 7. Patient/family input to integration management | 2. Patient care team for implementing integrated care | 8. Physician, team and staff education and training for integrated care | 5. Coordination of referrals and specialists | 4. Continuity of care between primary care and behavioral/mental health | 3. Providers' engagement with integrated care ("buy-in") | 1. Organizational leadership for integrated care | 6. Data systems/patient records |
|---------|------------------------------|---|---|---|--|---|--|--|---------------------------------|
| BL      | 2.4                          | 2.9   | 2.9   | 3.4   | 4.3  | 4.4   | 5.3  | 5.4  | 6.3                             |

The highest possible score in each of the survey elements is a 10; lower scores indicate a greater opportunity for improvement i.e. greater gap in performance.

Importantly, there was variation in the strengths and weaknesses between individual practice sites; this variation provided critical information for B1 project planning. Review of the individual practice assessments revealed the following:

- Overall, there are opportunities for all practice sites to improve integration across the two domains and 18 assessed areas;
- There are at least two practices leading the IDN in care integration setting up opportunities for others to learn from their peers. (Note: We have set the expectation that practices will participate in site visits, mentoring, and formal meetings/calls to share best practices);
- Of the practices that have completed initial assessments, there are no negative outliers/ or integration laggards. All practices have begun work toward health care integration.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

- The practices demonstrated initial strengths in the following areas:
  - Data Systems and Patient Records
  - Patient and family involvement in care planning
  - Screening and assessment of emotional / behavioral needs
  - Follow up of assessments
  - Providers’ engagement with integrated care
  - Linking to community resources
- The practices demonstrated the most room for growth in the following areas:
  - Funding sources / resources
  - Patient/family input to integration management
  - Patient care team for implementing integrated care

Level of Integration of IDN-1 B1 Practices as of 7/1/17:

### RFA Process:

The IDN-1 Executive Committee decided to use a request-for-applications (RFA) process to identify practices ready to examine their practice processes and to implement improvement work to improve integration (the terms RFA and RFP (request-for-proposals) are used interchangeably). All designated Primary Care and Behavioral Health practices, as captured in the Region 1 IDN attribution, will participate in the B1 project but they will participate in “waves;” cohorts of practices that ‘kick off’ implementation at various times during the next 12 months. This approach provides time for practices to prepare for the time-consuming improvement work, discovery of best practices from initial B1 cohorts, testing interventions, and dissemination and implementation of best practices to address the gaps at each clinic.

Region 1 Executive Committee [REDACTED] as the first B1 project team. Results of their integration assessments are as follows:

| Organization | Composite Score | SAMHSA Integration |
|--------------|-----------------|--------------------|
| [REDACTED]   | [REDACTED]      | [REDACTED]         |
| [REDACTED]   | [REDACTED]      | [REDACTED]         |

These two practices [REDACTED] partnered to submit an RFA to enhance integration between the two practice sites. Each of the practices currently fulfill some of the STC-defined ‘Coordinated Care’ requirements but considered together as a coordinated care practice there were several gaps identified to be filled including:

- A comprehensive core assessment that assesses all DSRIP STC required domains. Each practice uses a comprehensive screening process but all domains are not covered on either screening

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process. This gap will be addressed during the project by the [REDACTED] B1 team working with existing IT and data teams to ensure all required screening elements are included at both practice sites and the results of those screenings are available to providers at both sites;

- Multi-disciplinary team conferences and shared care planning across organizations does not happen today. Going forward, multi-disciplinary team meetings with a [REDACTED] will be initiated. A new role, the Care Team Coordinator, will be hired to coordinate care across the two practices, supporting monthly shared care planning meetings, ensuring information is shared appropriately, and community services engaged to meet patient needs. Workflows have been designed and roles and responsibilities for the new Care Team Coordinator are drafted;
- Staff have expertise gaps between the two organizations. Through cross-training using existing experts, the two practices will be able to provide a full spectrum of education for staff including basic education in chronic diseases as well as education in behavioral health topics.
- Information sharing between the organizations is limited at this time and hinders care coordination of patients that see both practices. Going forward information sharing will be supported by the IDN and is detailed in the Region 1 IT implementation plan.

Once the 'Coordinated Care' practice designation is achieved, one of the partners will be prepared to advance to the STC-defined 'Integrated Care' practice designation (as defined by DSRIP STC). Current gap assessment includes the following:

- Medication assisted treatment is not provided by [REDACTED]. [REDACTED] is not planning on initiating MAT services at their site and will not seek Integrated Care designation status. MAT is already in place at the [REDACTED].
- Primary care physicians already use evidence-based guidelines to treat depression and this is not a gap to address.

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

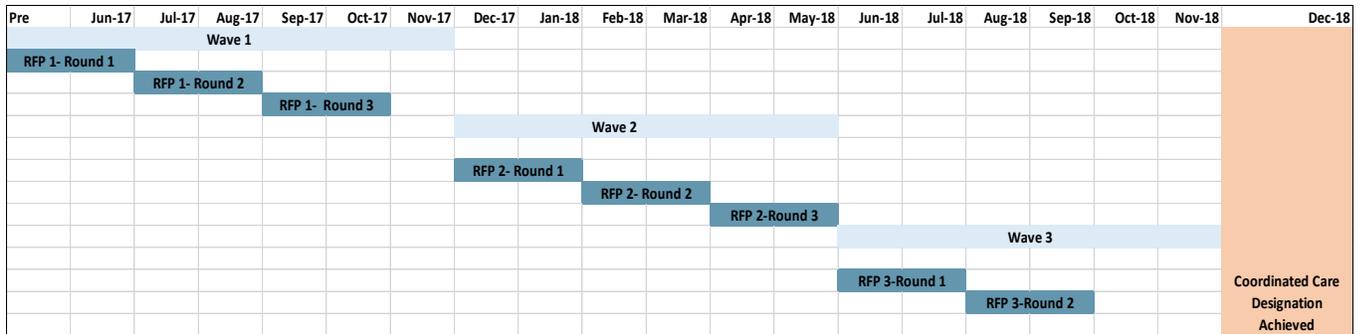
#### Deployment of B1 Implementation Projects:

As shown in the two figures below and as detailed in *B1: Appendix A*, the 21 practices targeted for project B1 will roll out implementations from July 2017 through May of 2018.

#### Redacted Table\*

**\*Please note the sequence of provider launch dates is not final for all practices coded in light orange. The graph above is a projection of anticipated implementation based on the ongoing dialogue between Region 1 IDN lead staff and the B1 providers.**

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IDN-1 Partners are self-determining their timing for engaging in project B1. Throughout the listening tour the IDN-1 Administrative Team let Partners know that there will be Partners that step forward to pioneer the projects beginning in late summer of 2017 while others may watch from the sidelines and engage deeply in the winter or summer of 2018. Partner engagement timing is a multi-factor decision based upon readiness, resource availability, and competing priorities (e.g., implementation of [REDACTED] EHR system at [REDACTED]). IDN-1 has determined that transformation is most likely to occur with Partners that come willingly to the project to fulfill shared interests. The RFA process and B1 project waves respect the Partner autonomy while giving opportunities for engagement.

The first wave of B1 integration teams will kick off with a [REDACTED] Health coordinated pilot detailed below. This pilot team will serve as the first test of the IDN 1 B1 strategies and implementation plan. IDN staff will support ongoing RFAs, adjusting processes for proposal solicitation and selection based on learnings from the initial waves. The implementation experiences from pilot teams in each cohort will provide important information for subsequent cohorts.

Region 1 IDN membership and the administrative team are committed to building an infrastructure for learning that will support continuous improvement and sustainable solutions. Dedicated quality improvement (QI) coaches will work across B1 teams, serving as “cross pollinators,” spreading best practices and helping to identify what resources could be ‘centralized’ to support multiple practices within our Region. The Region 1 website has been launched and provides a common platform for information sharing. Scheduled Knowledge Exchanges will provide education about specific topics and time for exchanging “lessons learned.” All-partner IDN meetings (Advisory Council meetings) are hosted 3 times a year providing a forum for learning between all projects (B, C, D, E).

### Region 1 IDN B1 RFP Process:

Achieving transformational change requires system redesign and management of change processes. IDN-1 has implemented a Request for Application (RFA) Process (also referred to as Request for Proposals (RFP) in this implementation plan) as an organizing structure for implementing transformational change. The RFA Process accomplishes multiple objectives:

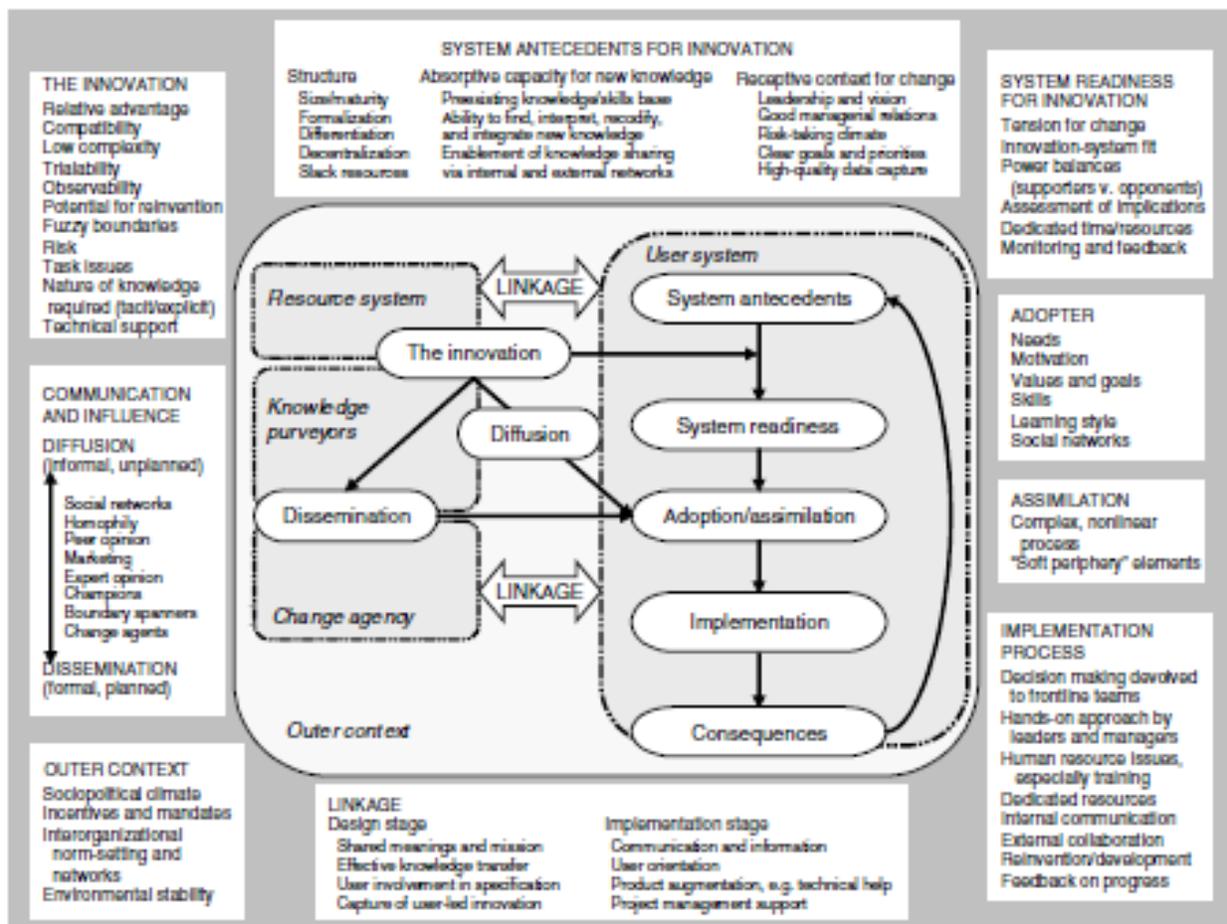
1. Offers individual organizations a forum for collaborating with other organizations to propose, fund, and implement a tangible transformational project and to share findings openly with other interested organizations for dissemination.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

2. Creates the collaborative conditions, inter-organizational trust, supporting resources, and funding for bottom up change.
3. Provides an open and transparent process for allocating 1115 Waiver funds supported by a multi-stakeholder / multi-disciplinary Independent Review Board and overseen by the multi-organizational governance body.

The RFA strategy was endorsed by the Executive Committee as the overarching strategy for Region 1 implementation of all projects. Due to important differences between the core integration project (B1) and the community-driven projects, the release of RFAs and the actual RFA template differs slightly between B1 and the community projects.

There has been an exponential growth in research on innovation, implementation, diffusion, dissemination, and system redesign especially in the field of health and health care services (*See Appendix B*). The diagram below is but one of many illustrations highlighting the complex set of interactions required for sustainable change (Greenhalgh T, et al. Diffusion of Innovations in Service Organizations. Millbank Q 2004).



Given the complexities of large scale change, it is no wonder that most researchers find most large-scale transformative changes are not sustained over time.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

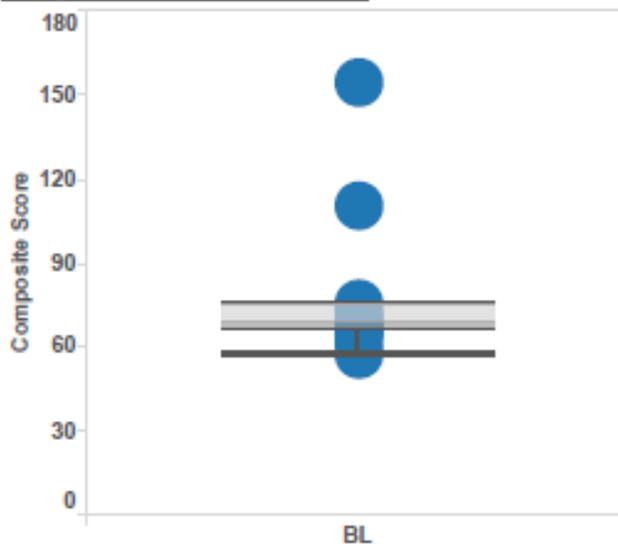
Region 1 leaders are committed to a strategy that would lead to transformative change that can be sustained even after DSRIP funding had ended. Leaders acknowledged that Region 1 is not a system, indeed there are at least 3 distinct regions within this region [REDACTED] containing many organizations which have never worked all together in systematic planning or implementation strategies. Furthermore, current state assessments show wide variation in important success factors for change.

The Executive Team from Region 1 completed an extensive “listening tour” to understand the common and unique barriers experienced by IDN partners working to improve health outcomes for Medicaid beneficiaries with behavioral health disorders. Results of these interviews demonstrated important differences between IDN partners related to key determinants of successful change:

- Variation in ‘readiness for change’;
- Variation in skills, knowledge, and/or resources for improvement or innovation work;
- Variation in experience with proposed Region 1 interventions (integration of behavioral health and primary care or community projects transitions in care, expansion of SUD treatment or enhanced coordination);
- Variation in current challenges at the partner organization, e.g. workforce shortages, sustainable funding for services, intra-organizational relationships, cultural differences, physical space.

Results from the Region 1 integration assessment report reaffirmed the variation discovered during partner interviews. As described in the Region 1 IDN B1 Implementation Plan, IDN partners completed the [REDACTED] survey in May-June 2017. This validated tool scores practices across two domains of care and the combined score correlates with the SAMHSA six levels of integration. The highest potential total score is 180 which is correlated with a SAMHSA six level. Results from Region 1 indicate significant variation in integration across the IDN partners:

**Composite Score Distribution**

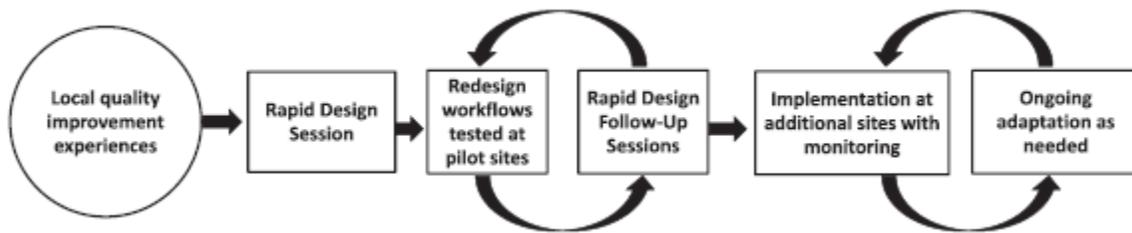


**Composite Scores by Practice**

| Practice | SSA No. |
|----------|---------|
|          | BL      |
| 1-106    | 111     |
| 1-110    | 155     |
| 1-111    | 58      |
| 1-112    | 62      |
| 1-114    | 76      |
| 1-116    | 71      |
| 1-117    | 71      |
| 1-120    | 67      |
| 1-121    | 67      |
| 1-122    | 66      |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

The variation between IDN partners, combined with the complexity of the DSRIP projects (core projects and community-selected projects), led the Region 1 Executive Committee to select the request-for-application (RFA) strategy to solicit pilot teams for initial DSRIP funding. This strategy allows partners who are ready for change to become Region 1 “early adopters” and provides an opportunity to create a regional learning system i.e. a system that learns from pilots and then disseminates and implements best practices to other partners to achieve measurable improvements in aggregate performance. The RFA process avoids the “top down” strategies that rarely work in system redesign; especially in systems with significant variation as seen in Region 1 analyses. By piloting interventions, processes can be refined, best practices discovered and adaptations made by IDN partners thus avoiding costly mistakes and investments in solutions that don’t meet the needs of all partners (Kraft et al. Building the Learning Health System. Learning Health System epub 2017).



The RFA process was endorsed as the strategy with the greatest likelihood of creating lasting change in the IDN and the most fiscally responsible strategy, avoiding investments in processes or structures that had not been tested for feasibility in our region.

The RFA processes and structures (templates, communication structures, etc.) were reviewed and endorsed by the Executive Committee. A timeline for the initial RFAs was established as outlined below:

| RFA Timeline Milestones  | Date  |
|--|---|
| RFP Process Shared with Region 1 IDN   | Thursday, May 4 <sup>th</sup>   |
| Region 1 Admin. Leads hold “Office Hours” and Q&A Webinars for RFA Support   | Weeks of May 8 <sup>th</sup> and 15 <sup>th</sup>                     |
| Application Deadline for Submission  | Monday, June 5 <sup>th</sup>  |
| Application Review Period by <ul style="list-style-type: none"> <li>• Admin. Leads</li> <li>• Project Teams</li> <li>• Independent Review Panel</li> </ul> | Weeks of June 5 <sup>th</sup> , 12 <sup>th</sup> and 19 <sup>th</sup> |
| Final Approval by Executive Committee  | Week of June 26 <sup>th</sup>   |

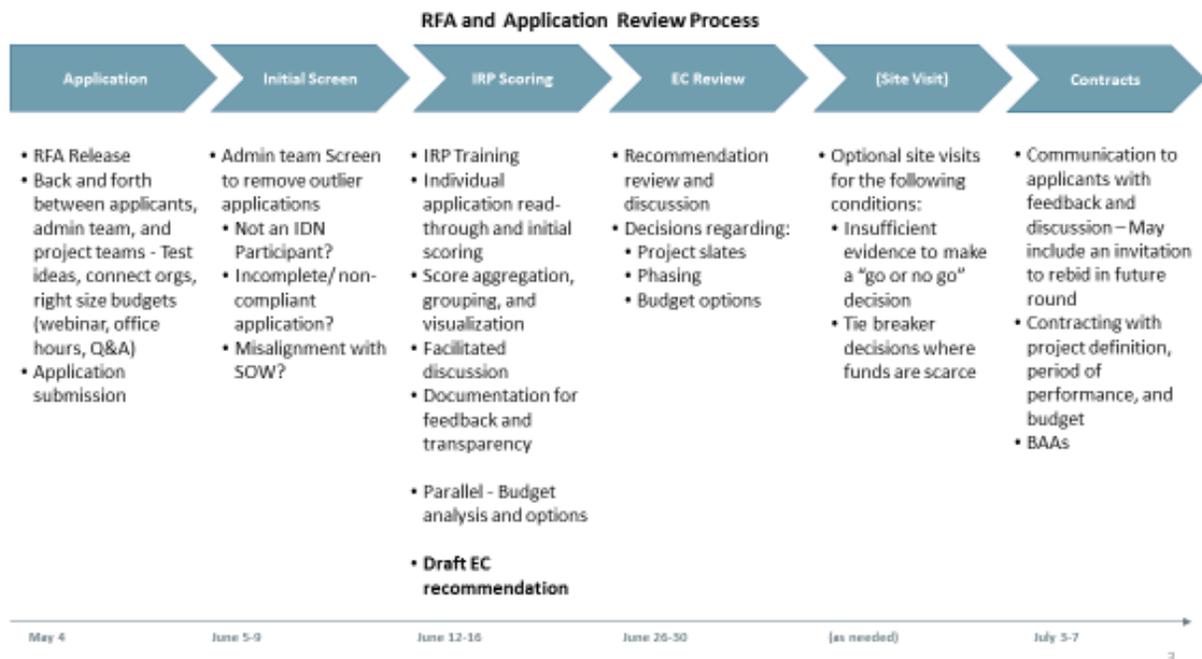
## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

Funding Disbursed

Not later than Friday, July 17<sup>th</sup>

The application template was developed by the administrative team working with each of the project teams (integrated care, coordinated care, expanded SUD treatment and enhanced care coordination) in collaboration with the Workforce and Data/IT workgroups. The Executive Committee provided feedback and then endorsed the final application template.

The process to review and approve RFAs was developed by the administrative team working with input from the Executive Committee and was endorsed by the Executive Committee. The diagram below outlines the review process:



An Independent Review Panel (IRP) was selected by the Executive Committee. The composition of the IRP was endorsed by the Executive Committee on May 9, 2017 and consisted of:

- Community Engagement Workgroup Member
- Clinical/Workforce Workgroup Member
- HIT Workgroup Member
- Finance Workgroup Member
- Executive Committee Member
- Administrative Lead Organization Member

The final slate of candidates was approved by the Executive Committee in May of 2017.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

The review process consisted of 3 separate “tiers” of review as outlined below:

| Tier | Committee Name                           | Committee Composition  | Evaluation Criteria   |
|------|--|--|---|
| 1    | <b>Administrative Leaders</b>            | <ul style="list-style-type: none"> <li>• Executive Director</li> <li>• Project Manager</li> <li>• Medical Director</li> </ul>  | <ul style="list-style-type: none"> <li>• Is the application complete?</li> <li>• <i>Solicit any additional information needed to make application complete through an iterative process with applicant.</i></li> <li>• Does this proposal align with the scope of work advanced by the project teams?</li> <li>• Is there a contract on file?</li> <li>• Are the necessary compliance and conflict of interest forms in place?</li> <li>• Recommend proposals as a slate for review by the Independent Review Panel.</li> </ul> |
| 2    | <b>Region 1 Independent Review Panel</b> | <ul style="list-style-type: none"> <li>• Finance Workgroup Member</li> <li>• HIT Workgroup Member</li> <li>• Clinical/Workforce Workgroup Member</li> <li>• Community Engagement Workgroup Member</li> <li>• Executive Committee Member</li> <li>• Administrative Lead Organization Representation</li> <li>• Executive Director (non-voting)</li> </ul> | <ul style="list-style-type: none"> <li>• Anticipated Transformational Impact</li> <li>• Anticipated Impact on Region 1 Medicaid Population</li> <li>• Levels of Collaboration</li> <li>• Partner Readiness</li> <li>• Level of Executive Commitment</li> <li>• Use of Funds</li> <li>• Recommend slate of proposals for final review by Executive Committee.</li> </ul>   |
| 3    | <b>Executive Committee</b>               | <ul style="list-style-type: none"> <li>• 7 voting members</li> <li>• 7 non-voting members (IDN Administrative Leadership Team)</li> </ul>  | <ul style="list-style-type: none"> <li>• Review all criteria and recommendations of Region 1 Independent Review Panel.</li> <li>• Does the slate of proposals advance transformation of care in our regions toward integration?</li> <li>• Ensure the proposals/slate of proposals preclude biases and conflict of interests?</li> </ul>  |

Scoring was completed using a rubric endorsed by the Executive Committee:

|                                     | Good (1 point)   | Better (2 points)  | Best (3 points)  |
|-------------------------------------|--|--|--|
| Anticipated transformational impact | Proposed project shows promise for serving the needs of Medicaid members but is not designed to change the | Proposed project shows some promise for positively transforming the way in which the health and wellbeing of Medicaid members is | Proposed project shows great promise for positively transforming the way in which the health and wellbeing of Medicaid members is supported. Proposed approach |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|   |  |  |  |
|---|--|--|--|
|   | current care delivery system.  | supported. Proposed approach is supported with some evidence of efficacy where available or demonstrates some ingenuity where evidence is scarce.  | is supported with significant evidence of efficacy where available or ingenuity where evidence is scarce.  |
| Partner Readiness                         | “Ready Later:” Applicant is ready to start in 2018. Proposed project is formulated but requires significant additional planning prior to launch. | “Ready Soon:” Applicant is ready to start in late 2017. Proposed project is well formulated but requires additional detailed planning prior to launch.   | “Ready Now:” Applicant is ready to start in July/Aug of 2017. Proposed project is already designed in detail and ready for immediate implementation.   |
| Anticipated impact on Medicaid population | Proposed project is expected to impact a small portion of the Medicaid members in the region.  | Proposed project is expected to impact a modest portion of the Medicaid members in the region. Alternatively, the proposed project is expected to impact a small number of Medicaid members with the most acute needs. | Proposed project is expected to impact a large portion of the Medicaid members in the region. Alternatively, the proposed project is expected to impact a modest number of Medicaid members with the most acute needs. |
| Level of Collaboration                    | Applicant proposes a single organization project. Applicant has not yet established working relationships with partners.                         | Applicant proposes to work with other organizations to implement the project. Applicant has established some working relationships with partners but requires additional connections and commitments to collaborate.   | Applicant proposes to work deeply with other organizations to implement the project. Applicant has established deep working relationships with all partners. Partners have committed to collaborate with Applicant.    |
| Level of Qualification                    | Applicant has little experience in implementing projects like the 1115 waiver.   | Applicant has a positive record in implementing projects similar to the 1115 waiver but of smaller size and scope.   | Applicant has a positive record in implementing projects of similar size and scope as the 1115 waiver.   |

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Level of Executive Commitment

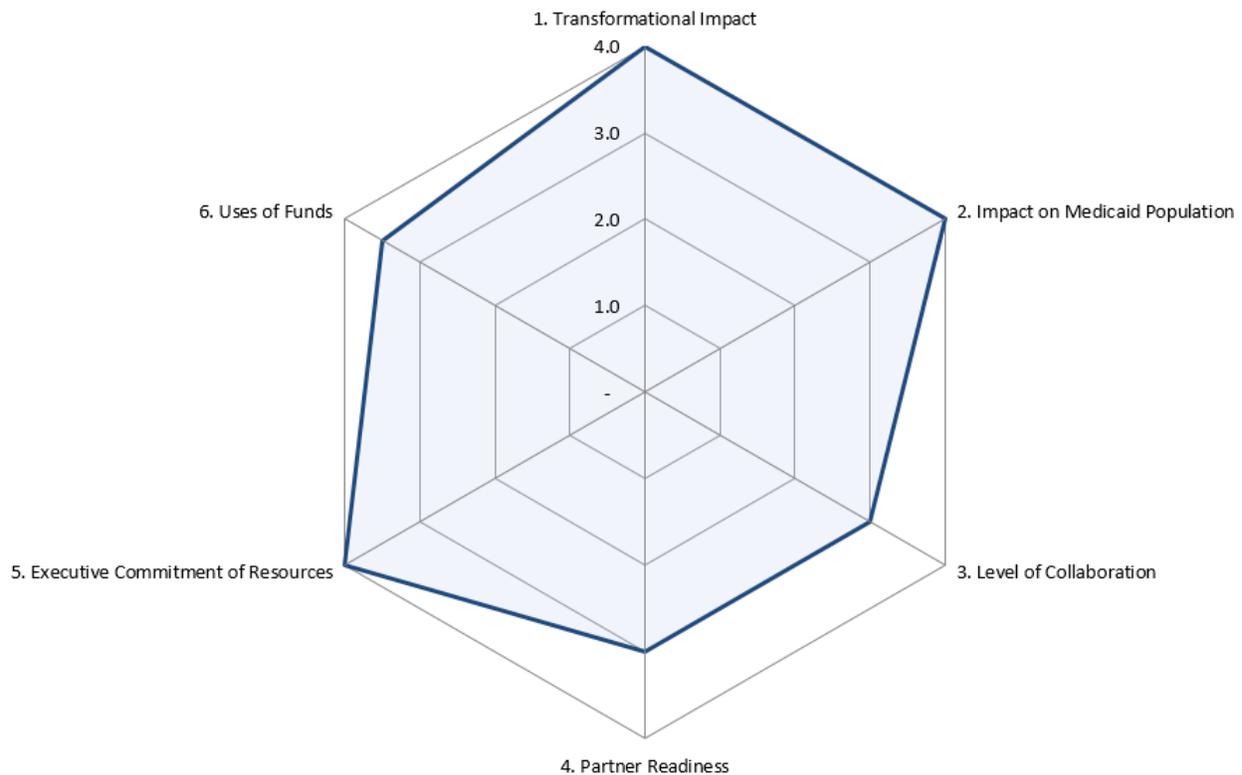
Top executive(s) of the applicant organization are absent from the project planning.

Top executive(s) of the applicant organization are involved in the project. The executive(s) see this project as important and have committed to devoting some of the organization's time, resources, and talent to the project.

Top executive(s) of the applicant organization are deeply involved in the project. The executive(s) have made the project a top priority and are committed to devoting a significant amount of the organization's time, resources, and talent to the project.

Results were graphically displayed using a spider diagram which allowed easy comparison between reviewers. An example is pictured below:

### Project 1



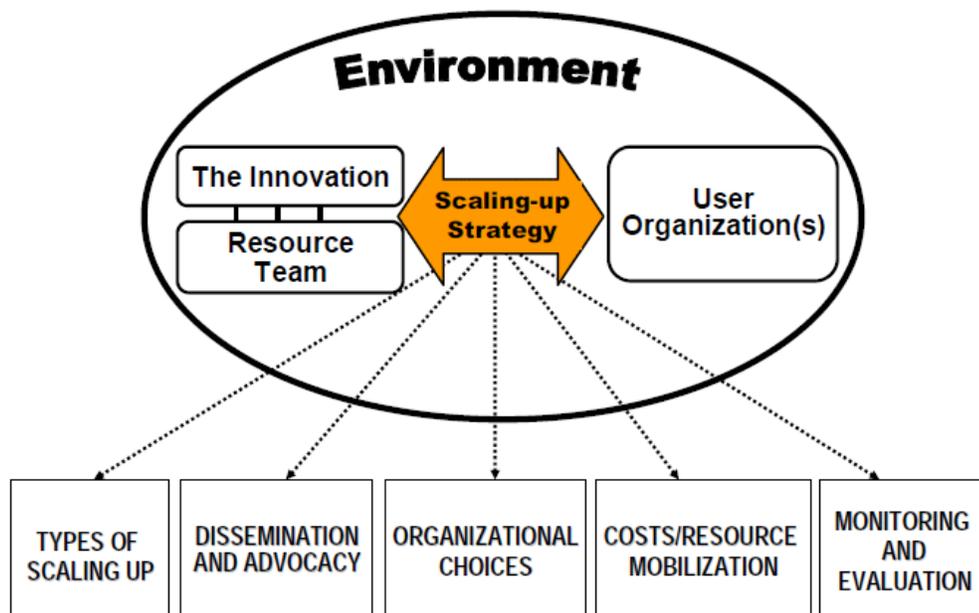
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Information about RFA and details on the review process were shared with all IDN partners through written communications, webinars, postings on the Region 1 website, and verbal communications.

There are important differences between the community selected projects and the core integration project and these differences impact the Region 1 implementation strategy. The core integration project is mandatory for general and behavioral health providers therefore the RFP process will be repeated rapidly in the first 12 months in order to accelerate the discovery of best practices and support implementation across all eligible providers. In contrast, the Care Transitions project is a relatively straightforward implementation of an evidence-based model which involves a subset of IDN partners and will not require as many RFP cycles on such a rapid timeline. Region 1 Executive Committee and administrative staff developed project timelines to optimize the discovery of best practices early in the DSRIP cycle and focus on implementation and sustainability in the last two years.

The goal of this iterative process is to develop a learning system; a system that is capable of using data across the continuum of care to continuously improve performance. Each funded RFP team agrees to collect and report data and to share their experiences so all members of the IDN can learn best practices. Funded project teams also agree to serve as mentors to other IDN partners, sharing details of their work, hosting site visits and participating in knowledge exchanges. Funding for project teams requires documentation that milestones have been met (*see Appendix C- Use of Funds Section*). Region 1 is committed to creating a sustainable system of learning capable of continuous improvement in the years to come.

**Figure 1: The ExpandNet Framework for Scaling-up**



WHO Nine Steps for Developing a Scaling Up Strategy

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

The Executive Committee completed the first RFP round in July 2017. In this round the Executive Committee reviewed the RFA Independent Review Panel’s assessment of all RFA submissions. The Executive Committee deliberated on the Independent Review Panel’s recommendations regarding which projects to fund in this round. The Executive Committee also upheld its fiduciary role and reviewed the proposed budgets to determine wave 1 award amounts in light of the overall IDN-1 budget.

The proposals considered in wave 1 are listed in the following table along with the approval decision of the Executive Committee.

RFP Proposals Received in Round 1 RFP

| Project Category | Organizational Applicants | Approved for Round 1 Funding |
|------------------|---------------------------|------------------------------|
| B1               | [REDACTED]                | Yes                          |
| C1/E5            | [REDACTED]                | Yes                          |
| D3               | [REDACTED]                | Yes                          |
|                  | [REDACTED]                | Not approved at this time    |
| E5               | [REDACTED]                | Yes                          |
|                  | [REDACTED]                | Not approved at this time    |
|                  | [REDACTED]                | Not approved at this time    |

### DH/WCBH Pilot-Wave 1

#### Overview

Dartmouth-Hitchcock primary care and Dartmouth-Hitchcock Psychiatric Department/Associates (DH) and West Central Behavioral Health (WCBH) partnered together to submit an RFP for a B1 project to improve integration of care between the two organizations through greater collaboration and integration. DH provides the full complement of primary care services (family medicine, pediatrics, and internal medicine) at the Heater Road Clinic and has a long history of embedded behavioral health providers co-located at that site and working collaboratively to serve patients. West Central Behavioral Health is a community-based, mental health organization providing a full continuum of behavioral health care including outpatient, emergency, case-management and residential services. WCBH is an affiliate of the Department of Psychiatry at DH.

DH/WCBH submitted a RFP which was evaluated and vetted through the established Region 1 RFP process. The Executive Committee endorsed the project and budget for this initial B1 pilot.

Working together, West Central Behavioral Health (WCBH) and Dartmouth-Hitchcock (DH) will launch the first B1 project in the Region 1 IDN. Targeted to advance patient centered care through an improved care

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

process of collaboration between the two organizations while advancing integration within their respective practice sites. WCBH and DH are the two largest providers of medical and mental health services in the Region 1 IDN north area, yet the two organizations have many opportunities to improve care coordination in a way that may address the needs of the Medicaid population with Behavioral Health needs.

To achieve improvements in the integration of behavioral and primary care, WCBH and DHMC will:

- Finalize and implement data-gathering tools and processes sufficient to create a Comprehensive Core Standardized Assessment (CCSA) which will include the required screening for behavioral health conditions and social determinants of health (SDOH);
- Use the CCSA to identify patients with, or at risk for, significant or chronic behavior health conditions and/or unmet social needs in core defined areas (as outlined in Attachment D) of the DSRIP planning protocol;
- Create a Shared Care Plan (SCP) and implement processes to securely share plans across both organizations;
- Establish a Multidisciplinary Team (MDT) that will meet monthly and include personnel from both organizations (WCBH and DH) as well as appropriate community partners;
- Develop a new member of the care team, the Medicaid Care Team Coordinator (CTC). This role is essential to the function of the MDT and will be responsible for running effective and efficient monthly case conference reviews. The Medicaid Care Team Coordinator (CTC) job will be defined collaboratively by DH and WCBH teams and processes/workflows established so this role serves as the inter-organization liaison for patients and their care teams.
- Create a culture of collaboration, integration, continuing learning, innovation and process improvement on behalf of the Medicaid patients in our area.

Together DH and WCBH will work to develop an inter-organizational team (DH/WCBH) and design processes that are patient-centered, improve health outcomes, improve patient access, improve the use of existing resources, and increase both patient and provider satisfaction. WCBH and DH will also work together to ensure that the new team and processes are sustainable and scalable. WCBH and DH have a long track record of collaboration. In this project, leadership from Dartmouth-Hitchcock's Department of Population Health Management, Primary Care-Lebanon (Family Medicine, General Internal Medicine and Pediatrics at DH), Department of Psychiatry along with the President and CEO of WCBH have attested to their support for the project. This support includes implementing appropriate screening processes and sharing this information to create a CCSA and SCP, co-recruiting, hiring, training and supervising a high-quality candidate for the CTC position, and supporting and organizing the MDT. It has been agreed that DH will directly hire and employ the CTC with input into the hiring process from WCBH staff and leadership. Supervision for the CTC will be provided by the appropriate clinical staff person as assigned by the clinical service line leader of DH's Department of Psychiatry. Physical office space and computer hardware will be provided at Dartmouth-Hitchcock Medical Center (DHMC).

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### Practice Improvement Resources:

To optimize success, Region 1 has contracted quality improvement coaches to provide at-the-elbow support for all B1 teams, beginning with the DH/WCBH wave 1 team. The coaches are experienced in implementation of integrated care processes. Coaches will help care teams understand their current processes and patterns of care and provide disciplined process improvement steps to achieve goals.

A B1 DH/WCBH project team will be chartered. Working with the QI coach, the team will complete a current state assessment and identify root causes for gaps in the current care model as compared to the coordinated care model defined by the DSRIP STC. There will be an initial series of approximately three one hour training sessions which will include representatives from each organization, the QI coach, and the CTC. The goals of these sessions are to:

- Learn the tools and process for gathering the information required in the CCSA.
- Learn the tools and process for constructing, updating and managing the SCP.
- Define the structure and function of the MDT.
- Explore and delineate the current cultural and systematic barriers to effective inter-organizational care coordination. Strategies will be developed to address these concerns.

The DH/WCBH project team will meet quarterly during the first year to review data, assess progress, and determine the need for programmatic changes.

### Evidence and Theory for B1 DH/WCBH Intervention

Collaborative and integrated care research has consistently highlighted the following evidence based principles for successful integration

— Int J Integr Care

#### **Box 1.**

#### **Suggested core principles guiding people-centred and integrated health services**

- 1 *Comprehensive* - a commitment to universal health coverage to ensure care is comprehensive and tailored to the evolving health needs and aspirations of people and populations
- 2 *Equitable* - care that is accessible and available to all
- 3 *Sustainable* - care that is both efficient, effective and contributes to sustainable development
- 4 *Co-ordinated* - care that is integrated around people's needs and effectively coordinated across different providers and settings
- 5 *Continuous* - continuity of care and services that are provided across the life course
- 6 *Holistic* - a focus physical, socio-economic, mental, and emotional wellness
- 7 *Preventative* - tackles the social determinants of ill-health through intra- and inter-sectoral action that promote public health and health promotion
- 8 *Empowering* - supports people to manage and take responsibility for their own health
- 9 *Goal oriented* - in how people make health care decisions, assess outcomes and measure success
- 10 *Respectful* - to people's dignity, social circumstances and cultural sensitivities
- 11 *Collaborative* - care that supports relationship-building, team-based working and collaborative practice across primary, secondary, tertiary care and other sectors
- 12 *Co-produced* - through active partnerships with people and communities at an individual, organisational and policy-level
- 13 *Endowed with rights and responsibilities* - that all citizens should expect, exercise and respect
- 14 *Governed through shared accountability* - between care providers for quality of care and health outcomes to local people
- 15 *Evidence-informed* - such that policies and strategies are guided by the best available evidence and supported over time through the assessment of measurable objectives for improving quality and outcomes
- 16 *Led by whole-systems thinking*

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

This pilot and future B1 implementation will directly incorporate the principles of Co-ordinated care (#4), Holistic (#5), Preventative (#7), goal-oriented (#9), Respectful (#10), collaborative (#11), Co-produced (#12), Evidence-informed (#15) and led by whole –system thinking with close cooperation between two of the largest medical and mental health providers in the IDN-1 North sub-region. This collaboration is also aligned with the recommendations of the AHA and AMA described in the links below.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3653278/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251472/>

<http://www.aha.org/content/15/ahaamaintegrleadership.pdf>

### DH/WCBH B1 Implementation Priorities:

Three primary areas for change have been identified:

- Comprehensive screening and creation of the Comprehensive Core Standardized Assessment (CSSA);
- Development and sharing of the Shared Care Plan (SCP);
- Implementation of the Multi-Disciplinary Care Team (MDT).

### Screening and creation of the Comprehensive Core Standardized Assessment:

Analysis of the current state at DH and WCBH revealed each practice site uses standardized screening tools.

- WCBH currently uses the Daily Living Activities DLA-20 which measures areas of daily living impacted by mental health or disability. This assessment tool is given to youth and adults at all initial assessment and intake appointments and is updated quarterly and annually. The DLA-20 includes key areas of the SDOH as outlined in the DSRIP planning protocol.  
<https://www.thenationalcouncil.org/wp-content/uploads/2012/11/DLA-Sample.pdf>
- DH currently screens for depression using the PHQ2, followed by PHQ9 if screened positive. Currently, a multidisciplinary team at DH has reviewed additional screening questions and pilots are underway adding: GAD 2 (branching to GAD 7); AUDIT; and DAST 10. After the initial pilot is completed, these additional screening tools will be included as standard screenings in DH primary care clinics.

Currently at DH primary care, adults are screened at annual visits with a series of questions that cover many of the required elements in the DSRIP core standardized assessment (see Appendix D). Social determinants of health (SDoH) are not routinely gathered but a DH taskforce is currently developing an evidence-based SDoH screener to be used in primary care across DH which references the recently released CMS-approved Accountable Health Communities Screening Tool (screening questions and processes are currently in development).

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DHMC Pediatrics currently uses the following validated screening tools:

- ASQ at 9 months, 30 months, and 5 years
- MCHAT at 18 and 24 months
- Bright Futures at all pediatric preventive care visits
- DartScreen for patients 13 and older: The DartScreen originally based on the GAPS model has been modified based on recommendation from the Clinicians Enhancing Child Health Network. From this modification nine adolescent health domains were kept: nutrition, exercise, school, safety, reproductive health, drugs, alcohol, tobacco, and psychosocial (depression, anxiety, and mental health). Included within the DartScreen are the PHQ, GAD, and SBQ. Following a branching logic additional questions are prompted if the primary risk was present.

Current screening tools meet most of the requirements of the DSRIP STC coordinated care requirements but missing elements need to be incorporated in all assessments. One of the initial tasks of the B1 pilot team will be to harmonize these different screening tools used at DH and WCBH and ensure that all elements are collected. The DH/WCBH team will need to compare tools and scoring rubrics so information/scoring is consistent across the organizations.

DH/WCBH team will be supported by our Region 1 IT director and Data/IT workgroup to create workflows and processes to ensure compliance with all privacy laws. Information from assessments and care will inform the shared care plan (SCP) which will be developed by the Region 1 Data/IT workgroup with clinical input from DH/WCBH B1 project team. The Care Team Coordinator (CTC) will be responsible for assuring the SCP is populated and this tool will be a critical resource for this role.

### Shared Care Plans:

This project will utilize the shared care plan (SCP) tool developed by the IDN-1 IT workgroup. The Shared Care Plan tool will support the multi-disciplinary core team to develop, capture, access, and periodically update a plan of care for Medicaid members. See the Region 1 A2 Implementation plan section for additional information.

### Multidisciplinary care team:

Development of a multidisciplinary core team (MDT) is a core component of the integrated healthcare project.

The DSRIP-funded Care Team Coordinator (CTC) is a new role to be developed as part of this B1 project. The CTC will provide coordination between the other team members on the MDT and assist in connecting patients to external community-based service organizations for referrals. This new role will be an important change agent; educating teams from each organization and creating the cultural change that promotes integration and collaboration (*see CTC job description in Appendix E*).

DH and WCBH will create an inter-organizational MDT led by a CTC. The CTC will ensure that a CCSA and SCP are completed on Medicaid members and will coordinate the monthly core team meetings on behalf of the identified sub-population with significant unmet medical, mental and/or social needs (DH/WCBH

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will refine the definition of “significant unmet needs”). The CTC will provide follow-up contacts with the MDT partners between monthly MDT meetings to ensure that steps in the plan are being carried out. The CTC will also assist in identifying patient, provider and system barriers to the care plan and bring these to the MDT for consideration and resolution where possible.

### Engaging Community Supports:

The CTC will make referrals to community organizations to meet SDOH needs. The B1 Pilot will rely heavily on their community partner network to support and facilitate the SDOH referrals and treatments identified in the CCSA and shared through the SCP. As the pilot works through initial implementation steps and training, the following partner organizations will be engaged at a level that makes sense to address the SDOH needs of the Medicaid population being served by the MDT. The CTC will be the point person for closed loop referrals to community supports. Details of the workflow processes are provided in sections B1-8h and B1-9D. Supporting technology is described in section A2.

| COMMUNITY PARTNERS IN THE IDN1 NORTH REGION        | SERVICE AREAS   |
|--|---|
| CHILD AND FAMILY SERVICES                          | Counseling, education, parenting guidance                             |
| NAMI   | Mental health support, advocacy                                       |
| TWIN PINES HOUSING TRUST                           | Housing   |
| TRI-COMMUNITY ACTION PROGRAM (CAP)                 | Housing, social service   |
| CITY OF LEBANON HUMAN SERVICES DEPARTMENT          | Emergency Funding (food, transportation, energy)                      |
| NH DHHS  | Insurance, financial support, disability services                     |
| SERVICE LINK                                       | Disabled and Elderly information, referral, medication assistance.    |
| NH VOCATIONAL REHABILITATION                       | Education and   |
| HEADREST   | IOP, SUD counseling, low-level residential care (transitional living) |
| WISE OF THE UPPER VALLEY                           | Prevention, education and advocacy for gender-based violence          |
| NH LEGAL SERVICES                                  | Legal services and support  |
| GRAFTON COUNTY MENTAL HEALTH COURT (HALLS OF HOPE) | Education, Recovery and Treatment                                     |
| STAGECOACH (MEDICAID)                              | Transportation  |

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|  |   |
|--|---|
| <b>LISTEN COMMUNITY SERVICES</b>               | Food Pantry, Housing Helpers, Heating Helpers, Financial counseling |
| <b>AA/NA</b>                                   | Addiction support and recovery services                             |
| <b>HABIT OPCO</b>                              | Outpatient Medication Assisted Treatment, including methadone       |
| <b>GROUPS, INC (FORMERLY RECOVER TOGETHER)</b> | Outpatient Medication Assisted Treatment                            |
| <b>ROAD TO A BETTER LIFE</b>                   | Outpatient Medication Assisted Treatment                            |

### Coordinating Care for Hospitalized/Institutionalized Patients:

The CTC will be responsible for coordinating with the care providers associated with an acute hospitalization or institutionalization event. Due to overlap in projects, this means the CTC will coordinate with Partners involved in community projects. For example, when a Medicaid beneficiary is seen in the ED, or admitted and discharged from inpatient medical, surgical or psychiatric services at DHMC, the CTC will coordinate with Inpatient Discharge Planners, Care Transition Case Workers, Community Mental Health Case Managers, Peer Recovery Support Workers, and any other identified team members, to ensure a safe and seamless transition back to the multi-disciplinary core team. This will include update of the member's treatment plans, reconciliation of medications and treatment protocols, and updates to the shared care plan.

### Learning Dissemination and Scalability:

An indicator of success is beginning to shift the culture toward a fully functional, effective and rewarding inter- and intra- organizational team and patient care experience. To achieve this goal, it is essential to provide comprehensive team training and an ongoing process to support team ownership of the project and process. Scheduled Knowledge Exchanges will be hosted on a monthly basis to facilitate Region 1 learning across the IDN. The DH/WCBH team will have an important role supporting early Knowledge Exchanges in the IDN as they are the first B1 project team to begin work in Region 1. Patients and families will also be educated and engaged in this team process. The DH/WCBH team will start by developing brief, patient-centered education materials to introduce patients to the screening process, information sharing, MDT structure, function and purpose. We will incorporate direct patient feedback through the CTC and other team members to inform improvement processes.

The capacity for integration and collaboration to be fully sustainable and scalable will depend heavily on the state's future steps in developing alternative payment models for this type of well-organized integrated care. The risk-sharing, accurate metrics for high quality care and the reinvestment of saved funds will be essential. This work is ongoing at the state level, and, as this program pilot develops, we will better be able to partner with the state in developing these markers of quality care and reimbursement for effective coordinated/integrated care. We will also be able to determine more accurate caseload estimates through real-world experience which will allow us to more accurately predict scalable needs for such programming.

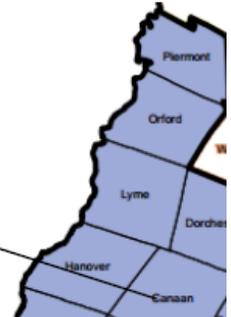
## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

### Population Estimates for the B1 DH/WCBH Intervention:

Recent Data from the IDN-1 Data book May 31, 2017 reports the following beneficiary numbers for the sub-region of the IDN the proposed program and CTC position would serve.

#### **IDN-1 North**

- **3,636 Members (13% of IDN-1)**
- **1,196 members with BH indication (14% IDN-1)**



There are two primary sub-divisions of the Medicaid beneficiary population in the IDN1 North sub-region. The first is all Medicaid beneficiaries ages >12 with identified behavioral health conditions. It is estimated that the total number of Medicaid beneficiaries in IDN-1 North is 3,636, of which 1,196 have an identified behavioral health condition. For all members in this sub-population, who seek or receive care at either WCBH Lebanon or DH Primary Care-Lebanon, an individual SCP, informed by the screening tools and CCSA and overseen by the CTC, will be created and updated at least annually. The SCP will reside in an electronic platform, currently in development by our HIT Workgroup.

The second sub-population is comprised of those beneficiaries with a ‘significant’ behavioral health condition, who seek or receive care at either WCBH Lebanon or DH Primary Care- Lebanon. “Significant”, for the purposes of this proposal is defined as “any Medicaid beneficiary who has a chronic mental health condition and/or has been recently hospitalized for medical or psychiatric care, evaluated in an emergency room for a mental health or substance use issue, or who through the behavioral health screening processes are judged to have ‘moderate to severe’ mental health or substance use symptoms or use.” For this sub-population, each beneficiary’s care will be reviewed, and the SCP updated, in a monthly MDT meeting. Combined, these two sub-groups represent 4.3% of the Medicaid population in IDN 1. The requested funding will primarily be focused on providing the staffing and resources necessary to support the creation and implementation of a CCSA and SCP for each of these beneficiaries. For both populations, a patient and family-centered approach will be taken. Patients and designated family members will have access to the SCP as developed and updated by the MDT. The CTC will solicit their input and address their concerns with the MDT, and, together, all parties will strive to achieve the optimal plan for the patient. As evidence shows the involvement of the patient and their family in care decisions and goal setting is incredibly important in seeing long term shifts especially, for those with highest acuity needs. We do not yet know how many of the 1,196 members with a BH indication may be in need of monthly MDT case conferences, yet, from these numbers we would assume that funding to support one, (1.0) FTE CTC would likely be adequate to meet this need.

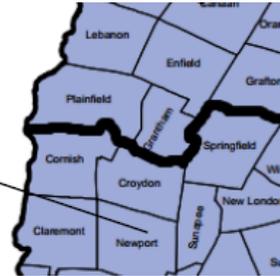
Based on the experiences and lessons learned in this pilot, the role could then be expanded to other IDN sub-regions where these two same institutions have other clinical enterprises, such as in Claremont,

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Newport and New London, where even a larger percentage of the Medicaid population receives services (IDN-1 Central sub-region).

### **IDN-1 Central**

- **8,347 Members (30% of IDN-1)**
- **2,805 members with BH indication (32% IDN-1)**



Details of an expansion including proposed funding are not included in this proposal. It is anticipated that the knowledge gained from this pilot would help inform a subsequent request in another wave of the RFP process outlined by IDN-1 and be shared across IDN B1 partners looking to frame their own implementation work.

This project will rely heavily on the support and resources from the HIT and Workforce work groups for:

- Assistance with implementation of the CCSA, including the collection and communication of data on SDOH
- Assistance with implementation of the SCP
- Training to meet the requirements for educating core team members of the MDT about key chronic medical conditions, behavioral health conditions and substance use disorders.

### Budget:

For the DH/WCBH Pilot: the majority of the cost is salary and benefits for the new essential role of the Medicaid – CTC. Other associated costs cover space rental, onetime computer costs, support for ongoing supervision, estimated travel, training as well as some funding to support the time required for the MDT representatives or each partner organization (WCBH and DHMC) to allow staff to participate in the monthly case review meetings. The budget and funding for the salary (1.0 FTE) and benefits of the CTC as well as costs to offset rental of physical space, provide computer access and support as well as funding to support some fraction of time for the members of the MDT are included in the budget. See the Budget Table in B1-5 for details on the pilot award.

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

*\*Please see Appendix G for Evaluation table and H for Evaluation framework*

Region 1 IDN leaders will monitor the implementation of the B1 projects across all eligible providers. The DSRIP performance metrics will provide information on the effectiveness of the project. The metrics below will be used to evaluate the Region 1 progress with implementation of core project components.

|  | Target | Progress Toward Target |
|--|--------|------------------------|
|--|--------|------------------------|

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| Performance Measure Name   |    | As of 12/31/17 | As of 6/30/18 | As of 12/31/18 |
|--|----|----------------|---------------|----------------|
| # Organizations Assessing Medicaid Members with the CCSA               | 21 |                |               |                |
| # Organizations Contributing to and/or accessing Shared Care Plan      | 21 |                |               |                |
| # Organizations Initiating Referrals to Supports                       | 21 |                |               |                |
| # Organizations Receiving Referrals to Supports                        | 10 |                |               |                |
| # of Organizations meeting requirements of "Coordinated Care Practice" | 21 |                |               |                |
| # of Organizations meeting requirements of "Integrated Care Practice"  | 4  |                |               |                |



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Per the Region 1 process for launching cohorts of practices in waves, IDN staff and the B1 project team staff anticipate some variance to the staffing projections in the table above. Currently, we are estimating that all of the Primary Care practices in Region 1 engaged in the B1 project will be the employer for the Medicaid CTC hired to support the Multi-Disciplinary Care Team. Given this current working logic we anticipate that practices will mirror the implementation planning set forth by the Dartmouth Hitchcock and West Central Behavioral Health collaborative pilot. The model currently being undertaken by the pilot team will have DH Primary Care hire and provide supervision for the CTC and then use that co-located staff member to support the MDT team including running the monthly case management meetings and making the external referrals to community based supports. This model would allow WCBH (and potentially external community based services) to reallocate current staff FTE as the CTC handles referrals and care coordination tasks. Following this logic, we have listed that staffing for the BH and other supportive services partners on the B1 list is a reallocation expense. Some areas of variance to this logic we feel are likely:

- If a bidirectional colocation for integration (BH into PC and limited PC services available in BH) there will be a higher need for new staff to support the pilot at both sites;
- In the instance of multi-practice implementation within a Wave through one PC organization. We would anticipate a need for at least 1 CTC FTE for each 2 to 3 practice teams depending on the patient volume. A data driven measurement process is being evaluated by the IDN team to guide this decision making and will be informed by the early B1 pilots;
- Region 1 IDN has received a commitment of support from 6 [REDACTED] from fall 2017 through fall 2018. The placement of these CMHW's has not been finalized but we anticipate that there will be some support of the B1 pilots.

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### B1-5 IDN Integrated Healthcare: Currently Approved Budget

The following budget is for the first year of the B1 wave 1 project between Dartmouth Hitchcock and West Central Behavioral Health. Note that the B1 budget will be updated periodically with the other B1 projects as they are proposed through the RFA process and approved/funded through the Executive Committee selection process.

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

|              |                    |                    |               |               |                     |
|--------------|--------------------|--------------------|---------------|---------------|---------------------|
| [REDACTED]   |                    |                    |               |               |                     |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| <b>Total</b> | <b>\$64,817.00</b> | <b>\$64,317.00</b> | <b>\$0.00</b> | <b>\$0.00</b> | <b>\$129,134.00</b> |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |
| [REDACTED]   | [REDACTED]         | [REDACTED]         | [REDACTED]    | [REDACTED]    | [REDACTED]          |



B1-6. Integrated Healthcare: Organization Commitment

| Organization/Provider | Agreement Executed (Y/N) |
|-----------------------|--------------------------|
| [REDACTED]            | Y                        |
| [REDACTED]            | In Process               |
| [REDACTED]            | Y                        |

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

| Name       | Title      | Organization   | Sign Off Received (Y/N) |
|------------|------------|--|-------------------------|
| [REDACTED] | [REDACTED] | Dartmouth Hitchcock Clinic -Lebanon                            | Y                       |
| [REDACTED] | [REDACTED] | Dartmouth Hitchcock Psychiatric Associates                     | Y                       |
| [REDACTED] | [REDACTED] | West Central Behavioral Health                                 | Y                       |
| [REDACTED] | [REDACTED] | Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care | Y                       |
| [REDACTED] | [REDACTED] | Monadnock Family Services                                      | Y                       |
| [REDACTED] | [REDACTED] | Alice Peck Day Primary Care                                    | Y                       |
| [REDACTED] | [REDACTED] | Monadnock Hospital and Primary Care                            | Y                       |
| [REDACTED] | [REDACTED] | New London Hospital and Medical Group Practice                 | Y                       |
|            |            | New London Pediatric Care                                      | Y                       |
|            |            | Newport Health Center Practice                                 | Y                       |
| [REDACTED] | [REDACTED] | Valley Family Physicians                                       | Y                       |
|            |            | Valley Regional Hospital                                       | Y                       |
| [REDACTED] | [REDACTED] | Planned Parenthood of Northern New England-Keene               | Y                       |
|            |            | Planned Parenthood of Northern New England- Claremont          | Y                       |

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

### B1-8a. CCSA Utilization Table

Please note that due to the waved implementation and launch structure of the B1 project pilots in Region 1 the IDN team will not begin to collect and report on data speaking to CCSA utilization until the pilot projects supported by a specific provider have formally launched. With this the table below shows the projections for CCSA utilization based upon the B1 wave launch table which can be found in *B1: Appendix A*.

Additionally, the Region 1 IDN team through ongoing provider meetings and listening tours with partners know that many domain areas are currently being captured by the B1 organizations but as no formal data will be collected on their full utilization of the CCSA questions until launch this informal information has not been included in the table at this time.

All fields on the table with no “Y or N” shown are fields where data is not currently in collection and the color corresponds to their proposed wave for implementation launch which speaks to the projected date of utilization of the CCSA.

See Table Below:



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### B1-8a. Pediatric Providers CCSA Utilization

Please note that due to the waved implementation and launch structure of the B1 project pilots in Region 1 the IDN team will not begin to collect and report on data speaking to Pediatric CCSA utilization until the pilot projects supported by a specific pediatric practice have formally launched. With this the table below shows the projections for Pediatric CCSA utilization based upon the B1 wave launch table which can be found in *B1: Appendix A*.

Additionally, the Region 1 IDN team through ongoing provider meetings and listening tours with partners know that many domain areas are currently being captured by the B1 organizations but as no formal data will be collected on their full utilization of the Pediatric CCSA questions until launch this informal information has not been included in the table at this time.

All fields on the table with “Y or N” shown are fields where data is not currently in collection and the color corresponds to their proposed wave for implementation launch which speaks to the projected date of utilization of the Pediatric CCSA.

See Table Below:

| Utilization July 1, 2017-December 31, 2017  |   |
|---|---|
| Validated Universal Screening: ASQ:3, and /or ASQ SE at 9, 18, 24/30 month pediatric visits | Developmental Screening using bright futures or other American Academy of Pediatrics recognized development tools |
| Providers   |   |
| [REDACTED]  | Anticipated utilization after launch- projected not later than May 2018   |
| [REDACTED]  | Anticipated utilization after launch- projected not later than May 2018   |
| [REDACTED]  | Anticipated utilization after launch- projected not later than October 2017                                       |
| [REDACTED]  | Anticipated utilization after launch- projected not later than September 2018                                     |

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|            |   |   |
|------------|---|---|
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Y   | Y |
| [REDACTED] | Y   | Y |
| [REDACTED] | Anticipated utilization after launch- projected not later than September 2018 |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than May 2018       |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than October 2017   |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than October 2017   |   |
| [REDACTED] | Anticipated utilization after launch- projected not later than October 2017   |   |

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|            |   |   |
|------------|---|---|
| ██████████ | Anticipated utilization after launch- projected not later than September 2018 |   |
| ██████████ | Anticipated utilization after launch- projected not later than May 2018       |   |
| ██████████ | Anticipated utilization after launch- projected not later than May 2018       |   |
| ██████████ | Y   | Y |

IDN-1 through the ongoing work with ██████████ and across the B1 project team meetings has many ongoing efforts to identify and support the completion of a gaps assessment for all required B1 providers.

IDN-1 anticipates that not later than January, 2018 a comprehensive gap analysis will have been completed for the domain need areas across the adult and pediatric CCSA domain fields. To meet this deadline for completion IDN-1 will:

- IDN-1 Medical Director ██████████, will continue to schedule and meet one on one with the B1 required practices assessing their current state of readiness for implementation and addressing the project core components with staff
- Host Knowledge Exchange sessions to support information sharing and case examples of active B1 implementation pilots
- Continued participation in the Social Determinants of Health Workgroup meeting across the ██████████ service line to design and implement an SDoH questionnaire that will cover the required domain areas within the CCSA framework.
  - Use of this tool will be optional for IDN-1 partners that are able to demonstrate current successful measurement of the domain areas through current processes
- Follow up with non-confirmed B1 organizations with a Letter of Intent to participate that will ask questions geared at assessing readiness, perceived gaps and a projected implementation timeline

Additionally, as B1 practices commence their pilots the IDN-1 team will group practices by their implementation Wave and offer data collection support and training. IDN-1 feels strongly about a cultivating a culture of data transparency through ongoing support and sharing across implementation pilots.

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

Please note that the Region 1 IDN team, quality improvement coaches, and practice teams will work closely together in preparation for launch in the B1 project waves. A large component of this pre-development and readiness work is assessing the current practice processes and workflows and determining which roles within each individual practice will be the best supports for the MDT. The Region 1 IDN feels strongly that to allow adequate time and consideration for internal practice dynamics, organization culture and current partnerships the MDT core team roles can be suggested but that the final decision should be tailored to the practice at time of implementation. Please note that for all B1 projects the role of the Behavioral Health Staff will be supported directly by a psychiatrist. With this the table below is representative of the Region 1 IDN and project team's suggestions for MDT roles but there may be some change to these as practices formally launch in B1. Please see section B1-1. For the B1 Project Team Scope of Work and *B1: Appendix E* for the Medicaid CTC Job Description for further description of the project teams MDCT conceptualization and the CTC role.

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|                  | <b>Multi-Disciplinary Core Team Members</b> |                                     |                                |
|------------------|---|-------------------------------------|--------------------------------|
| <b>Providers</b> | <i>Primary Care Staff Role</i>              | <i>Behavioral Health Staff Role</i> | <i>Case Manager Staff Role</i> |
|                  |   |                                     |                                |

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### B1-8c. Required Training

\* See *B1: Appendix I* for Training and Workflows currently supported by Region 1 IDN partners on the topics listed below.

Please note for all B1 projects all staff involved in the pilot implementation will receive training on the following areas. As many organizations have yet to launch their B1 work the exact number of staff this will include is unknown. For the currently funded projects we estimate at minimum training will be provided to 7 PC staff and 4 BH staff. Additionally, IDN-1 will be sharing the required training areas through recorded presentation to all IDN partners and plan to add 15 min of required knowledge training to the start of every monthly Knowledge Exchange session which will feature participants from across the IDN project areas.

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|  | Training Required                         |            |                 |            |                 |            |                                 |          |                       |            |
|--|---|------------|-----------------|------------|-----------------|------------|---------------------------------|----------|-----------------------|------------|
|  | Diabetes Hyperglycemia                    |            | Dyslipidemia    |            | Hypertension    |            | Mental Health Topics (Multiple) |          | SUD Topics (Multiple) |            |
| Providers  | PC Staff                                  | BH Staff   | PC Staff        | BH Staff   | PC Staff        | BH Staff   | PC Staff                        | BH Staff | PC Staff              | BH Staff   |
| <b>Dartmouth Hitchcock Clinic -Lebanon, Dartmouth Hitchcock Psychiatric Associates, West Central Behavioral Health</b> |   |            |                 |            |                 |            |                                 |          |                       |            |
| <i>Heater Rd Practice Team 1</i>   | Attained                                  | In Process | Attained        | In Process | Attained        | In Process | Attained                        | Attained | Attained              | In Process |
| <i>Heater Rd Practice Team 2</i>   | Attained                                  | In Process | Attained        | In Process | Attained        | In Process | Attained                        | Attained | Attained              | In Process |
| <b>Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services</b>                       |   |            |                 |            |                 |            |                                 |          |                       |            |
| <i>Practice Team 1</i>   | Attained                                  | In Process | Attained        | In Process | Attained        | In Process | Attained                        | Attained | Attained              | In Process |
| <i>Practice Team 2</i>   | Attained                                  | In Process | Attained        | In Process | Attained        | In Process | Attained                        | Attained | Attained              | In Process |
| <b>Alice Peck Day Primary Care</b>   | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>Monadnock Hopsital</b>  | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>New London Hospital and Medical Group</b>   | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>New London Pediatric Care</b>   | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>Newport Health Center Practice</b>  | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>Valley Family Physicians</b>  | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>Valley Regional Hospital</b>  | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>Child and Family Services</b>   | <i>Completion not later than 12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i>                 |          | <i>12/31/17</i>       |            |
| <b>Southwestern Community Services</b>   | <i>Completion not later than 12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i>                 |          | <i>12/31/17</i>       |            |
| <b>Crotched Mountain Community Care</b>  | <i>Completion not later than 9/01/18</i>  |            | <i>9/01/18</i>  |            | <i>9/01/18</i>  |            | <i>9/01/18</i>                  |          | <i>9/01/18</i>        |            |
| <b>MAPS</b>  | <i>Completion not later than 9/01/18</i>  |            | <i>9/01/18</i>  |            | <i>9/01/18</i>  |            | <i>9/01/18</i>                  |          | <i>9/01/18</i>        |            |
| <b>Mindful Balance Therapy Center</b>  | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>Phoenix House</b>   | <i>Completion not later than 5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>  |            | <i>5/31/18</i>                  |          | <i>5/31/18</i>        |            |
| <b>TLC Family Resource Center</b>  | <i>Completion not later than 9/01/18</i>  |            | <i>9/01/18</i>  |            | <i>9/01/18</i>  |            | <i>9/01/18</i>                  |          | <i>9/01/18</i>        |            |
| <b>PPNNE Keene</b>   | <i>Completion not later than 12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i>                 |          | <i>12/31/17</i>       |            |
| <b>PPNNE Claremont</b>   | <i>Completion not later than 12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i> |            | <i>12/31/17</i>                 |          | <i>12/31/17</i>       |            |

Please note that due to the waved implementation process being followed by the Region 1 IDN there will be written and/or recorded trainings for cohorts on each of the required training domain areas:

- Diabetes Hyperglycemia
- Dyslipidemia
- Hypertension
- Mental Health Topics (Multiple)

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- SUD Topics (Multiple)

The Region 1 team has worked with IDN partners to leverage all the current trainings in use across these domains and will tailor information from these sources into 15-30 minute trainings for B1 providers and staff to access. The Region 1 team will require that all providers implementing within a wave must demonstrate all applicable staff complete training through self-reporting of each training domain not later than the end of the wave (Wave 1: 12/31/17, Wave 2: 5/31/18, Wave 3: 9/30/18).

Additionally, the Region 1 team will allow for substituted trainings covering the domain area information that have been completed within the last year by any applicable staff member across any provider to serve as a mark for completion in one of the domain areas. The IDN will ask for the same self-reported attestation of completion for any substituted trainings.

In the instance that a provider expresses interest in expanded training or additional information across any of the domain areas the Region 1 IDN team will facilitate the noted provider staff gain access to more robust training in the field area either online or in-person.

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### B1-8d. Mental Health Training Schedule

|   |   | Mental Health First Aid Training Schedule to Include all Billing, Reception Staff at all Region 1 B1 Provider Sites |   |                                 |
|---|---|---|---|---------------------------------|
|   |   | July 1, 2017- December 31, 2017   | January 1, 2018-June 30, 2018             | July 1, 2018- December 31, 2018 |
| <b>Providers</b>  |   |   |   |                                 |
| Dartmouth Hitchcock Clinic -Lebanon, Dartmouth Hitchcock Psychiatric Associates, West Central Behavioral Health |   |   |   |                                 |
| <i>Heater Rd Practice Team 1</i>  | All applicable staff will have completed training by 12/31/17 |   |   |                                 |
| <i>Heater Rd Practice Team 2</i>  |   |   |   |                                 |
| Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services                       |   |   |   |                                 |
| <i>Practice Team 1</i>  | All applicable staff will have completed training by 12/31/17 |   |   |                                 |
| <i>Practice Team 2</i>  |   |   |   |                                 |
| Alice Peck Day Primary Care   | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| Monadnock Hospital  | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| New London Hospital and Medical Group Practice  | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| New London Pediatric Care   | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| Newport Health Center Practice  | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| Valley Family Physicians  | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| Valley Regional Hospital  | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| Child and Family Services   | <i>Completion not later than 12/31/17</i>                     | <i>Completion not later than 12/31/17</i>   | <i>Completion not later than 12/31/17</i> |                                 |
| Southwestern Community Services   | <i>Completion not later than 12/31/17</i>                     | <i>Completion not later than 12/31/17</i>   | <i>Completion not later than 12/31/17</i> |                                 |
| Crotched Mountain Community Care  | <i>Completion not later than 9/01/18</i>                      | <i>Completion not later than 9/01/18</i>  | <i>Completion not later than 9/01/18</i>  |                                 |
| MAPS  | <i>Completion not later than 9/01/18</i>                      | <i>Completion not later than 9/01/18</i>  | <i>Completion not later than 9/01/18</i>  |                                 |
| Mindful Balance Therapy Center  | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| Phoenix House   | <i>Completion not later than 5/31/18</i>                      | <i>Completion not later than 5/31/18</i>  | <i>Completion not later than 5/31/18</i>  |                                 |
| TLC Family Resource Center  | <i>Completion not later than 9/01/18</i>                      | <i>Completion not later than 9/01/18</i>  | <i>Completion not later than 9/01/18</i>  |                                 |
| PPNNE Keene   | <i>Completion not later than 12/31/17</i>                     | <i>Completion not later than 12/31/17</i>   | <i>Completion not later than 12/31/17</i> |                                 |
| PPNNE Claremont   | <i>Completion not later than 12/31/17</i>                     | <i>Completion not later than 12/31/17</i>   | <i>Completion not later than 12/31/17</i> |                                 |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

The Region 1 IDN staff in partnership with the Executive Committee and Project teams have decided that the most valuable application of Mental Health training for non-direct care staff would be targeted at all Billing and Reception staff across B1 organizations. At minimum IDN-1 will support required trainings across both of these staff positions. Due to current project phase the exact number of staff at each provider site is not yet known. If there is demonstrated need for expansion of positions to be trained the IDN will support additional trainings. Also, in the instance an IDN partner requests training across other staff areas the IDN will support this request. The Region 1 team plans to cover domain areas aligned with Mental Health First Aid training in a high level 30-45-minute web based training that will be recorded and disseminated to all applicable staff throughout the wave implementation process. The Region 1 team will require that all providers implementing within a wave must demonstrate all applicable staff completion through self –reporting of each training domain not later than the end of the wave (Wave 1: 12/31/17, Wave 2: 5/31/18, Wave 3: 9/30/18).

In the instance that a provider expresses interest in expanded training or additional information across any of the domain areas the Region 1 IDN team will facilitate the noted provider staff gain access to more robust training in the field area either online or in-person.

### B1-8e. Multi-Disciplinary Core Team Schedule

Please note that due to the current stage of project implementation there is no schedule for any provider that will be launching post- July 31, 2017.

On the table below all B1 organizations are coded by their projected wave launch date and those with a launch date post 12/31/18 are noted in gray as these providers would not have an MDCT (also referred to as MDT) schedule for July-Dec 2017.

As noted above these projections for provider launch are not firm and are subject to change. If there are applicable changes to the MDT schedule these will be noted and corrected on subsequent Semi-Annual Report submissions.

All B1 MDTs will meet the minimum requirements for monthly meetings. IDN-1 anticipates that many of the B1 teams will in fact meet more frequently than the monthly requirements in informal case conferencing and to address implementation barriers in project team meetings with the QI facilitators and IDN-1 Project Manager.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|  | July 1, 2017- December 31, 2017           |            |            | January 1, 2018-June 30, 2018 |            |            | July 1, 2018- December 31, 2018 |            |            |
|--|---|------------|------------|-------------------------------|------------|------------|---------------------------------|------------|------------|
| <b>Providers</b>   |   |            |            |                               |            |            |                                 |            |            |
| <b>Dartmouth Hitchcock Clinic -Lebanon, Dartmouth Hitchcock Psychiatric Associates, West Central Behavioral Health</b> |   |            |            |                               |            |            |                                 |            |            |
| Heater Rd Practice Team 1  | In Process                                | In Process | In Process | In Process                    | In Process | In Process | In Process                      | In Process | In Process |
| Heater Rd Practice Team 2  | In Process                                | In Process | In Process | In Process                    | In Process | In Process | In Process                      | In Process | In Process |
| <b>Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services</b>                       |   |            |            |                               |            |            |                                 |            |            |
| Practice Team 1  | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Practice Team 2  | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Alice Peck Day Primary Care  | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Monadnock Hospital   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Hospital and Medical Group Practice  | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| New London Pediatric Care  | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Newport Health Center Practice   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Valley Family Physicians   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Valley Regional Hospital   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Child and Family Services  |   |            |            |                               |            |            |                                 |            |            |
| Southwestern Community Services  |   |            |            |                               |            |            |                                 |            |            |
| Crotched Mountain Community Care   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| MAPS   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Mindful Balance Therapy Center   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| Phoenix House  | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| TLC Family Resource Center   | Not Applicable due to Project Launch Date |            |            |                               |            |            |                                 |            |            |
| PPNNE Keene  |   |            |            |                               |            |            |                                 |            |            |
| PPNNE Claremont  |   |            |            |                               |            |            |                                 |            |            |

# Integrated Delivery Network Region 1: Partnership for Integrated Care

## B1-8h. Documented Workflows and/or Protocols

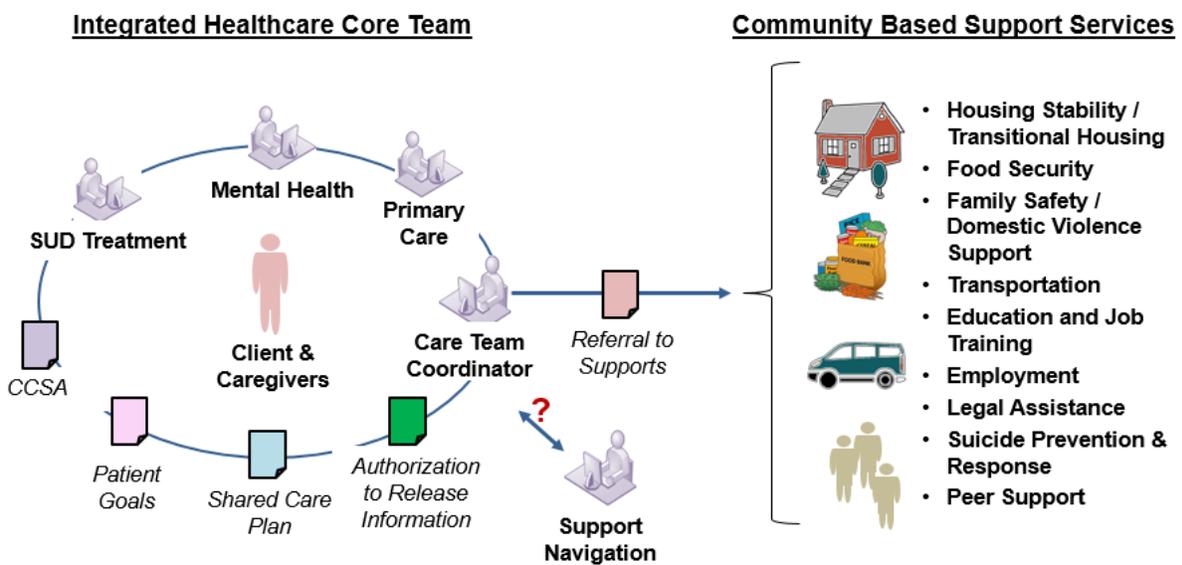
*\*Please see and Appendix J for Protocols and Workflows*

The following workflows and protocols have been supported by the Region 1 IDN team and will be shared with all B1 providers as potential operating pathways to follow. Our continued process will allow for some trial and flexibility with additional workflows or new protocols within a practice team if the case can be made for the potential benefit to the implementation processes.

### Interactions between providers and community based organizations

The Integrated Healthcare Core Team will use a formal closed-loop referral process to connect Medicaid Members with Community Based Organizations. The following protocol defines Population to be served, Support teams, communication process and supporting technology.

Figure 40: Integrated Care Delivery Model



### Population to be served:

NH Medicaid Beneficiaries with Behavioral Health Conditions or at risk for such conditions. Population is to be divided into three groups:

**High Needs Members:** Members that are high utilizers of area Emergency Departments and/or who have (or at risk of having) complex medical, behavioral health, and social determinants needs.

**Medium Needs Members:** Members that have Behavioral Health Conditions and who have (or at risk of having) moderately complex medical, behavioral health, and/or social determinants needs.

**Low Needs Members:** Members that have Behavioral Health Conditions and who have low complexity medical, behavioral health, and/or social determinants needs.

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The teams will focus on the high needs Medicaid Members as they transform care practice. Once new processes are established with this group they will be extended to the Medium Needs Members.

Note: These categorizations are to aid in prioritization – Members will likely move upward or downward in need over time

### Support Team

The Support Team is made up of the Medicaid Member and her/his Caregivers, an Integrated Healthcare Team, and Community Based Support Services:

Care is centered upon the Medicaid Member and her/his Caregivers

The Integrated Healthcare Core Team is comprised of representatives from a Medicaid Member’s Primary Care Provider, Mental Health Provider, Substance Use Disorder Provider (where applicable), and Care Team Coordinator.

The Community Based Support Services are comprised of organizations that can address a wide array of social determinants of health. These may include, but are not limited to, support services for:

- Housing Stability / Transitional Housing
- Food Security
- Family Safety / Domestic Violence Support
- Transportation
- Education and Job Training
- Employment
- Legal Assistance
- Suicide Prevention & Response
- Substance use treatment
- Peer Support

### Collaboration

The Integrated Delivery Team will follow the SAMHSA Six Levels of Collaboration framework and the corresponding definitions of Coordinated Care Practice and Integrated Care Practice from DHHS to guide intra-team communication. The organizations will baseline current level of collaboration with the Citizen’s Health Initiative assessment tool. With ongoing coaching from the [REDACTED], the Integrated Care Team will improve collaboration and communication over the waiver period.

Figure 41: SAMHSA Six Levels of Integration

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

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

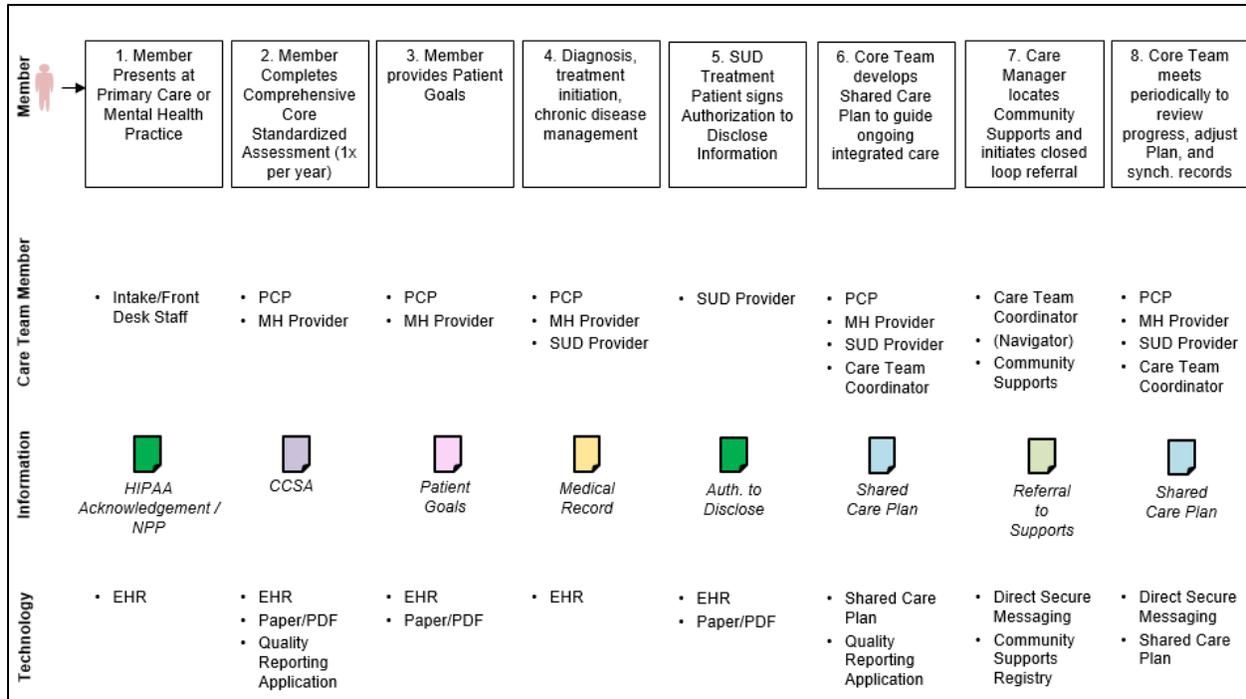
Source: Heath B, Wise Romero P, and Reynolds K. *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

### Integrated Care Team Process Flow

The Integrated Care Team will follow the process outlined below for interactions among the Integrated Core Team and with Community Supports Services organizations. This process flow diagram shows the Medicaid Member activities, the associated care team members supporting the Member, the information required at each step, and the technology supporting capture and exchange of the information. The same process applies whether in a primary care setting or a community mental health center. The Integrated Core Team will institutionalize this process flow in the first 6 months of the project rollout and will refine the process with learning and feedback.

Figure 42: Integrated Care Team Process Flow

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*



### Shared Care Plan

The Integrated Care Team will utilize a Shared Care Plan in conjunction with each organization’s electronic health record (EHR) to capture, share, and periodically update the following information:

- Care coordination instructions
- Patient Goals
- Shared Plan of Care informed by
- Patient Goals
- Results of Comprehensive Core Standardized Assessment
- Other relevant history from the Medicaid Member’s Medical Records

The Shared Care Plan is a novel concept and is not well supported nationally with standards or conventions. Therefore, the B1 project participants will develop an initial convention for the shared care plan in the first 6 months of the project and will continuously improve the convention thereafter. To avoid fragmentation and lack of standardization, the participants will develop the convention transparently and with support and input from the Data & IT Workgroup and with invitation to share with teams from the other IDNs.

### Closed Loop Referrals to Supports

The Integrated Care Team will interface with the Community Based Support Services organizations through a formal closed-loop referral process. The Care Team Coordinator will be the accountable member of the Integrated Care Team in all communications with the Community Based Support Services. Upon identification of a need for community support services by the Integrated Care Team, the Care Team Coordinator will begin the referral to supports process.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

Where the provider of supports is not known by the team, the Care Team Coordinator will work with Care Navigation resources to identify appropriate and available community supports. This may take the form of a care navigation organization such as ServiceLink or by using one of the care navigation data assets available in the region.

NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)

Refer Web - Servicelink Community Resource Directory (<http://www.referweb.net/nhsl/>)

NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)

NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)

2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance

Monadnock Regional Council for Community Transportation (<http://monadnockrcc.weebly.com/need-a-ride.html>) (other regions <https://www.nh.gov/dot/programs/scc/rcc.htm>)

The Care Team Coordinator will initiate a referral to the Community Based Support Service and send over pertinent information. This will be facilitated via secure [REDACTED]. Where EHRs are capable of initiating a referral over Direct, the EHR will be used. Where EHRs are incapable of initiating a referral, a Webmail will be used to send the referral to support. Community Support Services organizations will receive the referral to supports via a Direct Messaging Webmail inbox. As the process is being first implemented, the Care Team Coordinator will also follow up via phone to ensure that the Community Support Services organization is aware of the referral and is following up appropriately.

To complete the “closed loop” referral, the Community Based Support Service organization will acknowledge receipt of the referral, will inform the Care Team Coordinator of patient engagement with the services, and will provide updates periodically. The Care Team Coordinator will actively query Community Support Services Providers to follow up on “open” referrals.

### Timely communication

The Integrated Core Team will institute a framework for timely communication in the first 6 months of the project rollout and will refine actions and timing with learning and feedback. The initial framework for timely communication is as follows:

| Action   | Timing  |
|--|---|
| [REDACTED]   | Within 1 business days of integrated core team shared care meeting. |
| Initiate Referral to Supports (Care Team Coordinator)  | Within 2 business days of integrated core team shared care meeting. |
| Close the loop by acknowledging Referral of Supports (Community Support Services Organization) | Within 4 hours of message receipt                                   |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|  |  |
|--|--|
| For “open referrals” Close the loop by contacting the Community Support Services Organization to confirm referral receipt (e.g., by Phone, or SMS) | Within 1 business day of message send.   |
| For all referrals close the loop by Community Support Services Organization to confirm that Medicaid Member utilized services                      | Within 10 business days of message send. |

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

Patient privacy protection is required for all workflows implemented under the NH 1115 waiver. Much of the provision of care under the integrated model may be conducted with standard HIPAA policies, processes, and forms. A higher level of privacy protection is required for Medicaid Members engaging in Substance Use Disorder Treatment as dictated by federal 42 CFR part 2.

The Privacy framework is under development among the IDNs with support from the [REDACTED]. The privacy framework will be deployed in the fall of 2017 and will include the following components:

Updated Notice of Privacy Policies (NPP) document for each Partner organization – Which includes standard HIPAA language, organization privacy policy, and required language from the 42 CFR part 2 final rule

Patient acknowledgment of NPP provided at intake – process and form

Frameworks for identifying 42 CFR part 2 entities and for identifying when part 2 protections apply

Authorization to disclose protected information (consent) – process and form

Qualified Services Organization agreements among organizations as required

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

There are multiple case managers that may be involved in a Medicaid Member’s health management. These may include Payer/MCO case managers, IDN case managers, and healthcare organization case managers.

IDN-1 is seeking to benefit from the case management resources. This will require reducing confusion to Medicaid Members by supporting coordination with the various case managers. This will also require removal of duplicative roles and communication.

The Care Team Coordinator will be accountable for case manager coordination. She/he will determine the case management resources that are to be part of the integrated core team and the case managers that are to be kept informed of the shared care plan.

There is an open question to DHHS regarding the role of the MCO case managers in the NH 1115 waiver activity. Both the IDNs and the MCOs recognize the duplicative roles of their case managers, the potential

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

confusion to Medicaid Members, and the value in collaboration. We welcome guidance from DHHS on how to include the MCOs in the waiver.

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

IDN-1 will implement workflows to facilitate safe transitions from institutional settings back to primary care, behavioral health, and social support service providers. The most important information to accompany the patient is:

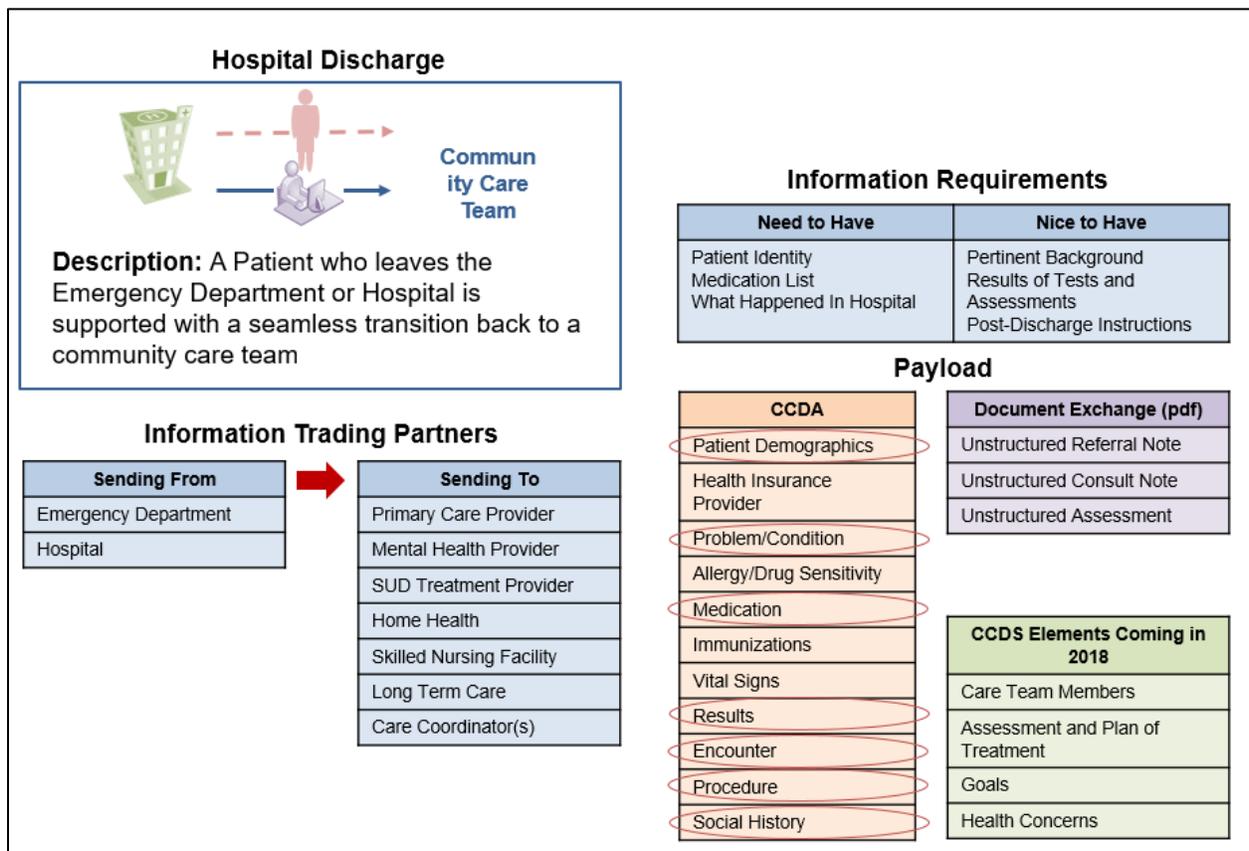
Current medication list – to enable medication reconciliation among all post-acute care providers and to prevent medication based adverse events.

Recent history of what happened during the hospitalization, any new problems discovered, any procedures undergone, and any new history discovered.

Instructions for who is to do what in a post-discharge hand-off between healthcare teams.

IDN-1 will use the following workflow for institutional transitions. The underlying technology is explained in project A2.

Figure 43: Institutional/Hospital Discharge Workflows



IDN-1 projects to have met all standardization requirements for workflows and protocols across the required Integrated Healthcare project not later than summer of 2018. Due to the waded nature of

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

project rollout the IDN will support the last onboarding of B1 practices and from there push for a formal adoption of standardized workflows and protocols. Allowing for all partner involvement in this process will be critical to use and adoption which necessitates a longer period to reach standardization.

### B1-9a. Report on progress toward coordinated care designation

As referenced in the sections of the SAR above the first steps have just gotten underway with the first B1 pilot in the Region 1 IDN. Additional steps have been to lay the foundation for other partner practices and to promote staged readiness. This has been done through the supported listening tours, RFP and Letter of Intent process, contract with QI coaches at CHI and the dissemination of the SSA Integration assessment. Next steps:

1. Complete SSA surveys by fall 2017
2. Re-define B1 partner implementation waves as needed by 12/31/17
3. Engage partners in practice change initiatives starting in October, 2017
  - o Using Knowledge Exchange sessions to form a cohort of partners
4. Plan for secondary steps to achieve CC status at each practice within 4-6 months of starting its B1 pilot

Additional updates will be available in subsequent SAR reporting quarters.

*\*Please see B1: Appendix K for the SSA Reports from Region 1 B1 Partners*

### B1-9b.

MAT and evidence based treatment of mild to moderate depression is currently in practice at the DH Lebanon Heater Rd clinic. MAT protocols are being refined at time of submission. Initial education and MAT training materials can be found in *Attachment\_B1.9b*.

At time of implementation the IDN through provider meetings and B1 assessment has been notified that the following agencies are supporting MAT assessment currently:

- Cheshire Medical Center [REDACTED]
- Alice Peck Day- Currently Implementing
- Phoenix House
- DH-Psych (PATP)

Through the ongoing analysis with B1 providers the IDN team will continue to assess new MAT capacity within providers and discuss readiness for implementation.

### B1-9c. HIT

IDN-1 will utilize health information technology to support the B1 project. Full details of the HIT supporting solutions are detailed in project A2. Four specific areas were identified in B1-9c for detail and are explained below:

**Use of Technology to Identify at Risk Patients:** IDN-1 will take a multi-pronged approach to identifying Medicaid Members, and in particular, Members that are at risk patients:

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

IDN-1 will work with DHHS to receive Medicaid Attribution files to identify the universe of members that fall under the 1115 waiver and the sub-universe of Members with a Behavioral Health indication.

IDN-1 will utilize [REDACTED] to identify patients that are frequent users of area Emergency Departments. ED use is a strong indicator that patients are at risk and/or have complex care needs.

IDN-1 will utilize the [REDACTED] to identify at risk patients as Medicaid Members that are not meeting measures or that are out of normal ranges for clinical quality outcomes measures.

IDN-1 Partners will work with the MCOs to receive analyses and reports generated by the MCOs for identifying high risk patients.

IDN-1 Partners will use their EHR systems to identify at risk Medicaid Members through chart review.

**Use of Technology to Plan Care:** IDN-1 will use multiple technologies to plan care:

IDN-1 Partners will use the patient medical record housed in the EHR as the primary care plan.

IDN-1 Partners will use the Shared Care Plan platform provided by the [REDACTED] to document a plan of care that may be shared with the Core Integrated Health team across multiple organizations.

Care plans will be informed by:

Patient medical records housed in the EHRs

Patient Goals – housed in the EHRs and Shared Care Plan

Comprehensive Core Standardized Assessment – housed in the EHRs and in document form.

**Use of Technology to Monitor/manage patient progress toward goals:** IDN-1 will utilize multiple technologies to monitor and manage patient progress toward goals:

Patient goals will be housed in the EHR and in the shared care plan

Partners will use the patient medical record housed in the EHR as the primary record for patient progress tracking.

Partners will use the Shared Care Plan platform provided by the [REDACTED] to document and periodically update a shared plan of care.

Progress of patients at the population level will be tracked in the quality data reporting platform.

**Use of Technology to Ensure closed loop referral:** IDN-1 will use Direct Secure Messaging as the primary technology for closed loop referrals. IDN-1 will remain open to other technologies that support closed loop referrals as they emerge.

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| Organization | Use of Technology to Identify at Risk Patients -<br>May Include:<br>-EHR System<br>-Pre-Manage<br>-Quality Data Center<br>-MCO Data | Use of Technology to Plan Care -<br>May Include:<br>-EHR System<br>-Pre-Manage | Use of Technology to Monitor/manage<br>patient progress toward goals - May Include:<br>-EHR System<br>-Pre-Manage<br>-Quality Data Center | Use of Technology to Ensure closed loop<br>referral - May Include:<br>-Direct Secure Messaging<br>-CommonWell/Carequality<br>-Other Referral Method |
|--------------|---|--|---|---|
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No   |
|              | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No   | EHR System: No<br>Pre-Manage: No   | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No   | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No   |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No   |
|              | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No   | EHR System: No<br>Pre-Manage: No   | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No   | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No   |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|              | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: Yes<br>Pre-Manage: No  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No   |

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|  |  |                                   |  |   |
|--|--|-----------------------------------|--|---|
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: No<br>Pre-Manage: No  | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No  | EHR System: No<br>Pre-Manage: No  | EHR System: No<br>Pre-Manage: No<br>Quality Data Center: No  | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: Yes<br>CommonWell/Carequality: No<br>Other Referral Method: No |
|  | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No<br>MCO Data: No | EHR System: Yes<br>Pre-Manage: No | EHR System: Yes<br>Pre-Manage: No<br>Quality Data Center: No | Direct Secure Messaging: No<br>CommonWell/Carequality: No<br>Other Referral Method: No  |
|  |  |                                   |  |   |
| Little or no IT capability to support the function.                      |  |                                   |  |   |
| Some siloed (single organization) IT capability to support the function. |  |                                   |  |   |
| Multi-organization IT capability in place to support the function.       |  |                                   |  |   |

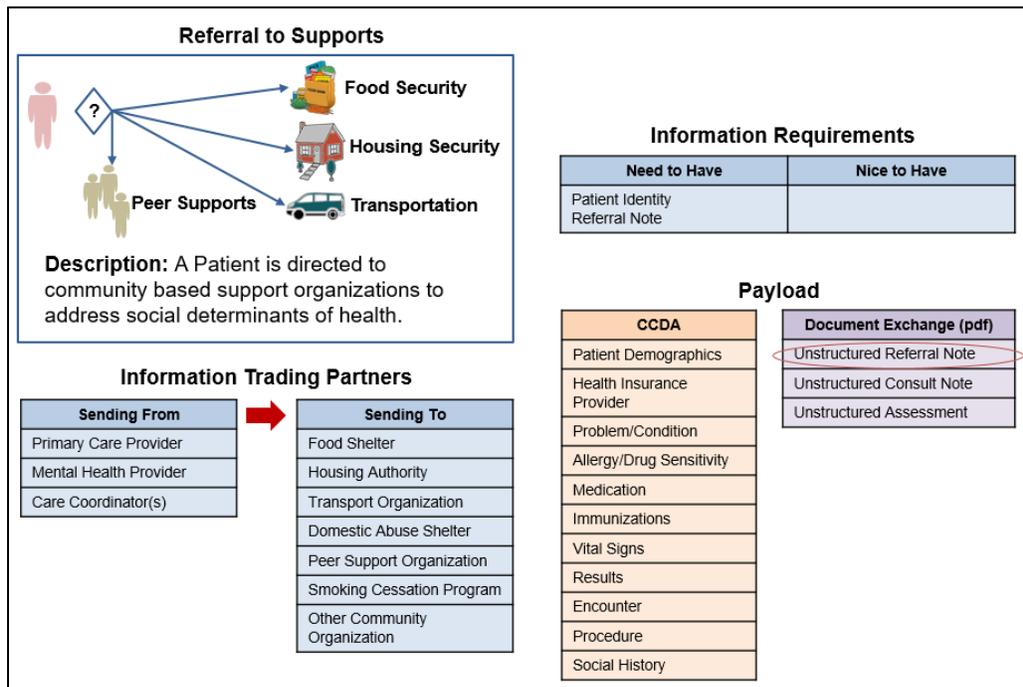
### B1-9d. Workflows

IDN-1 will support a formal bi-directional referral process when jointly serving patients with community based social support services organizations. There are two primary workflows:

#### Referral to Supports

This is a formal closed loop referral from a medical provider to a community supports organization that is used to initiate, acknowledge, and follow up on supports that address social determinants of health.

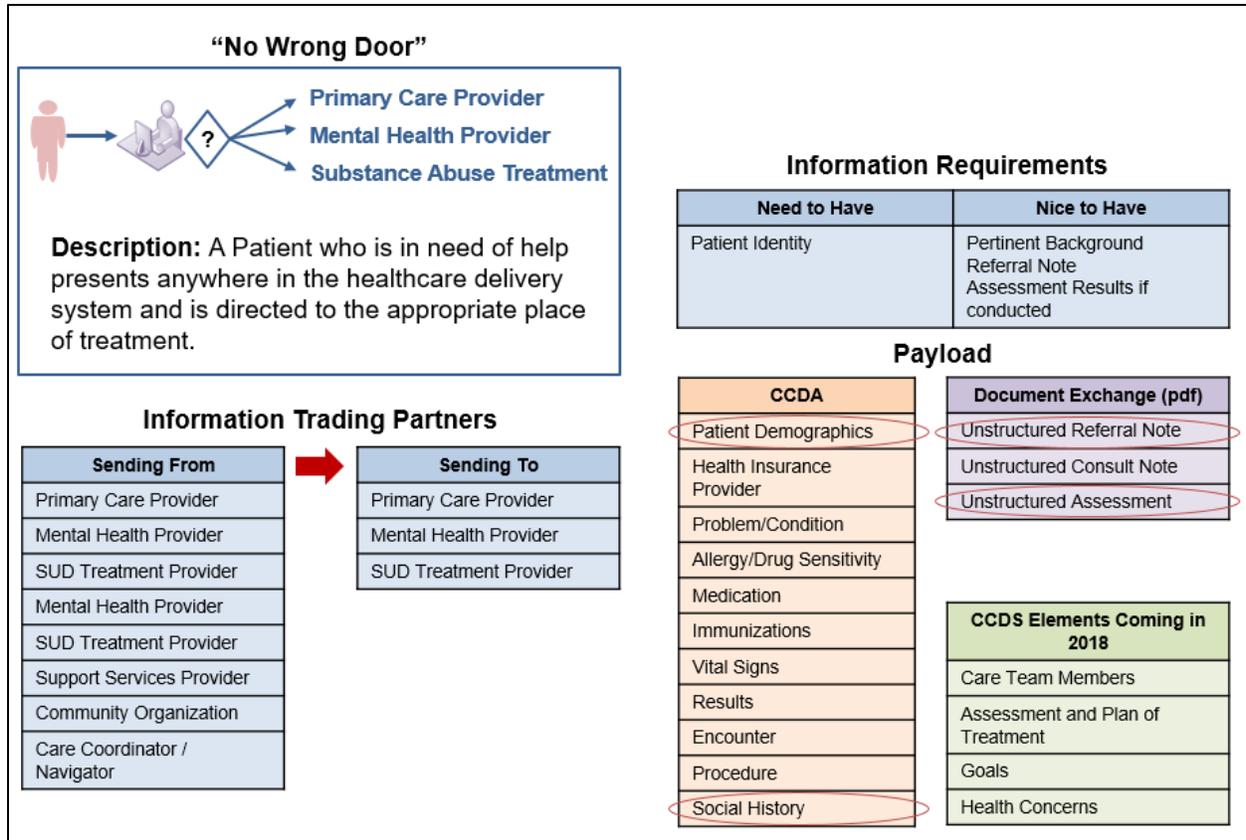
Figure 44: Referral to Supports Workflows



#### “No Wrong Door”

**“No Wrong Door:”** This is the inverse of a Referral to Supports in which a Medicaid Member is directed from a Community Supports organization to the most appropriate care setting via a closed loop referral.

Figure 45: “No Wrong Door” Workflows



The technology that supports these workflows is Direct Messaging (with or without and EHR) and is detailed in project A2.

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

Please see the section “Privacy, including limitations on information for communications with treating provider and community based organizations” above. Intake procedures to gather patient consent when required are a subcomponent of the privacy protocols.

**Adherence to NH Board of Medicine guidelines on opioid use:**

IDN 1 will support all Partners to ensure that their NH Board of Medicine compliance programs are in place for the new guidelines on Opioid use. Recognizing the acuity of the opioid crisis and the newness of the final rules for opioid prescribing adopted by the Board of Medicine on November 2, 2016, IDN-1 will assist Partner organizations to implement the guidelines.

IDN-1 will help inform prescribers of their responsibilities under NH law and the final rule. This includes connecting providers with resources offered by the State Government, the NH Medical Society, and multiple supporting organizations.

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Specifically, IDN-1 will promote use of the following resources with Partners that are updating their processes for opioid prescribing:

- NH Board of Medicine Resources: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Final Rule: PART Med 502 Opioid Prescribing:  
<https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf>  
[https://www.nhms.org/sites/default/files/Pdfs/NH\\_BOM\\_opioid\\_rules\\_11-2-16.pdf](https://www.nhms.org/sites/default/files/Pdfs/NH_BOM_opioid_rules_11-2-16.pdf)
- Board-Approved Risk Assessment Tools: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Training and Continuing Medical Education opportunities:  
<https://www.oplc.nh.gov/medicine/opioid-prescribing.htm> <http://www.nhms.org/opioidcme>
- Checklist for the Prescribing of Opioids for the Management or Treatment of Pain.  
[https://www.nhms.org/sites/default/files/Pdfs/1-4-17Opioid\\_Patient\\_Checklist\\_Med\\_502\\_Opioid\\_Prescribing\\_Rules.pdf](https://www.nhms.org/sites/default/files/Pdfs/1-4-17Opioid_Patient_Checklist_Med_502_Opioid_Prescribing_Rules.pdf)
- New Hampshire Opioid Prescribing Resources from the NH Medical Society:  
<https://www.nhms.org/resources/opioid>
- Opioid Dose Calculator from the Agency Medical Directors' Group:  
<http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

IDN 1 will support all practices participating in B1 as they implement prescribing processes and workflows that comply with the NH Board of Medicine opioid prescribing guidelines for both acute and chronic pain conditions. IDN-1 will check with its Partners to be sure programs are in place though formal compliance monitoring will remain a Board of Medicine function.

### B1-10. Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of *Integrated Care Practice* Designation Requirements

### B1-11. Project Scoring: IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

|                                  | Total Goal Number Designated | Baseline Designated 6/30/17 | Number Designated 12/31/17 | Number Designated 6/30/18 | Number Designated 12/31/18 |
|----------------------------------|------------------------------|-----------------------------|----------------------------|---------------------------|----------------------------|
| <b>Coordinated Care Practice</b> | 21                           | 0                           | At minimum 1               | At minimum 5              | Up to 21                   |
| <b>Integrated Care Practice</b>  | 4                            | 0                           | 0                          | Up to 1                   | Up to 2                    |

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|                                  |   |                 |                  |                   |
|----------------------------------|---|-----------------|------------------|-------------------|
| <b>Coordinated Care Practice</b> | <b>List of providers identified to make progress toward Coordinated Care Practice designation</b> | <b>12/31/17</b> | <b>6/30/2018</b> | <b>12/31/2018</b> |
|                                  | 21  | At minimum 1    | At minimum 5     | Up to 21          |

|                                 |  |                   |                  |                   |
|---------------------------------|--|-------------------|------------------|-------------------|
| <b>Integrated Care Practice</b> | <b>List of providers identified to make progress toward Integrated Care Practice designation</b> | <b>12/31/2017</b> | <b>6/30/2018</b> | <b>12/31/2018</b> |
|                                 | 4  | 0                 | Up to 1          | Up to 2           |

Please note that providers in the Coordinate Care Practice Designation cohort may shift as providers target further integration activities over the lifetime of the IDN implementation period. See the table below for Integrated and Coordinated Designation targets by IDN1 B1 providers:

| Organization | Coordinated Care | Integrated Care |
|--------------|------------------|-----------------|
|              |                  |                 |

### C1: Care Transitions

#### C1-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

##### C1 Core Components

###### *Per STC's*

The Care Transitions project aims to integrate a time-limited care transition program led by a multi-disciplinary team that follows the [REDACTED] approach. Focusing on providing care at staged levels of intensity to support patients with serious mental illness during transitions from the hospital setting to the community. A primary goal of CTI is aimed at preventing readmissions to acute care, inappropriate use of the ED, and recurring homelessness among individuals with mental health conditions. The projects primary target population is adults on Medicaid with serious mental illness transitioning from the hospital setting into the community.

The primary objectives of the project as referenced above are to integrate the CTI model throughout the Region 1 IDN. The CTI model follows a phased approach with Phase 1: Case Worker provides support and begins to connect client to providers and agencies that will gradually assume the primary support role. During Phase 1, the case worker will meet client prior to discharge. Collaborate with mental health professional and primary care provider on client assessment. Make home visits to meet with client and caregivers. Identifies and meets with existing supports and introduces the client to new supports as needed. Phase 2: Case worker monitors and strengthens client support network and clients self-management skills. Phase 3: Case worker completes the termination of CTI services with the clients support network safely in place.

##### Scope of Work Development:

The Region 1 IDN followed a community driven process for project solicitations that began in January, 2017 with the convening of project teams across all of the 6 IDN projects. These teams met on average twice monthly and had more than 50 stakeholder agencies represented across the four project areas. Meeting through late April, 2017 membership assisted the Region 1 administrative staff in assessing the current state within the Region 1 catchment area. From this assessment the team members supported the Region 1 staff in carving out of the STC requirements addressed above the focus areas within each project stream to be targeted in Round 1 of the Request for Proposal Process. The Scope of Work listed below is the Region 1 team's synthesized and directed focus that served as the framework for the projects selected within each project category. The SOW below has been included to provide context and supportive documentation to the Pilot Project outlines listed below and the Core STC Components.

##### C1 Scope of Work:

**Goal:** Support Medicaid beneficiaries with transitions from institutional settings to the community.

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**Description:** This project will follow the evidence-based “Critical Time Intervention” (CTI) approach to providing care at staged levels of intensity to patients with serious mental illness during transitions from the hospital setting to the community. It is designed to prevent readmissions to acute care, inappropriate use of the ED, and recurring homelessness. Under CTI, a multi-disciplinary team follows a three-phase approach to assisting individuals with transitions out of the hospital. For more information on Critical Time Interventions, check out <https://www.criticaltime.org>.

**Target Population:** Adults with serious mental illness.

**Target Participating Organizations:** Hospitals (including New Hampshire Hospital), primary care providers, behavioral health providers, community-based social services organizations.

- This project entails a team approach to supporting Medicaid patients with Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) who are transitioning from a hospital setting back into the community.
- The project requires implementation of a nine-month, three-phased model. Each of the phases is approximately three months. This intensive case management process supports and mentors the patient through the development of a patient-centered plan to develop independent living skills and build effective support networks, ensuring they are able to sustain independent living in the community at the conclusion of the nine-month intervention.
- The intervention team encompasses:
  - A Bachelor’s Degree level or Master’s Level caseworker trained in CTI (carrying a caseload of no more than 20 patients at a time);
    - *Please note training in CTI will be offered Statewide through the IDN’s with a Kick-off on June 1<sup>st</sup>*
  - A licensed Master’s Degree level clinical supervisor (who carries a caseload of no more than 10 patients at a time);
  - A lay professional or Bachelor’s Degree level fieldwork coordinator, who provides support to the caseworker and clinical supervisor to assist in providing linkages to community resources specific to the needs of the patient.
  - Some organizations may choose to combine the clinical supervisor and fieldwork coordinator roles.
  - Some organizations or collaborations may identify existing roles to allocate to this team and others may need to build the entire team. The accompanying application will ask for clarification on funds requested and how this model will be operationalized within the participating organization(s).
  - The number of CTI workers on a team is flexible however the maximum number of individuals served by a team is not to exceed 70 at one time.

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- CTI staff will participate in multi-day training, as well as coaching/Community of Practice activities with our training consultant: [REDACTED]  
[REDACTED] The training and coaching will be part of a larger effort with the other 4 IDNs who are implementing CTI in their regions.
- The Region 1 Care Transitions Teams project team has recommended that the IDN pilot this program in one community before expanding to other communities. .

Interested organizations are encouraged to speak directly with any member of the administrative lead team or the Care Transitions Teams project chairs or committee members. Please contact Jessica Powell at [Jessica.J.Powell@hitchcock.org](mailto:Jessica.J.Powell@hitchcock.org) for more information.

### Phases:

#### *Pre-CTI*

Develop a trusting relationship with client (prior to discharge).

#### *Phase 1: Transition*

Provide support & begin to connect client to people and agencies that will assume the primary role of support.

- Make home visits
- Engage in collaborative assessments
- Meet with existing supports
- Introduce client to new supports
- Give support and advice to client and caregivers

#### *Phase 2: Try-Out*

Monitor and strengthen support network and client's skills.

- Observe operation of support network
- Mediate conflicts between client and caregivers
- Help modify network as necessary
- Encourage client to take more responsibility

#### *Phase 3: Transfer of Care*

Terminate CTI services with support network safely in place.

- Step back to ensure that supports can function independently
- Develop and begin to set in motion plan for long-term goals
- Hold meeting with client and supports to mark final transfer of care
- Meet with client for last time to review progress made

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- If needed the client will be referred for enhanced services beyond the scope of the CTI case management.

### Region 1 IDN's Initial C1/CTI Implementation Project

*\*Please see attached C1: Appendix A: Implementation Timeline*

In response to our May 2017 RFP process, the Region 1 IDN Executive Committee selected a proposal from Monadnock Family Services to implement a CTI project starting July 1, 2017. This is consistent with our CTI Project Team's recommendation that our region start our work with one CTI project pilot then pursue additional CTI projects later in 2017. Below is application text from the Monadnock Family Services proposal that provides a description of this planned project:

### MFS "Co-Pilot" Project:

Monadnock Family Services (MFS), the Monadnock Collaborative (MC), and Cheshire Medical Center/Dartmouth Hitchcock (CMC/DH) are the three lead partners for the Co-Pilot project. The project will combine implementation efforts for Enhanced Care Coordination and Care Transitions into one project that accomplishes all the goals of the ECC and CTI work in the Monadnock sub-region of the IDN. As a collaborative team they will build upon the successful partnership between CMC/DH and MC, the local Service Link Resource Center (SL), where a coordinated care transition for high acuity patients has been in operation for several years by adding the community behavioral health perspective and expertise well established at MFS.

The mission of the Co Pilot program is to (a) create a person/patient-centered environment that considers and respects the desires, values, family situations, social circumstances and lifestyle of the individual, (b) to develop and coordinate a team of clinical care and community services responsive to this environment that both meets the needs and preferences of the individual and empowers their capacity for self-efficacy and (c) learn and demonstrate that new structures, practices and work flows can create a transformational delivery culture that improves satisfaction and effectiveness.

To achieve these goals a team of community based coordination and transition experts will be funded through this project. These individuals will effectively engage participants referred from medical services (CMC/DHK primary care teams), psychiatric inpatient facilities (New Hampshire Hospital), and involve them in person centered care planning. Directly assisting participants in carrying out their plan of care by accessing the community services that are needed in addressing their multiple and complex needs. Though based at MFS, team members will be visible and active at the CMC/ DHK facility, communicating and consulting with the participants and their care providers in both the inpatient and outpatient service setting.

This team will seamlessly implement the (1) Critical Time Intervention (CTI) approach to provide care at staged levels of intensity to patients with serious mental illness during transitions from Cheshire Medical Center or New Hampshire Hospital to the community setting and (2) community based coordination and

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direct support services for recipients regarded as having complex health care needs: physical or mental health challenges.

In addition to the three lead partners, several community organizations will be actively involved in this project. Though not an inclusive list, to ensure a holistic view of the social and emotional needs of these patients, the following organizations will be key referral partners:

- Keene Housing: Focused on participants stable housing and supportive housing assistance
- Home Health, Hospice and Community Service: Providing in home care for participants
- Community Volunteer Transportation Company: Free transportation assistance
- Southwestern Community Services: Will be providing numerous services such as fuel assistance, vocational assistance, and emergency housing
- Monadnock Area Peer Support Agency: Providing peer support groups and respite services
- Monadnock Region System of Care for At-risk youth: Offering supplemental services to area youth

The targeted population for this project will be (1) adults living in the Monadnock Region who currently have Medicaid insurance or are Medicaid eligible, have a behavioral health diagnosis, who have experienced multiple emergency room visits or inpatient hospitalizations at Cheshire Medical Center or New Hampshire Hospital and/or also have a co-occurring long term physical health problems and/or significant barriers to successfully living in the community (i.e.: homelessness, unstable community tenure, etc.) and (2) children less than 18 years of age living with a serious emotional disturbance, particularly those with other significant family challenges regarding SDoH.

According to the statewide IDN ad hoc report designated community mental health center in the Monadnock Region, MFS has received 132 discharges from NHH since July 2015, averaging about six people per month. 56.8% of those clients were admitted and discharged within the same month, indicating that many individuals needing involuntary admissions have protracted lengths of stay in that facility due to the severity of their symptoms.

In accordance with requirements for the CTI evidence-based model, the Care Transitions Coordinator will maintain a caseload of not greater than 20 patients at any time. Recognizing that not all referrals will accept services or remain within the program for the full 9 months, the 20 person caseloads will have turnover over the course of the year. During the year, it is expected that 50 patients will be served by one full time Care Transitions Coordinator (CTC) and 25 patients will be served by the half time CTC/clinical supervisor position. These positions will seek their training through the 5 Regional IDN contact with [REDACTED]. The first of these direct CTC trainings will take place in fall of 2017 followed shortly by the Supervisory training. See the attached CTI Scope of Work for the Training Overview in *C1: Appendix B*.

For the enhanced care coordination component of this proposal, it is expected that 20 patients will be served by one full-time Enhanced Care Coordinator (ECC) at any one time. This figure is proposed based on

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the complex needs presented by these high acuity patients that will require frequent community based interventions, telephone outreach, transportation and abundant communication with other responsible parties involved in the plan of care. The ECC role will meet all training requirements for an MFS community facing case manager and will additionally leverage the IDN Workforce plan trainings and educational opportunities.

The partners in this project envision a community of caring that respects and supports the behavioral and social needs for the targeted population. Particularly those who are transitioning to the community from in-patient settings and those with complex physical or mental health needs. The purpose of the Co-Pilot project is twofold: to ensure a seamless transition for identified patients moving from NHH, CMC/DH emergency room or inpatient setting to successfully living in the Monadnock region by utilizing [REDACTED] and to assist high need children and adults with disabling mental health conditions to create successful lives in the community. Both aims will be accomplished by using a person-centered approach to accessing care and services, direct assistance through a wrap-around approach that assures effective implementation of the individual's plan of care, ongoing communication among parties in the medical and social service community involved in the plan of care and a person centered review and improvement of the plan as circumstances change.

Co-Pilot will provide CTI for the Care Transitions component of this project and incorporate the enhanced care coordination as a warm hand off to CTI participants who do not qualify for pre-existing MFS services. This project demonstrates the collaboration with other community partners- including all organizations within the region that serve the targeted population, to ensure increased quality of life and decreased repeated utilization of NHH, CMC/DH emergency department and inpatient stay. The proposed services include: a system for how MFS, MC, CMC/DH and NHH will communicate and coordinate and develop an effective workflow, development of referral process, implementation of the three phases of the CTI model, implementation of the enhanced care coordination model, consistent monitoring of metrics before, during, and after CTI services are provided and same for enhanced care coordination. The administrative oversight for implementation of this project rests with MFS. MFS will provide staffing supports to ensure administrative aspects of this project are completed.

Complex case coordination services adds to existing interventions available to Medicaid recipients and fills a critical role that aims to unite often disparate services. These services will augment the multidisciplinary core team assisting the individual in the primary care B1 Integration work. These services will extend coordination, follow up, and actively support the adherence to the care plan in the person's home and community setting. Similarly, the Complex case coordination role will augment existing services available through MFS because they are freed from the eligibility criteria restrictions imposed by current regulations regarding the level of severity of mental health disability that individuals must pass to obtain limited services. In this way, individuals with behavioral health conditions and significant physical health challenges can obtain a new partner in their care – a co-pilot to help them launch and land a better approach to treatment, services and health – which previously had been unavailable.

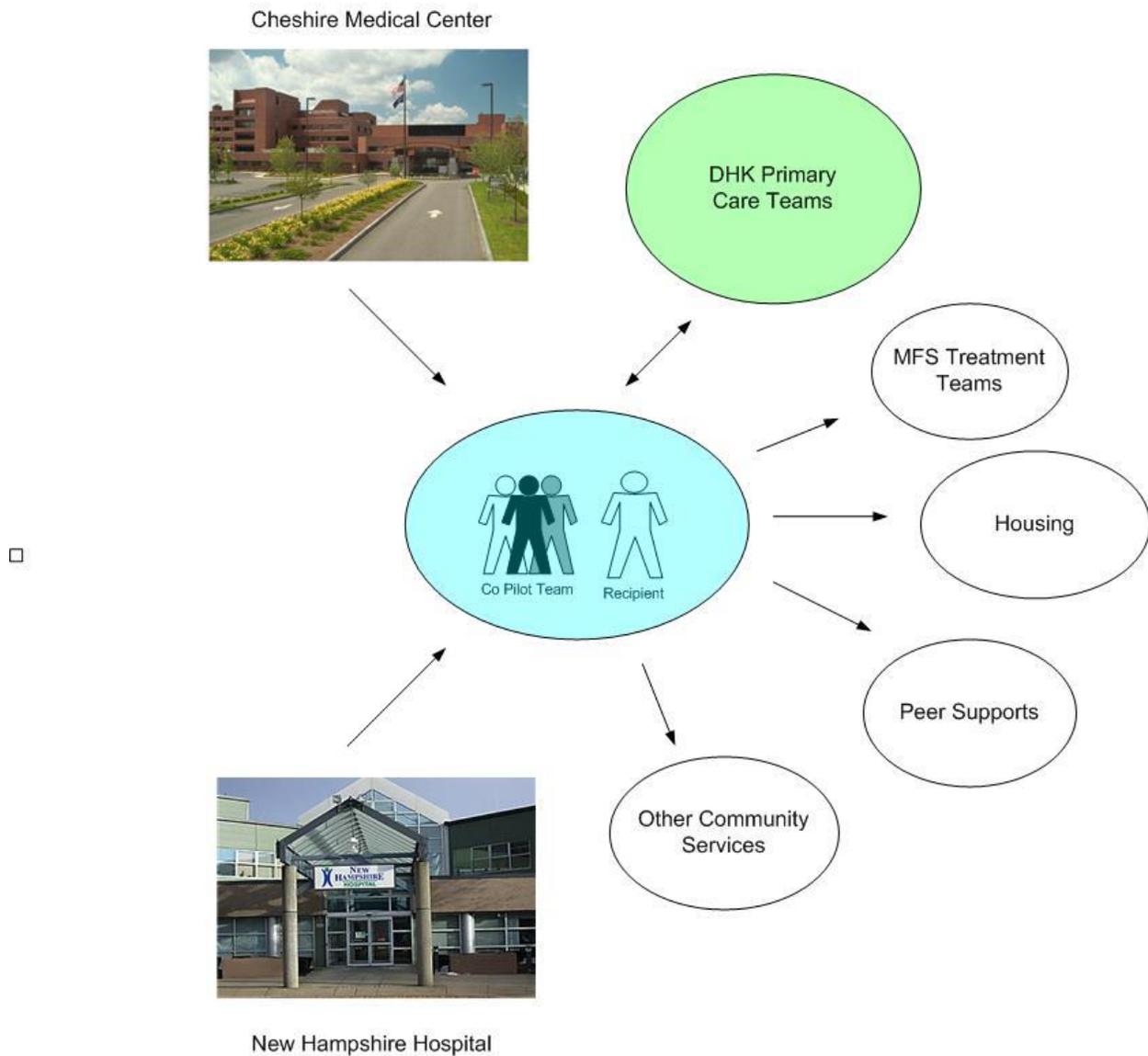
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Additionally, these proposal activities are aligned with the Council for a Healthier Community (the Greater Monadnock Public Health Advisory Board) and the Monadnock Community Health Improvement Plan that identified behavioral health as one of the priority areas for the region. Services will begin no later than six months from notification of funding award in July, 2017, with efforts at goal 1 beginning within 3 three months of award. Care Transitions Coordinator positions, one of which will also be the administrative lead for the project, are responsible for monitoring performance metrics, gathering data, and submitting reports to the Oversight Team. The Care Transitions and Enhanced Care Coordinators will be expected to participate in robust training, beginning with certification in the CTI model (for the Care Transitions Coordinators) and additional training topics to include but not limited to: behavioral health co-occurring chronic health conditions, medication management, health promotion programs (fitness, tobacco cessation), assessment, crisis management, HIPAA, team based collaboration, person centered planning and motivational interviewing among other topics.

Co Pilot will contain 4.1 full time equivalents. All staff will have either BA or MA level education and possess relevant experience in mental health, health care, community social services and advocacy. They will be supervised by a project manager who functions as a team leader/ administrator, coach and facilitator. He/ she will maintain program statistics and will report to the [REDACTED].

Please find below a concept map for the referral pathways envisioned in this project.

## Co Pilot Patient Flow Pathways



Co Pilot addresses the following needs:

1. Communication and Coordination among the various service providers
2. Patient/Person Follow Up
3. Housing and social supports
4. Therapeutic Supports
5. Medications Assistance
6. Transportation

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### Implementation Timeline

*\*Please see C1: Appendix A*

Post project award the Co-Pilot Project core team will establish an oversight team that will expand the core team membership, engaging referral and community based partners, to provide guidance and monitoring for program progress. The team should at a minimum include MFS, CMC/DH, NHH, MC, and the Region 1 IDN. One initial task of the core team will be to determine staffing structure, identifying project leads to support the additional administrative requirements in program implementation. Next, to develop a signed MOU between all key partners that identifies roles and responsibilities for each member organization, including but not limited to: administrative duties, reporting requirements, and communication needs. Ongoing tasks will include implementation of HIT software to bolster project capacity for utilization and pathways for Shared Care Plan connectivity

Other implementation steps prior to patient service will include:

- Craft “contracted liaison” language between CMC/DH and MFS for MFS staff access to necessary PHI
- Identify patient referral process and information workflow
- Recruit and hire Care Transition Coordinators and Complex Case coordinators
- CTI and other training and orientation for Co-Pilot staff
- Finalize internal reporting structures and processes. (See Roles and Responsibilities of Supervisor
- Determine patient eligibility guidelines and formalize referral processes among all providers
- Identify data collection needs based on performance metrics and process for collecting and analyzing data; tailor feedback informed treatment protocol to Co-Pilot team.

The process for patient care visits within the [REDACTED] will be as follows: ‘

- Pre-CTI: referral made, patient assigned, trusting relationship started before discharge
- Phase 1: Transitions, provide support and begin to connect patient to people and agencies that will assume primary role of support
- Phase 2: Try-out, monitor and strengthen support network and client’s skills
- Phase 3: Transfer of Care, terminate CTI services with support network safely in place
  - Additionally the CTI Coordinator will participate in the Community of Practice Meetings supported by the CACTI Training Partnership.

The process for patient visits with the enhanced case coordination features will include:

- Apply person centered planning approach to assigned individuals enrolled in Co-Pilot
- Communicate care plan to all stakeholders including relevant medical and mental health providers, social support resources and organizations, and other involved services
- Carry out plan of care; revise as necessary

As the Co-Pilot project gets underway in the “Co-Pilot” project and the team builds we anticipate there will be tailoring made to the process for evaluating clinical data, dependent on the final integration of HIT platforms and the projects workflows regarding data and reporting.

Initial steps will include assembling service use data for Co-Pilot participants based on Region 1 IDN Milestones, Evaluation Plan and project determined outcome measurements. Early project milestones will

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be targeted and in a parallel process continuous data evaluation will be undertaken from feedback informed treatment systems for every Co-Pilot participant and aggregated. Ultimately, the project will be utilizing the resulting data on participant satisfaction, clinical improvement measures, and project success measurements. The project oversight team will devise improvement plan and methods for communicating progress to all stakeholders once the formal communication pathways and protocols are in place and operational.

Spring 2018 will mark the first completion of the CTI phases of treatment. At this time the project team in alignment will hold a series of best practice determination meetings that will look to formalize and write up the process for CTI Implementation in Region 1. This will provide a framework for all subsequent Rounds of C1 project awardees to build from in addition to the CTI training.

### Budget

The Co-Pilot project budget for Year 1: July 1, 2017 to June 30, 2018 covers an award amount of \$215,283.00 to be taken from both C1: Care Transitions and E5: Enhanced Care Coordination project funding streams. Divided equally each project field will cover 2 FTE Staff positions and 50% of the remaining total budget expenses including but not limited to Technology, Recurring, and One-Time expenses. The majority of funding awarded to the Co-Pilot project is to account for capacity building and direct staff salaries. For all applicable services, MFS, a Medicaid BH provider will bill for the reimbursable services undertaken by the CTC or ECC coordinators.

[REDACTED]

### Training Plan

*\*Please see Attachment\_C-9 for CTI Statewide Scope of Work*

The Region 1 IDN has partnered with the other 4 IDN's implementing the C1 project to coordinate and contract with [REDACTED] TI the institution which, developed the Critical Time Intervention Model. The program leaders [REDACTED] kicked off the partnership at the Statewide CTI Kick off in spring, 2017.

The partnership will be formalized through a contract between CACTI and the Region 7 IDN. All of the other supporting IDN's will subcontract through the main contract for shared rounds of training in CTI for direct care coordinators, supervisors, and train the trainer sessions through 2017/2018. The first 2-day training session for direct care coordinators will launch the first week in November 2017. From IDN-1 there will be up to 10 attendants at Session 1. [REDACTED]

[REDACTED] To participate in the Supervisory training an individual must

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have completed the Coordinator training as a pre-requisite. With this information, the Region 1 admin team will continually target other interested IDN partners to send staff to the November Coordinator training until the maximum number of designated slots (10) have been filled.

With the lessons learned and interest garnered from the C1/E5 wave 1 pilot the Region 1 team hopes to launch at least 1 subsequent CTI project within the Region 1 IDN catchment area. Ideally, this pilot could service Sullivan and lower Grafton County to be determined by late spring or summer of 2018.

For ongoing support any C1 involved teams from IDN-1 will participate monthly in the statewide community of practice meetings held and supported through the [REDACTED]. These meetings will allow for shared learnings statewide as each IDN rolls out their CTI projects.

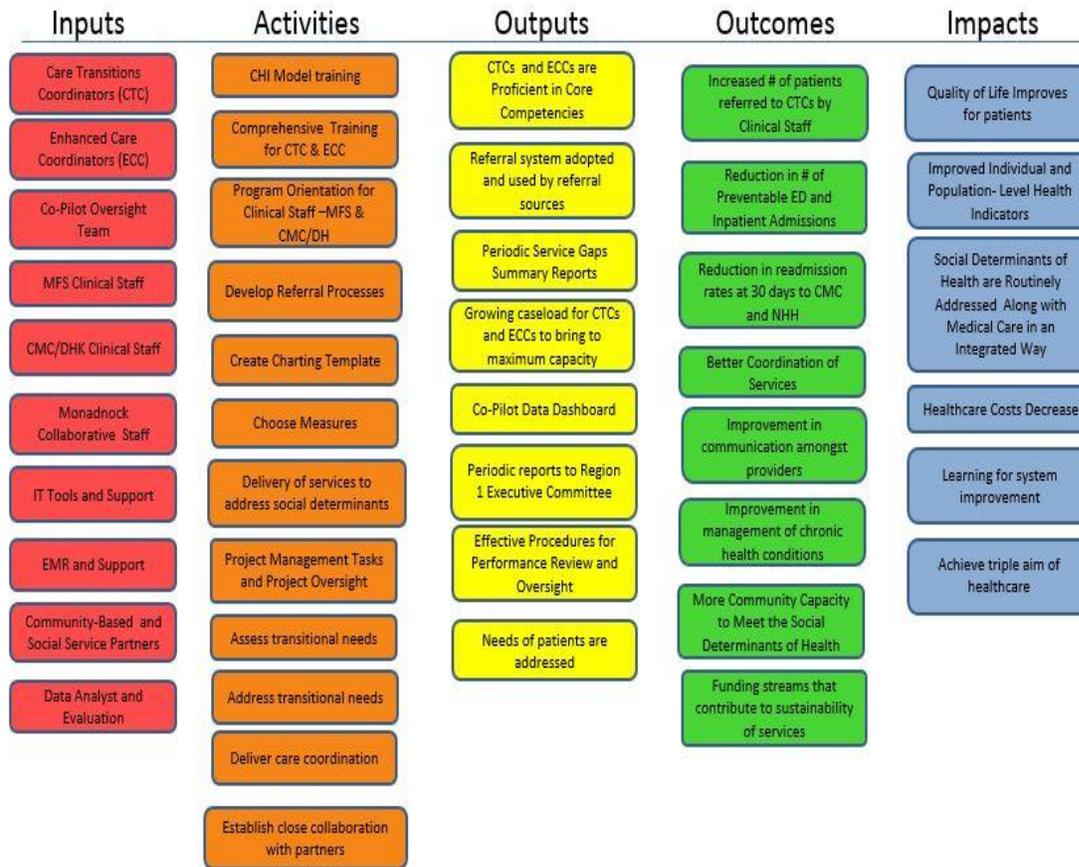
Additionally, in the subsequent direct care, supervision, and train the trainer sessions IDN-1 aims to fill the maximum allotted seats in each training with IDN partners, direct care staff involved in implementation.

### Process Milestones

*\*Please see C1: Appendix C: C1 Evaluation Table*

As the Co-Pilot project has been funded for 1 year through June 30, 2018 the project process milestones currently are reflective of the official project term. The IDN and project team will engage in continuous improvement efforts supported by the contracted Quality Improvement coaches in Region 1 that will likely tailor components of the implemented project. To allow for this natural change cycle the IDN staff will be highly involved in the projects relationship building, infrastructure support activities and ultimately in implementation. In partnership with the project team the Region 1 staff will meet throughout Q3, Q4 of implementation Year 1 to redefine the scope for contract extension and project expansion into Year 2. This process will include the creation of Year 2 process milestones that will reflect the project growth and scope expansion. At a high level the logic model below will guide the projects primary directives:

**Co-Pilot Logic Model**



**Evaluation Plan**

Due to the current phase of the Co-Pilot project development all of the desired high level project evaluation or internal outcomes measures have not yet been defined. Final Milestones and Evaluation Points will be selected by the Core Team in fall, 2017. See below for the current targeted outcomes;

**C1-2. IDN Community Project: Evaluation Project Targets**

\*Reference section C1-1: Process Milestones, Evaluation Plan for additional context for evaluation framing

| Performance Measure Name         | Target | Progress Toward Target |               |                |
|----------------------------------|--------|------------------------|---------------|----------------|
|                                  |        | As of 12/31/17         | As of 6/30/18 | As of 12/31/18 |
| Project Defined Patient Measures |        |                        |               |                |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|  |  |  |  |  |
|--|--|--|--|--|
| <i>Reduce the number of poor mental health days amongst adults from 3.8 in 2015 to 2.8 in 2019 (source: County Health Rankings)</i>    |  |  |  |  |
| Indicator 1: Decrease in client self-reported poor mental health days  |  |  |  |  |
| Indicator 2: Increase in number of social interactions per week  |  |  |  |  |
| Indicator 3: Increase in participation in any groups (social, religious, self-help, public service, etc.)                              |  |  |  |  |
| <i>Reduce overall homelessness in Cheshire county from 96 in 2016 to 86 (source: NHDHHS-County Level Information)</i>                  |  |  |  |  |
| Indicator 1: Increase in number of people placed in housing  | <b>Will become effective post Q1, Q2 of Project Implementation due to program launch, training</b> |  |  |  |
| Indicator 2: Increase in number of people working with housing services  |  |  |  |  |
| Indicator 3: Decrease in consecutive days without shelter  |  |  |  |  |
| <i>Reduce social isolation (source: GMPHN Community Survey)</i>  |  |  |  |  |
| Indicator 1: Increase the number of social engagements (i.e. church events, visits with neighbors/friends, attending community events) |  |  |  |  |
| Indicator 2: Increase the number of referrals accepted for services and social resources in the community                              |  |  |  |  |
| Indicator 3: Increase the number of individuals identified as members of their support network   |  |  |  |  |
| <i>Track Program Interest, Enrollment, and Retention throughout the life of the Pilot.</i>   |  |  |  |  |
| Indicator 1: Track # of Patients who express interest in CTI Case Management   |  |  |  |  |
| Indicator 2: Track all program enrollment and referral pathways  |  |  |  |  |
| Indicator 3: Track all patients throughout phase I, II, III of the   |  |  |  |  |

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|  |      |  |  |  |
|--|------|--|--|--|
| model- noting unfinished cases and completion through phases   |      |  |  |  |
| Indicator 4: Address program data measures with project team and update program goals as needed with expansion.                  |      |  |  |  |
| <b>STC Defined Program Measures</b>  |      |  |  |  |
| <i>All performance measures identified within the evaluation plan milestones</i>   | 100% |  |  |  |
| <i>Operationalization of Program</i>   | 100% |  |  |  |
| A. Implementation of Workforce Plan  |      |  |  |  |
| B. Deployment of Training Plan   |      |  |  |  |
| C. Implementation of any required updates to clinical protocols, or other operating policies and procedures                      |      |  |  |  |
| D. Use of assessment, treatment, management and referral protocols   |      |  |  |  |
| <i>Initiation of Data Reporting</i>  | 100% |  |  |  |
| A. Number of individuals served vs. projected  |      |  |  |  |
| B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected                                  |      |  |  |  |
| C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements |      |  |  |  |

### C1-3. IDN Community Project: Workforce Staffing

| 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 |
| <i>Care Transition Coordinator</i> | 2                    | 0- In process to Recruit to hire |                      |                     |                      |



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| Organization/Provider                      | Agreement Executed | Project Affiliation            |
|--|--------------------|--------------------------------|
|  | (Y/N)              |                                |
| Monadnock Family Services                  | Y                  | Project Lead                   |
| Monadnock Collaborative                    | Y                  | Project Lead                   |
| Cheshire Medical Center                    | Y                  | Project Lead                   |
| Keene Housing                              | Y                  | Community Based Support Agency |
| Home Health, Hospice and Community Service | Y                  | Community Based Support Agency |
| Community Volunteer Transportation Company | Y                  | Community Based Support Agency |
| Southwestern Community                     | Y                  | Community Based Support Agency |
| Monadnock Area Peer Support Agency         | Y                  | Community Based Support Agency |
| Monadnock Region System of Care            | Y                  | Community Based Support Agency |

### C1-6. IDN Community Project: Standard Assessment Tools

| Standard Assessment Tool Name                 | Brief Description  |
|---|--|
| CANS/ANSA (CMHC Mandated Screener) ; Refer7   | Child Needs and Strengths Assessment/ Adult Needs and Strengths Assessment; person centered options counseling |
| CTI Tracking Tool                             | CACTI Developed Patient Reporting Tool   |
| Framed by CTI Model, Person Centered Planning |  |

### C1-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management and Referrals

At the time of project plan submission the C1 pilot team had not made formal decisions about the blended process to inform patient protocols. The pilot team consisting of membership from Monadnock Family Services, Cheshire Medical Center, Crotched Mountain Community Care, Monadnock Collaborative and others are in the stages of review for existing collaborative initiatives and cross referencing to the protocol guidance and overview materials provided by [REDACTED] of the model.

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Additionally, through ongoing process mapping and analysis to determine the current state across the primary organization partners the project team will better be able to determine which protocols, patient flows, and new processes will best be added to the current systems. With the support of a QI facilitator the team hopes to define all processes and update with clinical protocols by mid-fall 2017 while working in parallel to hire the vacant positions and secure CTI training.

| Protocol Name                               | Brief Description   | Use (Current/Under development) |
|---|---|---------------------------------|
| Family Caregiver Assessment                 | Support and assistance questions, safety, & ADLs            | Service Link                    |
| Person Centered (PC) Counseling check sheet | Outline of key criteria that show fidelity to a PC approach |                                 |

### C1-8. IDN Community Project: Member Roles and Responsibilities

| Project Team Member | Roles and Responsibilities  |
|---------------------|---|
| [REDACTED]          | [REDACTED]  |
| ECC- 2 FTE          | <p>The role of the ECC position is still under review between the Monadnock Collaborative and Monadnock Community Services but this position will include the following basic criteria:</p> <ul style="list-style-type: none"> <li>• Entry level position with at minimum a BS in Psychology, Social Work, Psychosocial Rehabilitation, or related human services field.</li> </ul> |

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|            |  |
|------------|--|
|            | <ul style="list-style-type: none"> <li>• The ECC will plan, coordinate, provide, and monitor client’s therapeutic, rehabilitative, support and community integration services.</li> <li>• Coordination with B1 Multi-Disciplinary Core Team and involvement with the CTC.</li> </ul> |
| CTC- 2 FTE | <i>See attached CTC Job Description C1: Appendix D</i>   |

### C1-9. Training Plan and Curricula

*Please see Attachment\_C-9 for CTI Statewide Scope of Work for additional IDN1 planning information*

**High level curriculum taken from Hunter College proposal to coordinating IDN’s:**

#### Phase 1 CTI Kick-off Event (1/1/17- 6/30/17)

- [REDACTED] will attend this meeting to present background, evidence and brief overview of the CTI model and address questions from attendees. 10-15 participants from each of the 5 participating regions. Invitations also extended to DHHS and [REDACTED]

#### Phase 2 1<sup>st</sup> Staff Training (7/1/17- 12/31/17)

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

#### Supervisor Training (7/1/17- 12/31/17)

- [REDACTED] will plan, organize and deliver two-day face-to-face training for master’s level supervisors (maximum 10-15) who will be providing clinical supervision to CTI teams. Participants must have previously completed training in the CTI model (either face-to-face or distance training). Training on the CTI Implementation Self-Assessment measure will be provided as part of this training.

#### 2<sup>nd</sup> Staff Training (1/1/18- 6/30/18)

- [REDACTED] will plan organize and deliver training on the CTI model. This may be delivered via traditional in-person format (two days) or via distance training methods in collaboration with T3, [REDACTED] authorized distance training provider. All CTI direct service staff and CTI

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supervisors should participate in this training. Approximately 40 trainees from five regions are expected.

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

- **Community of Practice Meetings (7/1/17-6/30/19)**
  - CoP meetings will occur monthly following program implementation. These meetings of case managers and/or supervisors will allow providers to receive technical support during the implementation phase. A [REDACTED] will facilitate these meetings, with the goal of reducing their role as they help local trainers assume primary leadership responsibilities. Meetings may be held in-person or via web/phone depending on feasibility/cost issues.
- **Coaching Support for Individual Organizations (6/31/17-12/31/20)**
  - [REDACTED] will provide monthly telephone consultation to case managers and supervisors at individual provider organizations. This will ensure program staff ample opportunity to receive and offer feedback, and will provide assistance in identifying and overcoming challenges specific to their organization. Feedback may be provided on data collected via self-assessment tools that organizations can use to monitor fidelity to the CTI model.

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

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

### D3: Expansion of Intensive Substance Use Disorder Services

#### D3-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

##### D3 Core Components

##### Per STC's

##### Core Components

|  |   |  |
|--|---|--|
|  | <p>1. At least 1 higher intensity service: Intensive Outpatient (IOP), Partial Hospitalization (PH), Non-hospital based residential treatment services</p>      | <ul style="list-style-type: none"> <li>• Ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services, should be offered concurrent or in tandem, as indicated, with assisted treatment services (MAT) are also a critical component for effectively addressing substance use disorders</li> <li>• Providers will offer concurrent treatment for co-occurring tobacco use disorder</li> </ul> |
|  | <p>2. Ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services</p> | <ul style="list-style-type: none"> <li>• Should be offered concurrent or in tandem, as indicated, with assisted treatment services (MAT) are also a critical component for effectively addressing substance use disorders</li> </ul>   |
|  | <p>3. Regular outpatient counseling for substance use disorders or co-occurring disorders</p>   | <ul style="list-style-type: none"> <li>• Provided by qualified practitioners, for individuals with lower levels of acuity broadly across the spectrum of health and social service programs within the IDN</li> </ul>  |
|  | <p>4. Coordination to Core Competencies as required as part of Project B1 Integrated Healthcare</p>   | <ul style="list-style-type: none"> <li>• Including the use of screening, brief intervention, and referral to treatment (SBIRT)</li> <li>• See attached for full list of Core Competencies of B1</li> </ul>   |

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|  |  |   |
|--|--|---|
|  | 5. Workforce requirements coordinated with and incorporated into IDN's Workforce Capacity Development plan | <ul style="list-style-type: none"><li>• Link to Project A1 Behavioral Health Workforce Capacity Development</li></ul> |
|--|--|---|

### Scope of Work Development:

The Region 1 IDN followed a community driven process for project solicitations that began in January, 2017 with the convening of project teams across all of the IDN project areas. These teams met on average twice monthly and represented more than 50 stakeholder agencies across the primary four project areas. Meeting through late April, 2017 D3 project team members assisted the Region 1 administrative staff in assessing the current state of care coordination efforts within the Region 1 catchment area. From this assessment the project team members supported the Region 1 staff in carving out of the STC requirements, addressed above, the focus areas within each project stream to be targeted in Round 1 of the RFA Process.

The Scope of Work (SOW) listed below is the Region 1 team's synthesized and directed focus that served as the framework for the projects selected within each project category. The SOW below has been included to provide context and supportive documentation to aligning the Pilot Project outlines listed below and the Core STC Components.

### D3 Scope of Work

#### Medication Assisted Treatment Expanded IOP:

***Service Area: Cheshire County, Sullivan County, Upper Valley, Monadnock Region  
MAT Framework:***

Medication assisted treatment (MAT) will be a component of the IOP program, and those clients diagnosed with opioid use disorder, who are evaluated as good candidates for MAT, will receive educational information on MAT and if willing, will be set up with the MAT healthcare provider for an assessment and for induction to take place. An additional follow up appointment with the MAT provider will be scheduled within a few days following induction. All MAT clients in IOP will participate in at a minimum of one hour (of 9hrs a week) MAT specific group with a clinician and the MAT provider. Once they have completed IOP, or if they meet OP ASAM Level 1, clients will be enrolled in a weekly Ongoing Recovery Support group, which is a process group, as well as a one- hour MAT specific group. MAT patients can also request an individual session with the MAT provider.

#### ***Required Elements of MAT- IOP Framework:***

- Potential IOP clients will complete a thorough bio-psychosocial assessment, utilizing the Comprehensive Intake Assessment, a clinical interview, and meet the ASAM 2.7 level, prior to

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starting the program to identify their individual problems, needs, assets and strengths and to determine if the IOP is the appropriate level of care to meet these needs

- Clients will complete an individualized treatment plan with their counselor within the first week of treatment. The IOP Treatment plan must include all 6 domains of the ASAM.
- Clients commit to a minimum of 3 group sessions weekly for at least 6 weeks (recommended 10-12 weeks) (Maximum of 8-10 clients per group) of curriculum based psycho-education and group therapy.
- All clients in the IOP must be provided with an option to pursue individual counseling and a connection to recovery support services either internal or external to the organization.
- All clients are required to submit random urinalysis screenings
- The IOP will include a component of family involvement and education.

### ***Staff Required:***

- 1 FTE Masters Level Licensed Counselor or LADC with 2 years' experience
- 1 FTE Bachelors, License eligible (LADC Preferred)
- MAT Provider (Paid Hourly)
- .5 FTE Administrative

### ***Suggested and Recommended-Evidence Based Treatment Methods:***

- Matrix Model
- Seeking Safety
- Cognitive-behavioral Therapy (CBT)
- Motivational Enhancement Therapy (MET)

## Focus Area:

### ***Pregnant Women***

Perinatal substance use disorders affect an estimated 10-20% of pregnancies in the United States. New Hampshire reports relatively high rates of opioid use and ranks comparatively low in treatment availability. Untreated, perinatal substance use is associated with significant morbidity and mortality for women and their infants, including infectious disease, prematurity, poor fetal growth, and neonatal withdrawal leading to prolonged hospitalization. Of women delivering at DHMC in Lebanon, 7.5% are in treatment for opioid use disorders at the time of admission. We know that the actual figures are higher, since some women with opioid use disorders are not in treatment during pregnancy. (*Taken from NNPQIN*)

### ***Specific Needs:***

- Gender Specific
- Trauma Informed
- Parenting
- Life Skills

## Region 1 IDN's Initial D3 Implementation Project

In response to our May 2017 RFP process, the Region 1 IDN Executive Committee selected a proposal from Dartmouth Hitchcock- PATP to Implement an Intensive Outpatient Program project starting July 1, 2017.

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This is consistent with our D3 Project Team's recommendation that our region start our work with one D3 project pilot then pursue additional Intensive SUD focused projects later in 2018. Below is application text from the DH-PATP proposal that provides a description of this planned project:

### Perinatal Addiction Treatment Program Intensive Outpatient Project:

The PATP- IOP project pilot will build off of the existing structure of the Perinatal Addiction Treatment Program to develop and pilot an evidence-based, gender-specific, trauma-informed intensive outpatient treatment program to meet the critical treatment needs of pregnant and parenting women with substance use disorders (SUD) in the DSRIP Region 1 catchment area. The project will serve Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services, with a particular emphasis on the needs of women who are pregnant or parenting young children. The primary project objectives are as follows:

- Implement and evaluate an evidence-based, trauma-focused curriculum to meet the special needs of women qualifying for ASAM level 2.7 (Intensive Outpatient) services, including medication assisted treatment
- Address the comprehensive medical and psychiatric needs of participants through provision of co-located psychiatric and reproductive health services with linkages to primary and specialty medical care
- Develop protocols for comprehensive screening and service coordination to address social determinants of health which present particular barriers to treatment and recovery for women
- Provide on-site childcare to facilitate access to and engagement with treatment for women with young children
- Clearly define and develop the business case for a scalable, integrated intensive outpatient model of care for the target population
- Help women to consolidate their recovery as an investment in their own lives and their children's future

Currently the only gender-specific SUD treatment option in Region 1 is that provided by the Dartmouth-Hitchcock Perinatal Addiction Treatment Program (PATP) in Lebanon, a once weekly office-based outpatient program. The proposed project builds on the existing infrastructure of the current program, which includes deep knowledge of the social and health needs of this population, medication assisted treatment, weekly group therapy, peer support, integrated psychiatric and reproductive health care, and case management for pregnant and parenting women.

The PATP currently sees upwards of 40 woman during their two session clinical Wednesday. The IOP will target women from this pre-existing patient pool who need higher intensity services and from there will expand the number of individuals served. The proposed program will provide a replicable model for increasing access to intensive substance use treatment services for a population with significant vulnerability and barriers to care. Specifically, we anticipate that:

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- 25-50 women of reproductive age will be provided with comprehensive, intensive addiction treatment annually that they would not be able to access otherwise
- 25-50 women with difficult to treat co-occurring disorders will be provided access to psychiatric care and will have the opportunity to stabilize their mental health disorders
- 25-50 women and their children will be able to access resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.

In 2016, 563 births at D-H occurred to residents of Region 1. Approximately 10% of all births at D-H are affected by opioid use disorders, and nearly all of these mothers are insured by NH Medicaid. Mothers of preschool-aged children would also be eligible for services. We anticipate that approximately 25-50 Region 1 women meeting criteria for ASAM level 2.7 services will participate annually. Since women in our current office based program have at least two children on average

Additionally, the IOP program will support all components of the D3 project requirements as it seeks to provide high-intensity SUD treatment expansion, medication assisted treatment (MAT) and will offer supportive outpatient counseling options for program participants in addition to group therapy. Please see the detailed overview of program components below:

- Comprehensive intake assessment using the Addiction Severity Index (ASI) as well as face to face evaluation with an addiction clinician
- Psychiatric evaluation
- Complete medical and reproductive health history
- Collaborative development of an individualized treatment plan by the participant and her care team, addressing all ASAM domains, medical, and psychiatric needs
- 8-week intensive outpatient program with 3 group sessions weekly (9 hours) including psycho-education and evidence-based group therapy utilizing trauma-informed, gender-relevant approaches
- Individual counseling
- Medication assisted treatment when indicated
- Smoking cessation counseling and treatment
- Peer support/recovery coaching
- Case management
- Life skills programming (including skill development regarding parenting skills, healthy relationships, nutrition and self-care)
- On-site childcare when mothers are in individual or group therapy
- Urine drug screens and breathalyzer testing
- Continuing care: following completion of the intensive outpatient program, women may continue to receive services, including MAT, through the PATP outpatient program for as long as they continue to benefit

Special needs of women. Women with substance use disorders (SUD) are a particularly vulnerable population who face significant barriers to accessing appropriate treatment. Frequently, these women

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have a history of sexual and physical trauma that influences their ability to engage in and benefit from traditional substance use treatment in a mixed gender setting. Co-occurring depression, anxiety, PTSD and emotion dysregulation complicate women's ability to achieve sobriety and maintain recovery over time unless co-occurring mental health symptoms are addressed concurrently. Therefore, in addition to evidence-based intensive outpatient treatment and medication assisted treatment for substance use, the program also emphasizes developing skills and supports to manage co-occurring mental health disorders effectively. This will be accomplished through on-site psychiatric assessment, weekly individual therapy, and psychiatric medication management where appropriate, in addition to trauma-informed group addiction treatment.

Childcare. A major barrier to treatment for this population is a lack of childcare. Typically, this population struggles with inadequate social supports: extended family and fathers of their children may also be struggling with substance use disorders, or may be alienated as a consequence of previous substance use or family trauma. Frequently, women with SUDs are the sole care providers for their children. Because no other IOP program in Region 1 welcomes children, women who are unable to succeed at the outpatient level of treatment and are referred to higher level of care are faced with the choice of leaving their children in an unsafe environment, surrendering custody of their children or declining necessary care. Our current outpatient program addresses this barrier by providing on-site childcare during therapy sessions; this program will be expanded to accommodate the duration required by IOP.

Resource needs. Women with severe substance use disorders who are pregnant and parenting typically have overwhelming social and resource needs. The majority of women who enter our current outpatient program are coping with severe financial stress, unstable housing, lack of access to transportation, exposure to domestic violence in the home, lack of sober social supports, unemployment, unmet educational needs, and/or unresolved legal problems. If they are to succeed in their efforts to develop and maintain a sober lifestyle they need substantial assistance in accessing resources to provide a safe and secure environment for themselves and their children. Our current program has demonstrated the benefits of on-site case management, integrated with the treatment team, to address this barrier. This essential program component will be expanded to provide comprehensive assessment, case management, and care coordination for each woman as an integral part of treatment.

Reproductive health needs. Women in this population frequently enter treatment with unmet reproductive and primary health care needs. They are at increased risk for unplanned pregnancy, infectious disease, and untreated chronic illness, and are less likely to seek timely or consistent prenatal care. A majority of women with severe SUDs are survivors of sexual trauma, which further interferes with their engagement in reproductive health services. This program will provide integrated, on-site prenatal and reproductive health care services in a safe and secure setting; services will be provided with sensitivity to the unique needs of women who have histories of sexual and physical trauma complicated by substance use disorders. The program will also provide health education, prevention of sexually transmitted disease, contraceptive counseling, nutrition assessment, and referrals for dental care.

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Multidisciplinary endorsement of integrated models. The integration of addiction treatment with maternity care has demonstrated effectiveness in improving access to treatment, engagement in prenatal care, and perinatal outcomes, and is endorsed by the American College of Obstetricians and Gynecologists, the American Society for Addiction Medicine, the American Society for Pediatrics, and the World Health Organization [1-4]. However, integrated care models have not been widely implemented due to lack of workforce capacity and the need for development of a scalable model. Furthermore, this model is limited due to its focus on office-based treatment (ASAM level 1) only, and on the prenatal and immediately postpartum period. Our experience shows us that women and families continue to need support postpartum and are at risk to be lost to follow up at times of transitions of care. Our innovative model addresses this issue through continuing to provide integrated psychiatric and reproductive healthcare and on-site pediatric services to postpartum and parenting women in the context of accessible gender-specific, trauma-informed intensive outpatient treatment.

Participating partners in developing program services include the Dartmouth-Hitchcock Departments of Psychiatry, Obstetrics/Gynecology, and Pediatrics; with consultation from the Dartmouth Trauma Interventions Research Center. We also have close ties to the Center for Technology and Behavioral Health (a research component of our Department) and are initiating a research partnership with them.

### Implementation Timeline

*\*See the D3: Appendix A*

The PATP-IOP will begin recruit to hire activities for new staff in early July, 2017. As they are building upon an existing project infrastructure and program there are foundational components to support direct hiring early on in the project process. Additionally, as much of the staff time is being re-allocated from current positions and implementation will be offset by in-kind time donation from PATP staff. As of September 2017, depending on the timeline for hiring, the project will seek to begin staff training and start utilizing the screening tools for program participants. With 1.0 FTE MD and 2.0 FTE Masters Level clinicians currently employed with the PATP, the project team will be able to leverage these current staff positions to support the IOP formation. Also, gearing up to recruit for one additional .5 FTE Masters Level clinician to be combined with another PT position, and then for the roles of Social Work Manager and the Child Care/Family Support Worker. Additional, .3 FTE time for an MD is still needed. It is not yet clear whether this time will be supported by an existing position or will result in a new hire.

The current PATP program follows strict attendance and adherence practices to ensure patient success throughout the program. The IOP will follow the same policies for adherence to attendance measures.

The PATP leadership team is meeting weekly currently to work on logistics of the program: scheduling, curriculum, intake processes, etc. The first milestone will be getting the above new positions posted in early August.

In regard to training, the current Masters Level Clinicians employed by the PATP completed the Circle of Security Training early in summer, 2017. All current staff are participating in Motivational Interviewing

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refresher trainings as well during summer, 2017. A number of treatment modalities and evidence based addiction treatments will be used for the PATP IOP program primarily:

- Cognitive Behavioral Therapy, CBT
- Dialectical Behavioral Therapy, DBT
- Motivational Interviewing
- Motivational Enhancement
- Relapse Prevention
- Circle of Security

For new staff there will be a hybrid of team supported training and formal external trainings but all areas of project programming will be covered. More details on the specifics of the training schedule and trainings will be shared as the program evolves.

The official start date of the PATP-IOP is scheduled for Mid-October 2017. The project will look to meet full capacity for participation within the IOP as soon as possible. Please see listed below a high level overview of the implementation timeline:

July – August 2017:

- 1) New staff recruitment begins. Additional staff needs identified and new positions posted.
- 2) Budget revisions to reflect partial funding of grant request
- 3) Planning process begins for integrating PATP outpatient program with PATP IOP.
- 4) Creation of Patient Advisory Board to provide feedback and consultation.

August-September 2017:

- 1) New hires identified and credentialing process begins
- 2) Ongoing planning and curriculum development for PATP/IOP integration
- 3) Begin outreach/public information campaign to inform about PATP/IOP

September/October 2017:

- 1) New Hires begin orientation to program and department
- 2) Begin accepting referrals to IOP
- 3) Begin implementing structural changes to PATP outpatient program to integrate with IOP (Begin second day of treatment, to include med management, group therapy and individual therapy)
- 4) Case management role fully integrated into PATP outpatient and IOP
- 5) Childcare program expanded to second day
- 6) All PATP referrals receiving full psychosocial evaluations by LICSW prior to beginning program
- 7) Begin assessments of new referrals to IOP

October/November 2017:

- 1) PATP-IOP groups begin
- 2) Childcare, recovery coaching and case management expanded to third day

November 2017- June 2018

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

- 1) Ongoing evaluation and refinement of PATP structure, policy and procedures and curriculum, with an emphasis on smooth transitions from IOP level of care to outpatient level of care.

January 2018-July 2018

- 1) Focus on continuing to engage community partners in PATP program and to facilitate connections between PATP and community agencies
- 2) Continue to enrich program curriculum and refine program structure
- 3) Document processes and protocols
- 4) Document curriculum
- 5) Collect and interpret data regarding outcomes

April/June 2018

- 1) Begin planning and establish objectives for 2018/2019 funding cycle

### Budget

\*Please see Budget Table in D3-4

The PATP-IOP project budget for Year 1: July 1, 2017 to June 30, 2018 covers an award amount of \$186, 000.00 to be taken from the D3: Expansion of Intensive SUD Programs project funding. The project was awarded a one-year compensation with the mutual understanding that, the IDN will continue to support the IOP development at a tapered funding level across the IDN remaining implementation out years.

In addition to the DSRIP funding the PATP-IOP will be billing for IOP clinical services and will continue to pursue other funding streams to offset the operating costs.

### Training Plan

The existing PATP began utilizing the Circle of Security Parenting (COS-P) Training, and due to the success of that implementation are looking to follow this approach to supplement the IOP framework. The COS-P protocol presents Circle of Security content in a consolidated training platform. The overarching program goals are to:

- Increase security of attachment of the child to the parent
- Increase parent's ability to read child's cues
- Increase empathy in the parent for the child
- Decrease negative attributions of the parent regarding the child's motivations
- Increase parent's capacity to self-reflect
- Increase parent's capacity to pause, reflect, and chose security-promoting caregiver behaviors
- Increase parent's capacity to regulate stressful emotional states
- Increase parent's ability to recognize ruptures in the relationship and facilitate repairs
- Increase parent's capacity to provide comfort when their child is in distress

These targeted population, in the case of the IOP, is mothers with SUD as well as challenges with emotional regulation, impulse control, aggression, detachment, and disruptive behavior patterns. The training

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requirements will be met by the identified IOP staff members and can be completed in a 4-day training with a total of 24 hours of training.

Elements of Co-located Women’s Health Services: All IOP staff will receive training and support on the following areas of care:

Pregnancy-focused

- Prenatal care
- SUD-specific prenatal education:
  - Risks of substance exposure, inclusive of tobacco/marijuana
  - Managing pregnancy-associated side effects of MAT (primarily nausea and constipation)
  - Optimizing nutrition during pregnancy and breastfeeding
  - Neonatal abstinence syndrome: diagnosis, management, aftercare
  - Pregnancy, HCV and/or HIV testing
  - Breastfeeding and MAT
  - Hospital drug testing policies
  - Mandated reporting and the Plan of Safe Care

Not pregnancy-focused

- Screening and treatment for sexually transmitted disease, including partner treatment
- Safe sex counseling, including condom distribution
- Cervical cancer screening
- Hepatitis and HIV education, screening, and referral
- Pregnancy testing, options counselling, and access to abortion care (referrals)
- Tuberculosis testing
- Counselling for pregnancy intention
- Influenza vaccination
- Domestic violence screening
- Tobacco use counselling and treatment
- Reproductive health education

Process Milestones:

*\*Please See attached D3: Appendix B: Evaluation Table*

|  |
|--|
| <b>Y1Q1</b>  |
| PATP additional staff recruited and hired, including clinician, case manager and childcare provider                      |
| PATP-IOP schedule developed, including staffing schedule   |
| PATP-IOP protocols developed including intake protocols, participation guidelines, family support (childcare) guidelines |
| PATP-IOP initial curriculum developed  |
| <b>Y1Q2</b>  |
| PATP fully staffed and oriented  |
| Outreach to community agencies to inform about program and invite referrals  |
| Intake provided to initial group participants  |

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|   |
|---|
| PATP outpatient program expanded to second day                                  |
| <b>Y1Q3</b>   |
| First cycle of PATP-IOP completed   |
| PATP-IOP graduates transitioned, when appropriate, into PATP outpatient program |
| PATP-IOP curriculum and structure assessed and adjusted as needed               |
| <b>Y1Q4</b>   |
| Outcome data accumulated and reviewed   |
| Curriculum and Program Structure Documented                                     |
| PATP-IOP ongoing and fully integrated with PATP-outpatient program              |
| Budget for 2018-19 developed and funding sources identified                     |

### Evaluation Plan

#### Projected Improvement Outcomes

- 1) Improved access to care. Participating women will be provided with:
  - a. Comprehensive, intensive addiction treatment annually that they would not be able to access otherwise.
  - b. Treatment of co-occurring psychiatric disorders
  - c. Intensive support in accessing resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.
- 2) Improved outcomes for families in which DCYF has assumed custody of the children because of the impact of active addiction.
- 3) Improved health outcomes for enrolled women and children due to increased engagement in on-site medical services, including decreased morbidity and mortality related to injection drug use during and after program.

#### Indicators to be measured

- 1) Number of women successfully completing the IOP program
- 2) Number of women engaged in continuing care one month following completion of IOP
- 3) Proportion of women with negative urine toxicology on observed specimen at delivery and at end of program, compared to intake
- 4) Number of women receiving reproductive health services during program including recommended cervical cancer screening, testing for STIs, screening for HCV and HIV, and discussion of pregnancy intention/contraception
- 5) Number of pregnant women who attend recommended prenatal visits during program
- 6) Proportion of women with an established primary care provider at completion of program as compared to intake

## D3-2. IDN Community Project: Evaluation Project Targets

\*Reference section D3-1: Process Milestones, Evaluation Plan

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Please note that as the IOP target numbers will be determined by program size and will be updated once the IOP is seeing patients.

| Performance Measure Name  | Target  | Progress Toward Target |                  |                   |
|---|---|------------------------|------------------|-------------------|
|   |   | As of<br>12/31/17      | As of<br>6/30/18 | As of<br>12/31/18 |
| Number of Medicaid women successfully completing the IOP program  | Will be defined in Q2, Q3 – Dependent upon program enrollment |                        |                  |                   |
| Number of women engaged in continuing care one month following completion of IOP  |   |                        |                  |                   |
| # of women whose UDS indicate abstinence from all substances not prescribed to them for 4 consecutive weeks prior to completion of the program  |   |                        |                  |                   |
| Number of women receiving reproductive health services during program including recommended cervical cancer screening, testing for STIs, screening for HCV and HIV, and discussion of pregnancy intention/contraception |   |                        |                  |                   |
| Number of pregnant women who attend recommended prenatal visits during program  |   |                        |                  |                   |
| Proportion of women with an established primary care provider at completion of program as compared to intake  |   |                        |                  |                   |
| <b>STC Defined Program Measures</b>   |   |                        |                  |                   |
| <i>All performance measures identified within the evaluation plan milestones</i>  | 100%  |                        |                  |                   |
| <i>Operationalization of Program</i>  | 100%  |                        |                  |                   |
| A. Implementation of Workforce Plan   |   |                        |                  |                   |
| B. Deployment of Training Plan  |   |                        |                  |                   |
| C. Implementation of any required updates to clinical protocols, or other operating policies and procedures   |   |                        |                  |                   |
| D. Use of assessment, treatment, management and referral protocols  |   |                        |                  |                   |
| <i>Initiation of Data Reporting</i>   | 100%  |                        |                  |                   |
| A. Number of individuals served vs. projected   |   |                        |                  |                   |
| B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected   |   |                        |                  |                   |
| C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements  |   |                        |                  |                   |

### D3-3. IDN Community Project: Workforce Staffing

| Provider Type | IDN Workforce (FTEs) |
|---------------|----------------------|
|---------------|----------------------|

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|                                     | Projected Total Need | Baseline Staffing on 6/30/17   | Staffing on 12/31/17 | Staffing on 6/30/18 | Staffing on 12/31/18 |
|-------------------------------------|----------------------|--------------------------------|----------------------|---------------------|----------------------|
| <i>Masters Level clinician (BH)</i> | 1.5 FTE              | Recruit to Hire                |                      |                     |                      |
| <i>Psychiatry (MD, ARNP)</i>        | .3 FTE               | Recruit to Hire                |                      |                     |                      |
| <i>OB/GYN( ARNP, CNM)</i>           | .1 FTE               | Recruit to Hire                |                      |                     |                      |
| <i>Pediatrician (MD, ARNP)</i>      | .1 FTE               | Recruit to Hire                |                      |                     |                      |
| <i>Social Work Case Manager</i>     | .5 FTE               | Recruit to Hire                |                      |                     |                      |
| <i>Recovery Coach</i>               | .5 FTE               | Recruit to Hire                |                      |                     |                      |
| <i>Childcare Providers</i>          | .75 FTE              | Recruit to Hire                |                      |                     |                      |
| <i>Administrative Support Staff</i> | .5 FTE               | Hired, Utilizing Current Staff |                      |                     |                      |
| <i>Certified Medical Assistant</i>  | .5 FTE               | Hired, Utilizing Current Staff |                      |                     |                      |



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D3-5. IDN Community Project: Key Organizational and Provider Participants

| Organization/Provider | Agreement Executed |
|-----------------------|--------------------|
|                       | (Y/N)              |
| [REDACTED]            | Y                  |
| [REDACTED]            | Y                  |
| [REDACTED]            | Y                  |

D3-6. IDN Community Project: Standard Assessment Tools

| Standard Assessment Tool Name   | Brief Description   |
|---------------------------------|---|
| Comprehensive Intake Assessment | This assessment will be paired with use of the Addiction Severity Index (ASI) as well as face to face evaluation with an addiction clinician. The initial assessment will be used as a starting point for clients to access the services available through the PATP-IOP listed below.   |
|                                 | Psychiatric evaluation<br>Complete medical and reproductive health history<br>Collaborative development of an individualized treatment plan by the participant and her care team, addressing all ASAM domains, medical, and psychiatric needs<br>8-week intensive outpatient program with 3 group sessions weekly (9 hours) including psycho-education and evidence-based group therapy utilizing trauma-informed, gender-relevant approaches<br>Individual counseling<br>Medication assisted treatment when indicated<br>Smoking cessation counseling and treatment<br>Peer support/recovery coaching<br>Case management<br>Life skills programming (including skill development regarding parenting skills, healthy relationships, nutrition and self-care)<br>On-site childcare when mothers are in individual or group therapy<br>Urine drug screens and breathalyzer testing |

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The PPATP-IOP will incorporate Motivational Interviewing, Cognitive Behavioral Therapy and Dialectical Behavioral Therapy as foundational approaches to addiction treatment, all of which are evidence-based practices. In 2017 the current PATP will begin to incorporate the Circle of Security Parenting Program.

\*Additionally, the project team will be revising their current assessment package used at intake for the IOP program but plan to continue with the ASI as well as an assessment of ASAM level of care criteria. A case management intake form to determine psychosocial needs will be added. All women will receive a health/medical evaluation with the CNM as well as psychiatric evaluation completed by the program psychiatrist during intake. As the program is still in a phase of material development these finalized tools are not available at this time but will be updated in the implementation plan when possible.

### D3-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management and Referrals

The PPATP-IOP will incorporate Motivational Interviewing, Cognitive Behavioral Therapy and Dialectical Behavioral Therapy as foundational approaches to addiction treatment, all of which are evidence-based practices. In 2017 the current PATP will begin to incorporate the Circle of Security Parenting Program (COS-P) into its curriculum as its primary parent education format. COS-P is an evidence-based program developed to promote parent-child attachment in at-risk families.

We consider the long-term, comprehensive approach of the current PATP, which provides ongoing support for pregnant and parenting women with SUDs during the first five years of a child’s life, to be an innovative approach to treatment that has produced outstanding results in improving the lives of at-risk families. We believe that the addition of intensive outpatient treatment provided on site will further improve outcomes for families by providing a higher dose of treatment initially and as needed during periods of heightened risk for relapse.

Additionally, as the PATP-IOP expansion project team continues to meet through Fall of 2017 the team will aim to finalize and share all needed protocols not later than the close of the December 31, 2017 reporting period.

| Protocol Name   | Brief Description   | Use (Current/Under development) |
|---|---|---------------------------------|
| Treatment Contract (Pending IOP modification- Currently in use at PATP) | The IOP team is currently working to define the most needed areas for the treatment contract. This review includes PATP current contract review and outreach to other | Pending Final Version           |

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|                |   |                       |
|----------------|---|-----------------------|
|                | gender specific IOP programs to determine best practices.   |                       |
| IOP Curriculum | The IOP is working to formally pull together the curriculum and is drawing from similar treatment programs and the viable components from the PATP program. | Pending Final Version |

### D3-8. IDN Community Project: Member Roles and Responsibilities

| Project Team Member                 | Roles and Responsibilities   |
|-------------------------------------|--|
| 1.5 FTE Masters Level Clinician     | (3 half-time positions in total) (LCSW, LCMHC, LMFT, MLADC), one of whom will serve as Behavioral Health Coordinator, taking a lead role in coordinating the program and supervising case manager, childcare staff, and recovery coach. Provide group and individual therapy, conduct intake process and level of care assessments, develop individualized treatment plan for each client. Provide phone coaching and outreach to strengthen engagement, decrease drop-out rate, and care coordination with outside agencies such as Child Protective Services, Probation and Parole |
| 0.3 FTE Psychiatry                  | (MD, ARNP) with buprenorphine waiver, who will serve as medical director of program and supervise masters-level clinicians. Provide psychiatric evaluation and psychiatric medication management where appropriate. Provide medication assisted treatment with buprenorphine and/or other medications to address substance use disorders (e.g. naltrexone)   |
| 0.1 FTE OB/Gyn                      | (ARNP, CNM) Provide women’s health services including prenatal, postpartum, and well woman care. Coordinate health education with regard to women’s health and pregnancy related topics. Assist women with establishing care with a Primary Care Physician.  |
| 0.1 FTE Pediatrician                | (MD, ARNP) Provide well child care and pediatric services to children of enrolled women. Consult to other providers regarding child health. Coordinate health education on pediatric topics.   |
| 0.5 FTE Certified Medical Assistant | Assist in check in process, conduct urine drug screens including observed UDS when appropriate, conduct queries in VT and NH Prescription Monitoring Program at intake and periodically. Assist with prior authorization process. Track and coordinate calling patients in for   |

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|                                      |   |
|--------------------------------------|---|
|                                      | random urine drug screens and pill/strip counts. Occasionally assist in medical procedures with women's health or pediatric provider (e.g. pelvic exams)  |
| 0.5 FTE Social Work Case Manager     | (MSW preferred, BSW/BA considered) Conduct psychosocial assessment for each client and assist in connecting with community resources. Coordinate with community providers both for donations and for visits to the program to speak with clients. Track usage of community services. Coordinate health education program; engage community speakers and adjunctive services (i.e. diaper bank, food shelf, dental care, etc.) |
| 0.5 FTE Recovery Coach               | Provide peer support services, education, overdose prevention, connection to community recovery resources for enrolled clients. Attend group sessions as scheduled.   |
| 0.75 FTE Childcare Providers         | Supervise children while parents are in treatment, coordinate volunteer child care aide program, maintain play space, manage registration process for parents using the family support services   |
| 0.5 FTE Administrative Support Staff | Schedule appointments, update insurance and contact information, check patients in on arrival, answer phones and convey messages, track completion of intake paperwork and appropriate releases of information. Assist with completion of prior authorizations and prescription data monitoring program queries.  |

E5: Enhanced Care Coordination

E5-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

| Category        | Objective   | Related Criteria  |
|-----------------|---|---|
| Core Components | 1. Identify care teams that include care coordinators/managers, primary care providers, and behavioral health providers   | <ul style="list-style-type: none"> <li>Utilize Behavioral Health Needs Assessment conducted in Fall, 2016</li> <li>Coordinate with Statewide Workforce Taskforce</li> </ul> |
|                 | 2. Develop and/or utilize systemic strategies to identify and intervene with target population (See Outline)  | <ul style="list-style-type: none"> <li>Review evidence based best practices and current models utilized across NH</li> </ul>  |
|                 | 3. Utilize a comprehensive core assessment and a care plan for each enrolled patient, updated on a regular basis  | <ul style="list-style-type: none"> <li>Coordinate with Integrated Healthcare Project Team</li> <li>Review data reported from CSA gap analysis</li> </ul>                    |
|                 | 4. Utilize Care coordination services that facilitate linkages and access to needed primary and specialty health care prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services | <ul style="list-style-type: none"> <li>Coordinate with other Project Teams</li> </ul>   |
|                 | 5. Transitional care coordination across settings, including from hospital to the community   | <ul style="list-style-type: none"> <li>Coordinate with Statewide HIT Taskforce and Region 1 IT/Data Workgroup</li> </ul>  |
|                 | 6. Utilize technology based systems to track and share care plans   | <ul style="list-style-type: none"> <li>Coordinate with Statewide HIT Taskforce and Region 1 IT/Data Workgroup</li> </ul>  |

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|  |   |  |
|--|---|--|
|  | 7. Develop a robust patient engagement process around information sharing consent | <ul style="list-style-type: none"> <li>Coordinate with Statewide HIT Taskforce and Region 1 IT/Data Workgroup</li> </ul> |
|  | 8. Coordination with other care coordination/management programs                  | <ul style="list-style-type: none"> <li>Review current Region 1 projects and Statewide initiatives</li> </ul>             |

Scope of

### Work Development:

The Region 1 IDN followed a community driven process for project solicitations that began in January, 2017 with the convening of project teams across all of the 6 IDN project areas. These teams met on average twice monthly and represented more than 50 stakeholder agencies across the primary four project areas. Meeting through late April, 2017 E5 project team members from Cheshire Medical Center, Patient and Family Representatives, Valley Regional Hospital, Crotched Mountain Community Services, Monadnock Family Services, and Servicelink assisted the Region 1 administrative staff in assessing the current state of care coordination efforts within the Region 1 catchment area. From this assessment the project team members supported the Region 1 staff in carving out of the STC requirements, addressed above, the focus areas within each project stream to be targeted in Round 1 of the RFA Process.

The Scope of Work (SOW) listed below is the Region 1 team’s synthesized and directed focus that served as the framework for the projects selected within each project category. The SOW below has been included to provide context and supportive documentation to aligning the Pilot Project outlines listed below and the Core STC Components.

### E5 Scope of Work

**Goal:** *To develop comprehensive care coordination/management services, including the integration and leveraging of community-based social services and other resources for high need adult and child Medicaid populations with multiple physical health and behavioral health chronic conditions.*

**Description:** These services are intended to maintain or improve an individual's functional status, increase the individual's capacity to self-manage their condition, streamline and simplify access to services integrate interventions and communications among all identified services to improve the quality of care, eliminate unnecessary clinical testing and repetitive enrollment/admissions processes, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

### Target Population:

- Adults (18 years or older): individuals with behavioral health disorders (specifically, serious mental illness or Substance Use Disorders, including opioid addiction) with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors (such as homelessness) that are barriers to community living and well-being.

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- Children (Under 18 years): children diagnosed with serious emotional disturbance.
- Developmentally Disabled (DD) population, Aged Blind and Disabled (ABD) population with co-occurring behavioral health disorders.

**Target Participating Organizations:** Primary Care Providers, Behavioral Health Providers, Community-based Social Support Services \* this is not an exclusive list of participatory organizations.

### Focus Area: Community-based Complex Case Manager

**Service Area:** *Upper Valley, Sullivan County, Cheshire County, and Monadnock Region*

The Community-based Complex Case Manager position would serve as a direct point of contact for clients as they navigate through the social support services available in their community. Client referrals to the Complex Case Manager may originate from the Multi-Disciplinary Core Team meetings, or other referral pathways. The Complex Case Manager's relationship with the Multi-Disciplinary Core Team will be developed in a parallel process that is being supported by Project B1: Integrated Healthcare. One time monthly, a team including representation from Primary Care, Behavioral Health, and Community-based Case management will come together to case conference on those individuals who have been identified through the Core Standardized Assessment (CSA) and flagged on the Shared Care Plan (SCP) for their significant needs. This case conference will serve as the primary point of integration for an individual's care team. The Community-based Complex Case Manager will serve to identify with the care team the client's highest need areas for social support services as identified in the CSA. For any formulation and modification of the clients community-based care plan, it is essential to involve the client and family.

### **Staff required and key functions:**

Community-based Complex Case Manager

- Will serve as a liaison between the multi-disciplinary core team and one geographic community of support services
- Must leverage existing supportive services relationships and possess the capacity to continually develop and strengthen the working relationships within a geographic community of services
- Must have a thorough understanding of the supportive services landscape and a developed skillset to support high-need individuals in navigating available services
- Maintain communication and follow-up protocols for all individuals and providers
- Sensitive to individuals' backgrounds, environments, capabilities, and limitations
- Will maintain an inventory of community resources and update regularly
  - and/or leverage existing database of contacts

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- Comfortable with home or office-based services
- Ability to provide supportive individual-centered care with an emphasis on barrier-free access and flexibility to promote individual choice in treatment and service selection
- Will create and foster relationships among the providers active in the E5 project in Round 1 and those that may be looking to move forward in subsequent waves

### Minimum Qualifications:

- Bachelors
- At least 2 years of proven relevant work experience
- Knowledge of and training in Motivational Interviewing and willingness to be trained in other person-centered empowerment tools and skills
- Preferred for supervision by community/clinical social worker or equivalent
- LCMHC

### Region 1 IDN's Initial E5/ECC Implementation Project

In response to our May 2017 RFA process, the Region 1 IDN Executive Committee selected a proposal from Valley Regional Hospital to Implement an Enhanced Care Coordination, ECC, project starting July 1, 2017. This is consistent with our E5 Project Team's recommendation that our region start our work with one ECC project pilot then pursue additional ECC expansion projects later in 2017. Below is application text from the Valley Regional Hospital proposal that provides a description of this planned project:

### Valley Regional Hospital "Coordinated Referral" Project:

The Coordinated Referral project based at Valley Regional Hospital (VRH) aims to provide enhanced care coordination between individuals and providers, enabling the target population to be supported within their communities. This will be achieved through increased collaboration with community partners in the Region and especially within the Continuum of Care (CoC) network. The Coordinated Referral partnership process piloted by the project will improve and streamline access to services across partner agencies, reduce redundancy and care costs, and address service gaps.

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The project will add 1 FTE with benefits for a complex case manager, with a [REDACTED]. The position will be supervised by the Coordinator of Care Management at VRH. The Case Manager will be based out of VRH, with weekly supervisory meetings. Training and orientation will be provided by VRH case management staff, in conjunction with partner agencies.

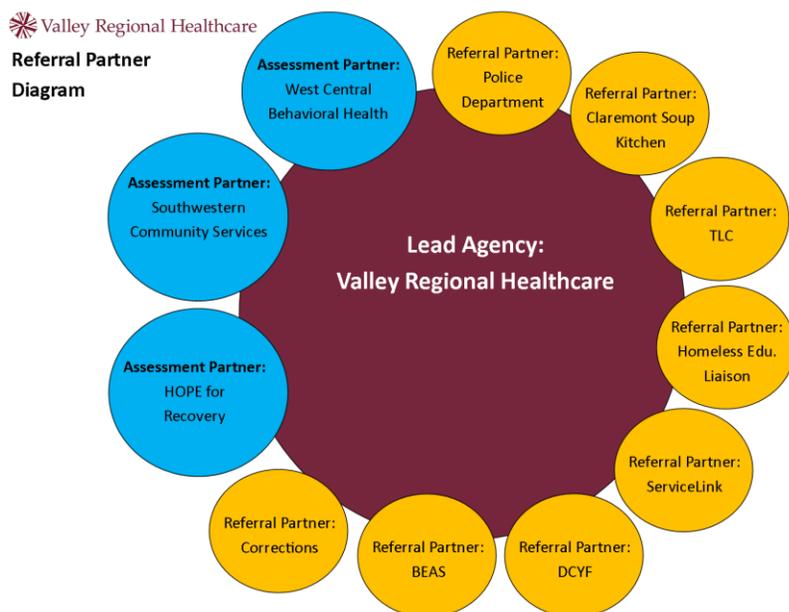
The program will develop comprehensive care coordination/management services, including the integration and leveraging of community-based social services and other resources for high need adult and child Medicaid beneficiaries with multiple physical health and behavioral health chronic conditions.

This project will create a Coordinated Referral Partnership supported by the local Continuum of Care network structure, which will meet regularly to streamline referrals and access to services. The Partnership will improve information exchange, referral processes, and access to services. Through streamlined access and referrals, the project will reduce healthcare costs associated with readmission and high utilization of the emergency department.

These services are intended to maintain or improve an individual's functional status, increase the individual's capacity to self-manage their condition and simplify access to services, integrate interventions and communications among all identified services to improve the quality of care, eliminate unnecessary clinical testing and repetitive enrollment/admissions processes, address the social determinants creating barriers to health improvement, and reduce the need for acute care services. Another component of the program implementation, similar to the objective for the B1 project, is to actively involve the patient and their family in creating and targeting their goals for wellness. This participation will serve as a benchmark for improvement across the system of community-based supports. A robust Continuum of Care, staffed by the IDN -funded community-based Complex Case Manager will result in improved partner collaboration and increased access to services for this high needs population. Referrals to the Case Manager will come through the CoC referral process outlined in the Coordinated Referral Partnership Agreement (below). All partners in this partnership will be able to make referrals, and this agreement is open-ended, encouraging the ongoing addition of new partners for collaboration. This project will use a phased approach to create a framework for partnership collaboration and referral, developing the processes needed to improve communication, eliminate redundancy, reduce barriers to care, and reduce utilization of acute care services.

The project will provide screening to identify individuals who qualify for high acuity, wrap-around services through existing programs. Clients who do not qualify for existing programs, or are “falling through the gaps,” will be prioritized for case management from the Complex Case Manager.

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This project invites collaboration with a variety of stakeholders and key partners to create a streamlined, “no wrong door” system, to increase access to services for the adult and child Medicaid population. The current approach is that each agency works alone to serve individuals, with limited coordination among providers. The Coordinated referral approach will create a more effective use of existing resources, which will increase the capacity of partner agencies. As the project progresses from the initial phase, there will be increased collaboration and partnership as relationships and efficiencies develop. Limited staff and other resources are challenges for this project, but it addresses them by creating incentives to draw partners into collaboration. Providing additional resources--enhanced case management and quality improvement coaching--, as well as improved efficiency and effective referrals, are all powerful incentives. The project will be organized by a Coordinated Referral Partnership Agreement that outlines the expectations and role of each partner agency, with a designated Lead Agency, Assessment Partners, and Referral Partners. The Complex Case Manager will take primary responsibility for maintaining and updating the agreement and recruiting new partner agencies.

The project will be supported by the full suite of HIT services detailed in project A2. IT services will be deployed in tandem with the rollout of the program steps to support team communication, at-risk patient identification, shared care planning, referrals to supports, patient privacy protection, and clinical quality reporting.

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### Implementation Timeline

*\*See E5: Appendix A*

Due to the current lack of coordination and shared referral sources in Sullivan County, the Valley Regional Hospital team has built lead time into their pilot project to allow for both the recruit- to-hire process and relationship development. Following the project award, the team will continue to identify additional key stakeholders and partner agencies. Coordinating with these agencies, and establishing practice community meetings, the team will work to strengthen the CoC network and fine tune the existing referral processes. Additionally, screening and barrier assessment tools will be developed to assist and cover gaps identified by the CoC partners. Ongoing education will take place across the practice Community. Throughout this initial phase, the team will work to create the foundational structure needed to successfully support patients and meet their needs. Following the first quarter of implementation, with support from the Quality Improvement Coaches contracted by the IDN, the team will initiate continuous improvement processes.

Throughout the project, the VRH practice team will continue to build and strengthen relationships with agency partners. One aspect of this relationship cultivation will be leveraging the Region 1 IDN monthly E5 Knowledge Exchanges to support education and process sharing across IDN partners.

To address long-term funding sustainability the practice team will be contributing information to the 1115 Waiver effort to move toward Alternative Payment Models. The teams will also be utilizing the VRH development infrastructure to pursue additional funding sources for future investment. As needed, the Region 1 Admin Lead team will offer their support to project sustainability efforts. Additionally, with the data outcome and project metrics being tracked quarterly, the practice team, with support from QI coaches and the Region 1 team, will present project success measures in a formal report to support funding applications.

### Budget

*\*Please see Budget Table in E5-4 for additional information*

The Coordinated Referral project budget for Year 1: July 1, 2017 to June 30, 2018 covers an award amount of \$87,884.40\* (*Pending Revision by the Executive Committee*) to be taken from the E5 Project Funds. The project's Year 1 funding will be designated to support and endorse additional system infrastructure and capacity. Additionally, the Year 1 funding will support both the recruit-to-hire activities and the full salary/benefits for 1 FTE.

### Training Plan

The Coordinated Referral Project will use client-oriented, evidence-based practices and methods determined by their community practice members. At this point in project development the identified approaches are Motivational Interviewing and Strengths-Based Approach models of

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case management. The project will also draw on the Continuum of Care model, which has been effective around the country in bringing multi-disciplinary stakeholders to the table to coordinate and collaborate for improved outcomes. Additionally, the project will look to leverage current staff training in the Coordinated Entry model developed in 2013 by the Vermont Housing Coalition and the Vermont Coalition to End Homelessness. The Coordinated Entry approach is a framework for creating effective partnerships to collaborate, coordinate, and streamline various community resources for the common goal of serving a target population. The approach was developed in coordination with a variety of service agencies across the state to create a standardized, tested approach. Pilot projects in the state of VT began in early 2014, with state-wide adoption in early 2015. The focus of the approach was not to increase resources through new or larger funding opportunities, but to connect and modify existing resources to create the most effective, integrated system possible. The coordinated aspects of the VRH project are built upon the lessons learned from the VT Coordinated Entry system. If this project is successful in streamlining existing resources to build capacity in partner agencies, it could be replicated throughout the state of NH to maximize other programs.

Additionally, since the approach was developed in Vermont, there is considerable opportunity for implementation support, contracted training and tool sharing. The high level milestones to implement Coordinated Entry in the Continuum of Care network structure are as follows:

- Completion of Local CoC Coordination Entry Orientation: Much of this work for the Coordinated Referral project at VRH has been completed in their project application and pre-work to implementation.
- Execution of Coordinated Entry Partnership Agreements: See the form to be used by the VRH team below.
- Execution of Data Sharing Agreement: Support from the Region 1 ID/Data group and required data sharing agreements across IDN partners.
- Shared Release of Information: Support from the Region 1 Privacy and Legal workgroups
- Creation of Local Resource Inventory: The Sullivan County Public Health Network and existing CoC structure will support and aid in the development of this inventory as it will be made available to all area agencies.

*\*See attached Coordinated Referral Template Form in E5: Appendix B*

The Coordinated Referral project will leverage and support the Region 1 IDN Workforce Training Implementation Plan. Also, as IDN partner organizations are identified as interested in E5 Enhanced Care Coordination projects, the VRH team will share lessons learned through the E5 Knowledge Exchanges.

### Process Milestones:

*\*See attached E5 Evaluation Table E5: Appendix C*

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

As the Coordinated Referral project has been funded for 1 year through June 30, 2018, the project process milestones currently reflect the official project term. The IDN and project team will engage in continuous improvement efforts, supported by the contracted Quality Improvement coaches, in and will likely modify components of the implemented project. To allow for this natural change cycle, the IDN staff will be highly involved in the project's relationship building, infrastructure support activities, and, ultimately, in deployment and operations. In partnership with the project team the Region 1 staff will meet throughout Q3, Q4 of implementation Year 1 to redefine the scope for contract extension and project expansion into Year 2. This process will include the creation of Year 2 process milestones that will reflect the project growth and scope expansion.

Additionally, the E5 project team is reviewing measurable ways to address program impact for the identified patient pool and will incorporate tracking of adherence to case management meetings, partner attendance at pilot team meetings, and

### Evaluation Plan

Due to the current phase of the Coordinated Referral project development, not all of the desired high level project evaluation or internal outcomes measures have been defined. We anticipate finalized measures to be available in early fall 2017. In an effort to gain a comprehensive current state assessment of the population targeted, there is continued assessment being conducted by the VRH project team. Once this data is formally analyzed, the team, in collaboration with the Region 1 staff and contracted QI coaches, will define the final evaluation points. In the interim, the measures addressed below reflect the current targets:

- **Increased # of Patients referred to Primary Care**
  - The Complex Case manager will track the number of clients who are established with a PCP and make arrangements for those who are not established to become referred. Data will be taken on each client served.
    - 12/31/17: 50 % of the total number of clients served with CCM will be referred to a PCP.
    - 6/30/18: 65% of the total number of clients served will be referred to a PCP.
    - \*Pending Project Continuation: 12/31/18: 80 % of total clients will be established with a PCP.
- **All Coordinated Referral Staff and Partners ensure Patient Follow up within 2 business days of contact**
  - 12/31/17- A referral form will be developed that specifically addresses best way to reach the client or any barriers to connecting with the client that may exist. CCM will attempt some form of reaching a client within 2 business days 50 % of the time.
  - 6/30/18- 75% of time CCM will attempt some form of contact with a client
  - \*Pending Project Continuation: 12/31/18-85 % of the time CCM will attempt some form of contact with a client.
- **At minimum quarterly Continuum of Care Meetings with increased levels of provider involvement**

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

- 12/31/17: Identify coordinated referral core team, assessment partners and referral partners. Create a yearly calendar of meeting dates to disseminate to increase planning and attendance.
- 6/30/18: 50 % attendance among assessment partners over the 6 month period (1/1/18- 6/30/18). Attendance of 3 referral partners over the 6 month period.
- \*Pending Project Continuation: 12/31/18: 75 % attendance among assessment partners over the 12 month period. Attendance of a referral partner 6 times over the 12 month period.
- **Assess program impact through number of individuals interested, served, and overall program adherence**
  - From the point of patient services inception the E5 team at minimum will document all program interest through referrals, all active clients and review program adherence quarterly. \*It is anticipated that these measures will be tracked monthly as the program gets underway.

### E5-2. IDN Community Project: Evaluation Project Targets

\*Reference section E5-1: Process Milestones

| Performance Measure Name   | Target  | Progress Toward Target |               |                |
|--|---|------------------------|---------------|----------------|
|  |   | As of 12/31/17         | As of 6/30/18 | As of 12/31/18 |
| <b>Project Defined Measures</b>  |   |                        |               |                |
| <i>Measure 1:</i> At least 80% of identified clients will have established with a PCP.   | <b>Will become effective post Year 1 Implementation: Q1, Q2 due to program launch, training</b> |                        |               |                |
| <i>Measure 2:</i> Established clients of the Complex Case Manager will receive a follow up within 2 business days.                                       |   |                        |               |                |
| <i>Measure 3:</i> Establishment of a Continuum of Care that meets regularly with a variety of partners to discuss referrals.                             |   |                        |               |                |
| <i>Measure 4:</i> Shorten the time between identification of an eligible individual and referral to appropriate services. Baseline determination needed. |   |                        |               |                |
| <b>Note: Measures are still in process and will be revised/expanded by Project Start</b>   |   |                        |               |                |
| <b>STC Defined Program Measures</b>  |   |                        |               |                |
| <i>All performance measures identified within the evaluation plan milestones</i>   | 100%  |                        |               |                |
| <i>Operationalization of Program</i>   | 100%  |                        |               |                |
| A. Implementation of Workforce Plan  |   |                        |               |                |
| B. Deployment of Training Plan   |   |                        |               |                |
| C. Implementation of any required updates to clinical protocols, or other operating policies and procedures  |   |                        |               |                |
| D. Use of assessment, treatment, management and referral protocols   |   |                        |               |                |
| <i>Initiation of Data Reporting</i>  | 100%  |                        |               |                |
| A. Number of individuals served vs. projected  |   |                        |               |                |
| B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected  |   |                        |               |                |
| C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements                         |   |                        |               |                |

Integrated Delivery Network Region 1: *Partnership for Integrated Care*

E5-3. IDN Community Project: Workforce Staffing

| IDN Workforce (FTEs)   |                      |  |                      |                     |                      |
|------------------------|----------------------|--|----------------------|---------------------|----------------------|
| Provider Type          | Projected Total Need | Baseline Staffing on 6/30/17             | Staffing on 12/31/17 | Staffing on 6/30/18 | Staffing on 12/31/18 |
| Community Case Manager | 1 FTE                | Recruit to Hire - Fall 2017              |                      |                     |                      |
| Supervisor             | 0.1 FTE              | Previously Employed at Lead Organization |                      |                     |                      |

E5-4. IDN Community Project: Budget

\*See E5-1: Budget Narrative for Additional Detail

*Please note that due to the initial award approval there is an additional 6 month approval for funding passing through the Executive Committee in August, 2017 to formally update the award for the full \$87,756.40.*

Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|   |                                 |                    |                    |  |                                 |
|---|---------------------------------|--------------------|--------------------|--|---------------------------------|
| <b>Organization Name:</b>   | <b>Valley Regional Hospital</b> |                    |                    |  |                                 |
| <b>Project Title:</b>   | <b>Coordinated Referral</b>     |                    |                    |  |                                 |
| <b>Start and End Date:</b>  | <b>7/1/2017 to 9/1/2020</b>     |                    |                    |  |                                 |
|   |                                 |                    |                    |  |                                 |
|   |                                 |                    |                    |  |                                 |
| <b>Budget</b>   |                                 |                    |                    |  |                                 |
|   |                                 |                    |                    |  |                                 |
|   |                                 |                    |                    |  |                                 |
| <b>Direct Expenses</b>  |                                 |                    |                    |  |                                 |
|   |                                 |                    |                    |  |                                 |
|   |                                 |                    |                    | \$60,000.00                                    | \$60,000.00 \$165,000.00        |
|   |                                 |                    |                    | \$1,456.00                                     | \$1,456.00 \$6,272.00           |
|   |                                 |                    |                    | \$21,510.00                                    | \$21,510.00 \$61,530.00         |
|   |                                 |                    |                    | \$200.00                                       | \$200.00 \$1,400.00             |
|   |                                 |                    |                    | \$385.00                                       | \$385.00 \$2,607.40             |
|   |                                 |                    |                    | \$4,267.00                                     | \$4,267.00 \$12,950.00          |
|   |                                 |                    |                    | \$0.00   | \$0.00 \$300.00                 |
|   | <b>Total</b>                    | <b>\$24,551.40</b> | <b>\$49,872.00</b> | <b>\$87,818.00</b>                             | <b>\$87,818.00 \$250,059.40</b> |
| <b>Indirect Expenses</b>  |                                 |                    |                    |  |                                 |
|   |                                 |                    |                    | \$8,743.00                                     | \$8,743.00 \$21,016.00          |
|   |                                 |                    |                    | \$96,561.00                                    | \$96,561.00 \$271,075.40        |
|   |                                 |                    | <b>49,872.00</b>   | <b><u>Year 2, 3 Totals are Unconfirmed</u></b> |                                 |
|   |                                 |                    |                    |  |                                 |
| <b>** See Budget Narrative in Region 1 IDN E5 Implementation Plan. Docx</b> |                                 |                    |                    |  |                                 |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

### E5-5. IDN Community Project: Key Organizational and Provider Participants

| Organization/Provider                     | Agreement Executed | Project Affiliation                              | Agreement  |
|---|--------------------|--|--|
|   | (Y/N)              |  |  |
| Valley Regional Hospital (Lead)           | Y                  | Project Lead                                     | Subcontract Agreement (IDN)                      |
| West Central Behavioral Health            | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| HOPE for Recovery NH                      | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| Claremont Soup Kitchen                    | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| Sullivan County United Way                | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| Claremont Emergency Services              | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| Newport Emergency Services                | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| TLC Family Resource Center                | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| DCYF                                      | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| ServiceLink                               | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |
| Sullivan County Department of Corrections | Y                  | Referral Partner: Community Based Support Agency | Coordinated Referral Partnership Agreement (VRH) |

### E5-6. IDN Community Project: Standard Assessment Tools

| Standard Assessment Tool Name | Brief Description  |
|-------------------------------|--|
| VRH: Screening Referral Tool  | Simple household information sheet completed by a Referral Partner Agency to capture personal information to provide an initial referral to an Assessment Partner Agency |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|                          |   |
|--------------------------|---|
| VRH: Barriers Assessment | Needs assessment completed by an Assessment Partner Agency to determine triage level and existing barriers to accessing preventive care, self-maintenance, and health improvement |
|--------------------------|---|

### E5-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management and Referrals

The project will utilize the protocols for Patient Assessment, Treatment, Management and Referrals that are detailed in Project B1 as a foundation (See Section B1). This will help the project benefit from the same components of integrated care delivery while focusing on more complex Medicaid Members. At the same time, it will help prevent fragmentation of processes which can significantly hinder adoption.

The project will augment the B1 protocols where there are unique patient needs, specific evidence based practices, or innovative approaches to deploy. The project team intends to deploy the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) in the first year.

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

| Protocol Name   | Brief Description  | Use (Current/Under development) |
|---|--|---------------------------------|
| Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT) Prescreen Triage Tool for Single Adults   | For this project we will be adopting a modified version of the VI SPDAT tool which is linked above. This tool has been utilized in Vermont housing to assist in triaging referrals. The VI SPDAT, VCEH Housing Crisis referral form and VCEH- CE Housing assessment will be modified to assess global risk and need of the population in order to help prioritize referrals. Additionally, the prescreen VI SPDAT tools for youth, families, and individuals will be used. | Under Development               |
| Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT) Prescreen Triage Tool for Youth, Families   |  |                                 |
| <a href="https://mainehmis.org/2015/12/31/vulnerability-index-service-prioritization-assistance-tool-vi-spdatt/">https://mainehmis.org/2015/12/31/vulnerability-index-service-prioritization-assistance-tool-vi-spdatt/</a> |  |                                 |

### E5-8. IDN Community Project: Member Roles and Responsibilities

|                                     |   |
|-------------------------------------|---|
| <b>Case Manager</b><br><b>1 FTE</b> | <ul style="list-style-type: none"> <li>• A Case Manager is a clinical business manager who assesses a client’s needs, develops and prioritizes a goal-directed plan of care based on diagnoses, presenting problems, skilled services and medical necessity to assure that proper utilization of resources takes place and quality is assured.</li> <li>• A Case Manager is a facilitator with a prospective vision of treatment planning for individual “cases,” establishing sound trusting relationships with all clients and caregivers.</li> </ul> |
|-------------------------------------|---|

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|  |   |
|--|---|
|  | <ul style="list-style-type: none"><li>• A Case Manager is a team leader, bringing together all clinical and service components of the client's care together and delegating team member tasks. The Case Manager encourages team spirit and promotes a unified direction and positive outcomes.</li><li>• A Case Manager is an educator of clients, nurses, families, physicians, other facilities and Administration who analyzes team function, monitors variances, reviews findings, shares information and makes recommendations to the team, building a fully informed partnership.</li><li>• A Case Manager is a client advocate who gauges the necessity and adequacy of care intervention taking place with the needs, wishes and desires of the client/family and negotiates on behalf of the client.</li><li>• A Case Manager demonstrates support of the hospital's mission and participates in Network programs as deemed appropriate by the Manager of Utilization/Case Management.</li></ul> <p>Essential Duties:</p> <ol style="list-style-type: none"><li>1. Establishes effective partnerships with local partner agencies to build a collaborative Continuum of Care for Coordinated Referral process.</li><li>2. Creation and implementation of Coordinated Referral program.</li><li>3. Plans, coordinates and implements care to assure that all medical, psychosocial, physiological and financial needs and concerns of the patient are addressed, appropriate action is taken and expected outcomes are achievable and measurable.</li><li>4. Functions independently and implements the care plan in a knowledgeable, skillful, consistent and continuous manner.</li><li>5. Reviews caseload activity on a quarterly basis, completes a report and submits statistics to the department manager.</li><li>6. Documents accurate and timely progress notes regarding the management of care, plans and outcomes.</li><li>7. Creates a positive environment for all clients, their families and all caregivers.</li><li>8. Liaison to physicians, nurses, ancillary staff, other external providers and regulatory bodies as indicated.</li><li>9. Identifies options for level of care movement in order to maximize resources, facilitate the addition of services if indicated, secure referrals and assure high quality case management services.</li></ol> |
|--|---|

Integrated Delivery Network Region 1: *Partnership for Integrated Care*

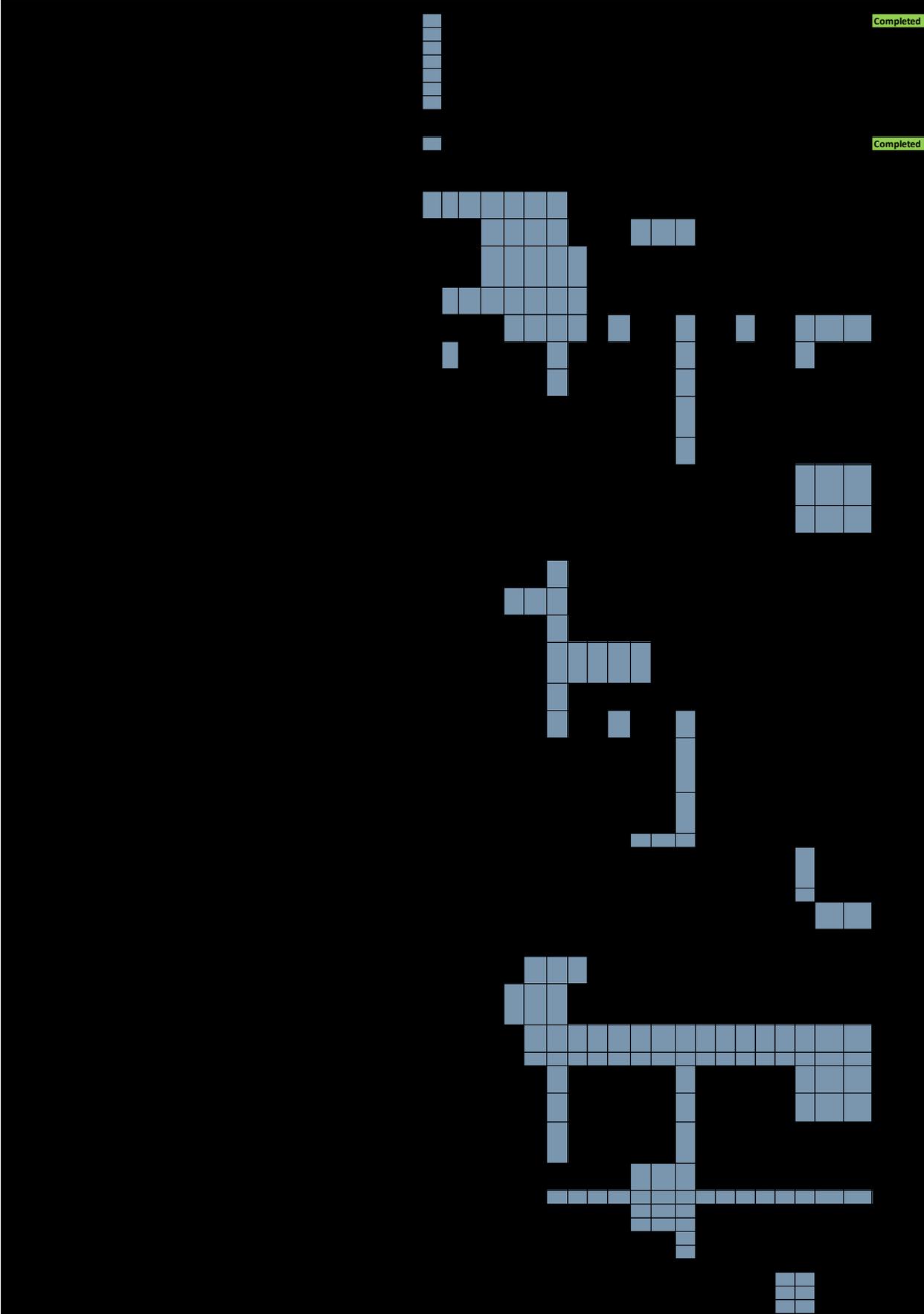
|                                |  |
|--------------------------------|--|
|                                | <p>10. Demonstrates appropriate clinical knowledge and management skills in order to assist providers in the holistic approach to health care maintenance and wellness.</p> <p>11. Resource for the interpretation of federal, state and other third party payer guidelines and community service regulations.</p> <p>12. Participates in educational programs to enhance knowledgebase in regards to health care, case management, professional clinical skills and self-improvement.</p> <p>13. Reviews and revises objectives for performance and professional growth with immediate supervisor.</p> <p>14. Initiates case conferencing with manager as necessity dictates.</p> <p>15. Adheres to Infection Control Policies and Safety Measures.</p> <p>16. Uses equipment and supplies effectively and efficiently and reports equipment malfunction or inadequate supplies to the appropriate individual.</p> <p>17. Complies with all applicable Policies and Procedures of Valley Regional Hospital.</p> <p>18. Additional responsibilities as may be required</p> |
| <p><b>Supervisor .1FTE</b></p> | <ul style="list-style-type: none"> <li>• Ensure monthly case conferences with clinical team occur on individuals identified</li> <li>• Supervise Case Manager including reviewing referrals and assignments from Coordinated Referral partnership, provides a critical insight in triaging and prioritizing caseload; works with staff to develop and implement new and changed systems</li> <li>• Attends interviews and recommends staff to be hired when applicable; counsels and disciplines staff when necessary; provides yearly performance reviews</li> <li>• Prepares and monitors budgets for programs within the scope of responsibility</li> <li>• Prepares monthly and quarterly statistical and narrative reports as established and identified in E5 goals, or requested by IDN or Coordinated Referral partnership</li> <li>• Uses effective relationship management, coordination of services, resource management, education, patient advocacy, and related interventions in training</li> </ul>   |

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|  |  |
|--|--|
|  | <ul style="list-style-type: none"><li>• Use in-depth understanding of local community resources to guide Complex Case manager.</li></ul> |
|--|--|



Integrated Delivery Network Region 1: *Partnership for Integrated Care*



A1: Appendix B. Signed Attestation

**Integrated Delivery Network Administrative Lead Contract  
Attestation Form**

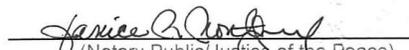
I, Sally Kraft, a representative of Region # 1, attest that I have reviewed and am in acceptance on behalf of Mary Hitchcock Memorial Hospital of the Statewide Workforce Capacity Development Strategic Plan as outlined in the New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver, IDN Process Measures Semi-Annual Reporting Guide for year 2 (CY2017) and Year 3 (CY2018), 2017-03-22 v.23

  
(Signature)

STATE OF NEW HAMPSHIRE

County of Grafton

The forgoing instrument was acknowledged before me this 29<sup>th</sup> day of June, 20 17.

  
(Notary Public/Justice of the Peace)

(NOTARY SEAL)

Commission Expires: 2/10/21

## Integrated Delivery Network Region 1: *Partnership for Integrated Care*

### A2: Appendix A: Program Risks and Mitigation

The 1115 Waiver is a large, broad, complex program with many risks to be managed. The following risks to HIT implementation will be monitored and mitigated. The implementation project plan will be actively managed to account for any timing changes resulting from these risk areas.

Figure 46: Risks and Mitigation

| Risk  | Mitigation Strategy   |
|---|---|
| Organizations may pull out of the Waiver where project requirements and administrative overhead overwhelms value.   | Help Partners identify shared interests between Waiver and their other high priority programs and future investments.<br>Shield Partners from project administration overhead.<br>Supplement and Support Partner staff to ease burden of Waiver activities. |
| Significant change to Medicaid policy at the Federal and/or State level may reduce or conclude funding mid-Waiver.  | Not in IDN control.<br>Communicate frequently with NH Medicaid.<br>Track Medicaid Policy federally.   |
| State Payment Reforms may not move forward on pace with the Transformation investment work. Sustainability of waiver investments post 2020 require Alternative Payment Model be in place. | Support NH DHHS to plan and implement APM.  |
| Software Vendors may not deliver functionality, technology deployment, training, and/or support as agreed to and on schedule.   | Vendor contract terms and SLAs.<br>Tight management oversight of vendor deployments.  |
| Patient Privacy Policies may take longer than planned to develop and deploy given complexity and high number of stakeholders involved.  | Engage legal assistance.<br>Meet and communicate with key personnel frequently.   |

Integrated Delivery Network Region 1: *Partnership for Integrated Care*

B1 Appendix A. Implementation Waves (Attachment B1.2A)

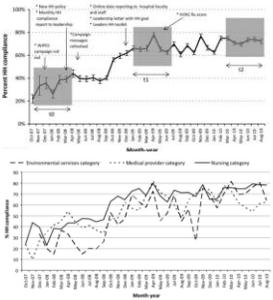
|                       |            | B1 Provider Wave Launch Times             |  |  |                                       |         |
|-----------------------|------------|---|--|--|---------------------------------------|---------|
| Region 1 B1 Providers |            | Wave 1 July 1, 2017-<br>November 30, 2017 | Wave 2 December 1,<br>2017- May 31, 2018 |  | Wave 3 June 1, 2018-September 1, 2018 |         |
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| [Redacted]            | [Redacted] | Pending Final<br>Launch Timeline          |  |  |                                       | [Green] |
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Integrated Delivery Network Region 1: *Partnership for Integrated Care*

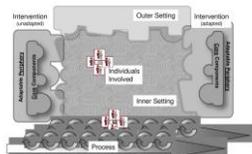
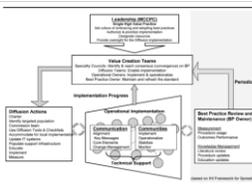
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| [Redacted] |            |  |  |  |  |  | [Orange] |

# Integrated Delivery Network Region 1: Partnership for Integrated Care

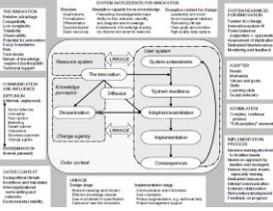
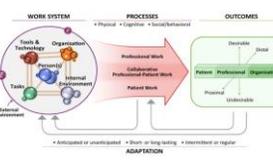
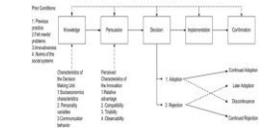
## B1 Appendix B. Innovation and Dissemination Bibliography (Attachment B1.2B)

| Author/s  | Journal (title, vol, year)                            | Type of article (review, RCT, observational, etc) | Definitions (implementation, dissemination, spread, etc)  | Major findings (include data if available)   | Include critical diagrams, tables, organizing frameworks   | Leadership and Culture   | Processes, people, roles and responsibilities   | Use of tools and technology (EHR, standardized protocols, etc)   | Systems to maintain learning and training. Infrastructure for continuous learning and  | APA Citation  |
|---|---|---|---|--|--|--|---|--|--|---|
| H. Aboumatar, P. Ristaino, R. Davis et al.            | Infection Control and Hospital Epidemiology, 33, 2012 | Single Study                                      | <b>PRECEDE</b> (model of dissemination) :<br>Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation<br><b>HH</b> : Hand Hygiene<br><b>HAI</b> : Healthcare-associated Infection | "Overall hand hygiene compliance increased by 2-fold after full program implementation (P < .001), and this increase was sustained over a 20-month follow-up period (P < .001). The odds for compliance with hand hygiene increased by 3-fold in the 6 months after full program implementation (95% confidence interval, 3.53–4.23; P < .001), and this increase was sustained. There was even a modest increase at 20 months of follow up. Hand hygiene compliance increased among all disciplines and hospital units. Hand hygiene compliance increased from 35% in the first 6 months after program initiation to 77% in the last 6 months of the study period among nursing providers (P < .001), from 38% to 62% among medical providers (P < .001), and from 27% to 75% among environmental services staff (P < .001)." |    | Leadership kicked off the campaign with an institution-wide letter announcing a focus on preventing infection and a followup letter was sent announcing the goal achieving 75% HH compliance by the end of the year. Toolkits, checklists, and promotion guides were sent to all unit managers who were then instructed to encourage HH compliance. Additionally, leadership recognized high performers. | One full-time employee (or equivalent) to conduct observations. Relatively low-tech communications campaign.  | Around 2,500 alcohol-based hand rub dispensers were installed at recommended locations throughout the hospital. Dashboard communicating unit/team HH compliance. | An online HAI prevention course was made mandatory for all incoming healthcare providers. A feedback system including both an online dashboard showing HH compliance by unit/team, and biweekly reports to leadership was implemented. | Aboumatar, H., Ristaino, P., Davis, R. O., Thompson, C. B., Maragakis, L., Cosgrove, S., ... Perl, T. M. (2012). Infection Prevention Promotion Program Based on the PRECEDE Model: Improving Hand Hygiene Behaviors among Healthcare Personnel. <i>Infection Control and Hospital Epidemiology</i> , 33(2), 144–151. <a href="http://doi.org/10.1086/663707">http://doi.org/10.1086/663707</a> |
| AHRQ  | Report  | Meta-analysis                                     |   | "Multicomponent strategies that address a combination of reach, ability, or motivation appear to be more effective than one strategy alone for affecting clinician behaviors, particularly guideline adherence (7 trials; moderate SOE) and for clinical outcomes, although many comparisons examining clinical outcomes were not significant (6 trials; low SOE)." "Our findings offered us no or insufficient evidence, however, to determine the comparative effectiveness of each dissemination strategy within a multicomponent strategy."  | Framework: Three "key questions" that are analyzed and answered by various studies. Description of fields lacking in studies is included in the "Limitations of the Literature Specific to Key Questions" section.   | Includes section on the "Implications of This Report for Clinicians and Policymakers" which encourages "multicomponent strategies" of dissemination and reminds us that there is "insufficient evidence, however, to determine the comparative effectiveness of each dissemination strategy within a multicomponent strategy."   | Argue that the process is specific to the group and the setting, not necessarily a one size fits all approach.  | Not applicable   | Not applicable   | Agency for Healthcare Research and Quality. (2013). <i>Communication and Dissemination Strategies To Facilitate the Use of Health-Related Evidence.</i>   |
| American Medical Group Association                    | Report  | Report  |   | This report defines what a high-performing health system is. There are seven categories that a system must perform highly in to be recognized as a high-performing health system and are as follows: efficient provision of services, organized system of care, quality measurement and improvement activities, care coordination, use of IT and evidence-based medicine, compensation practices, accountability.  |  | Not applicable   | Care coordination requires that health systems provide a SDM process to patients and quality measurement requires that they provide preventative care | Use of information technology and evidence-based medicine.   | The provider must be accountable for their actions (financially and otherwise) as well as transparent with their outcomes and finances.  | American Medical Group Association. (n.d.). <i>High-Performing Health System Definition</i> .   |
| C. Bosk, M. Dixon-Woods, C. Goeschel et al.           | Lancet, 374, 2009                                     | Perspective Article                               |   | The Keystone Initiative is not a success because of the checklists that it used to reduce mortality rates of surgical procedures, but rather because the dissemination model it used. In fact, saying so may increase complacency within the organization which makes surgery more dangerous. The dissemination method encourages some main topics listed right.   | Framework of dissemination model: "recruit advocates within the organisation, keep the team focused on goals, create an alliance with central administration to secure resources, shift power relations, create social and reputational incentives for cooperating, open channels of communications with units that face the same challenges, and use audit and feedback." | Recruitment of advocates and the shifting of power relations are two parts of the method/model that strongly tie into the leadership. Additionally, the alliance between central administration and the channels of communication tightly tie into this column. Lastly, the authors describe this project as a cultural and organizational change effort.  | One of the emphases was the processes of audit and feedback.  | Not applicable   | The auditing and feedback process in addition to the teams being focused on goals (if long term goals are set) maintain long term gains.   | Bosk, C. L., Dixon-Woods, M., Goeschel, C. A., & Pronovost, P. J. (2009). Reality check for checklists. <i>Lancet</i> , 374, 444–445. <a href="http://doi.org/10.1016/S0140-6736(09)61440-9">http://doi.org/10.1016/S0140-6736(09)61440-9</a>   |
| P. Carayon, T. Wetterneck, A. Rivera-Rodriguez et al. | Applied Ergonomic, 45, 2013                           | Meta-analysis                                     | <b>HFE</b> : Human factors and Ergonomics   | The SEIPS model is an effective way of promoting HFE in healthcare. There doesn't seem to be statistical evidence to support their claim, but they have examined many studies done in the past.  | Description of the SEIPS model and then explores studies which show how it is effective. Framework: tasks, organization, tools/technology, persons, and physical environment.  | Leadership under the SEIPS model is described mostly as organization. This is because the person at the center of their model can not only be a physician or nurse, but a patient as well. Leadership/culture in this model includes rules and procedures as well as organizational structure.   | Described as tasks under the SEIPS model. There is also a section under the SEIPS model described as the person at the center of the system.          | Tools/technology is another category in the SEIPS model. It includes even things as simple as pillboxes.   | In some ways the tasks work system also plays a role in this section. When the tasks involve a process of making sure one is maintaining best practices months after dissemination the system  | Carayon, P., Wetterneck, T. B., Rivera-rodriguez, A. J., Hundt, A. S., Hoonakker, P., Holden, R., & Gurses, A. P. (2013). Human factors systems approach to healthcare quality and patient safety. <i>Applied Ergonomics</i> , 45, 14–25.   |

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| D. Carpenter, V. Nieva, T. Albarghal et al. | Advances in Patient Safety, 4, 2005                                  | Meta-analysis              | <b>Diffusion:</b> "a passive process by which an innovation is communicated through channels over time in a social system"<br><b>Dissemination:</b> "a                                  | The feedback they got from researchers who used their tool in their planning process was positive. Researchers seemed to appreciate that they were filling a need that had to be met. One called it "a very effective developmental tool."  | Framework: This is a guide to why using the Dissemination Planning Tool developed by these researchers is beneficial. It goes through the purpose, development, a description, and feedback they received about the tool.                     | Describes how having an opinionated leader who likes the product is a more effective model of dissemination than a presentation at a conference.   | Not applicable  | The Dissemination Planning Tool can be used by researchers to assist in clearly thinking through the development and dissemination process.  | Not applicable  | Carpenter, D., Nieva, V., Albarghal, T., & Sorra, J. (2005). Development of a Planning Tool to Guide Research Dissemination. <i>Advances in Patient Safety</i> , 4, 83–92.   |
| P. Carter, P. Ozieranski, S. McNicol        | Implementation Science, 9, 2014                                      | Single Study               | <b>QIC:</b> Quality Improvement Collaborations  | QICs are not always effective ways of disseminating best care processes. Some of the troubles highlighted by the paper include free-riding, social loafing, and collaborative inertia. There is little incentive for high performing systems to stay in the system while those are the systems that need to contribute most to the group.   |   | A focus of leadership must be on creating incentive in high performers. Leadership in the health system "needed to have sufficient authority ('oomph') and dedicated time within their role in order to implement and sustain quality improvement."  | "For any project team to be effective, clarity about membership, leadership, continuity, and the  | Not applicable   | Not applicable  | Carter, P., Ozieranski, P., McNicol, S., Power, M., & Dixon-Woods, M. (2014). How collaborative are quality improvement collaboratives: a qualitative study in stroke care.  |
| L. Damschroder, D. Aron, R. Keith et al.    | Implementation Science, 4, 2009                                      | Meta-analysis              | <b>CFIR:</b> Consolidated Framework for Implementation Research<br><b>Implementation:</b> "constellation of processes intended to get an intervention into                              | The CFIR model tries to be the most comprehensive, all-inclusive model for research implementation to date. The effort was made to take all the previous models and pull out their important characteristics. For an in depth look at the models they reviewed examine additional file two. For a look at what each topic/description mean examine fill three.  | Additional file one provides a somewhat cheesy abstract diagram of what CFIR looks like as a puzzle. Although it doesn't add to our knowledge really at all, the few pages following it do help give a less lengthy description of the model. | This model includes leadership engagement and culture as two separate topics that need to be addressed in dissemination. They are defined as "[c]ommitment, involvement, and accountability of leaders and managers with the implementation" and "Norms, values, and basic assumptions of a given organization." respectively. | Process involves five steps which include planning, engaging, executing, and reflecting/evaluation. Engagement also includes many more substeps.  | This section would appear to either be included in the intervention portion of the dissemination process or not at all.  | The reflection and evaluation portion of the dissemination process ensures "team debriefing about progress and experience." This encourages systems to maintain learning/training.  | Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009a). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science.  |
| L. Damschroder, D. Aron, R. Keith et al.    | Implementation Science, 4, 2009                                      | Meta-analysis              | See above   | This file is a strange diagram that abstractly tries to describe the CFIR process of dissemination as described above.  |   | See above  | See above   | See above  | See above   | Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009b). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science File 1:   |
| L. Damschroder, D. Aron, R. Keith et al.    | Implementation Science, 4, 2009                                      | Meta-analysis              | See above   | This file displays the aspects of other models which were studied and fit into aspects of the CFIR model.   |   | See above  | See above   | See above  | See above   | Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2007). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science File 1:  |
| L. Damschroder, D. Aron, R. Keith et al.    | Implementation Science, 4, 2009                                      | Meta-analysis              | See above   | This file describes the different aspects listed above.   |   | See above  | See above   | See above  | See above   | Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (n.d.). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science File 3: CFIR Constructs with Short Definitions.  |
| I. Dilling, S. Swensen, M. Hoover et al.    | The Joint Commission Journal on Quality and Patient Safety, 39, 2013 | Meta-analysis/Single Study | <b>Diffusion:</b> (Rogers definition) "the process by which innovations—ideas, knowledge, or processes—are communicated among the members of a social system such as a health care org. | MAYO has studied various forms of dissemination and adapted a combination of their favorites into their own model. The results are a complete dissemination of best practices to all twentyfour hospitals within eighteen months. They have also achieved a culture change within the hospitals; the adoption of best care models are welcomed and now initiated by teams on the floors.  |   | They've put together a Clinical Practice Committee which is made up of "physician and administrative" leaders" and has abundant funding and authority to facilitate the dissemination process. Other high powered administrative and clinical teams have also been formed with similar interhospital goals.                    | There is a specific formula they follow for their process. Every dissemination project goes through the same steps listed in "The Diffusion Work Flow Chart" and is tracked by administrators | This is a low-tech solution to the problem of dissemination. Aside from the tracker and the flow chart (which are simple forms they've created) there appears to be little to no technology used to disseminate information. | Long term "best-practice owners" are assigned to each project and make sure not only that the hospitals continue implementing the best practice model, but also making sure that the model is tweaked if any new research comes out on the subject. | Dilling, J. A., Swensen, S. J., Hoover, M. R., Dankbar, G. C., Donahoe-Anshus, A. L., Murad, M. H., & Mueller, J. T. (2013). Accelerating the Use of Best Practices: The Mayo Clinic Model of Diffusion. <i>The Joint Commission Journal on Quality and Patient Safety</i> , 39(4), 167–176.       |
| M. Dixon-Woods, S. McNicol, G. Martin       | BMI Quality and Safety, 2012   | Meta-analysis              |   | An analysis of the major barriers to dissemination with occasional recommendations of how to avoid these barriers. Similar in style to Maher et al. below, with focus on the following areas. The design and planning of improvement interventions which can be related to process. The organizational and institutional contexts, professions, and leadership which goes under the leadership column. And finally, beyond the intervention: sustainability, spread, and unintended consequences which I would put under the long | See left.   | These four challenges fall under the leadership category: organizational context, culture and capacities, tribalism and lack of staff engagement, leadership, and incentivizing participation and 'hard edges.'  | These four challenges fall under the process category: convince people there's a problem, convince people of the solution, data collection and  | Not applicable   | These two challenges fall under the infrastructure for continuous learning: securing sustainability, and side effects of change.  | Dixon-Woods, M., McNicol, S., & Martin, G. (2012). Ten challenges in improving quality in healthcare: Lessons from the Health Foundation's programme evaluations and relevant literature. (April). <a href="http://doi.org/10.1136/bmjqs-2011-000760">http://doi.org/10.1136/bmjqs-2011-000760</a> |

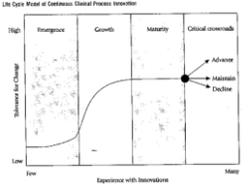
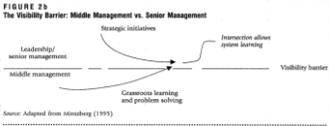
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| M. Dixon-Woods, C. Bosk, E. Aveling et al. | The Milbank Quarterly, 89, 2011                | Single Study                    | <b>CVC:</b> Central Venous Catheter(ization)  | This study identified the six reasons why a dissemination model worked for reducing CVC HAIs in Michigan. The reasons include: "isomorphic pressures, networked community efforts, reframing the issue as a social problem, changing practice and culture at the sharp end by using interventions with different effects, using data as a disciplinary force, and skillfully using 'hard edges.'"   | None   | Due to general physician resistance to "managerial" rules" the study reinforces the idea that "[l]eaders with the necessary authority to breathe legitimacy . . . into what is being advocated are therefore critical." Changing the culture around CVC infections as to not being seen as inevitable was arguably the most important part of what Michigan accomplished.  | The horizontal nature of the program was emphasized as being crucial to culture change and sustained improvements. The nurses had an  | The project asked hospitals to complete their own checklist that complies with safety measures recommended by the collaborative. Teleconferences, face-to-face workshops, and mentorship programs | "Regular feedback on performance can be used to motivate sustained efforts, as it can provide a sense of progress or help keep participants' on task." Referring to blinded data shared by collaborative.  | Dixon-Woods, M., Bosk, C. L., Aveling, E. L., Goeschel, C. a., & Pronovost, P. J. (2011). Explaining Michigan: Developing an Ex post theory of a quality improvement program. <i>Milbank Quarterly</i> , 89(2), 167–205. <a href="http://doi.org/10.1111/j.1468-0009.2011.00625.x">http://doi.org/10.1111/j.1468-0009.2011.00625.x</a>   |
| V. Fuchs, A. Milstein                      | The New England Journal of Medicine, 364, 2011 | Perspective Article             | None  | This is, in essence, an opinion article about why it is so difficult to adopt a more efficient health system. Some reasons are as follows: insurance company resistance, large employer resistance, media interference, legislator and hospital administrator and physician resistance.   |  | Resistance from legislators stems from their abundant campaign contributions from the healthcare industry. Hospital administrators and physicians are both resistant because it changes the way they charge and how they are paid.   | Not applicable  | Manufacturers of the tools and technologies used by healthcare professionals have the most to lose from the diffusion of cost effective care.   | Not applicable   | Fuchs, V. R., & Milstein, A. (2011). The \$640 Billion Question - Why Does Cost-Effective Care Diffuse So Slowly? <i>The New England Journal of Medicine</i> , 364, 1985–1987.   |
| T. Greenhalgh, G. Robert et al.            | Millbank Q 2004                                | Meta-analysis/Literature Review | <b>Innovation service delivery and organization:</b> a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or user's experience and that are implemented by planned and coordinated actions. <b>Diffusion:</b> Passive | This study incorporates many research disciplines to define the different factors that affect dissemination in addition to the creation of their unique model. The six major categories that they listed as being part of their model are as follows: the innovation itself, the adoption process, communications/influence, the inner context, the outer context, and lastly the implementation process. As one can tell, these are very reminiscent of all the major categories we see in both the SEIPS model and the CFIR. Because it is referenced so often by other studies and it was published ten years ago, it seems to be one of the main benchmark studies in the field of dissemination literature. It also takes into account a tremendous amount of information: ended up using almost 500 studies of the 6,000 abstracts they examined. |    | The managerial attitude towards change, administrative intensity, centralization, and leadership/management are all crucial parts of their model. Centralization represents the "extent to which decision-making autonomy is dispersed or concentrated within an organization." Additionally, one of their ideas about healthcare improvement collaboratives is that some of the greatest success factors are whether or not the motivation can be created which is intimately related to culture. The champions described in this model have various roles: organizational maverick, transformational leader, organizational buffer, and network facilitator. | There are opinion leaders and champions in this system. In terms of a process, one of the things described is what is needed from formal dissemination programs. The change agency must: "take full account of potential adopters' needs and perspectives, tailor strategies to different subgroups, use message with appropriate | An important part of any model (including this one) is ensuring that the funding is there to pay not only the people that you need, but for the tools a healthcare system needs as well.          | An interesting concept here is their idea of "Absorptive Capacity for New Knowledge." The organization must be able to complete the following steps in order to be able to understand new knowledge: identify, capture, interpret, share, reframe, and recodify new knowledge. That's the primary learning system, but the long term learning system is what they call "routinization." Things they use to allow that to happen are adaption/reinvention and feedback. | Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. <i>The Milbank Quarterly</i> , 82 (4), 581–629. <a href="http://doi.org/10.1111/j.0887-378x.2004.00325.x">http://doi.org/10.1111/j.0887-378x.2004.00325.x</a>   |
| R. Holden, P. Carayon, A. Gurses et al.    | Ergonomics, 56, 2013                           | Meta-analysis                   | <b>Internal environment:</b> physical environment (lighting, space, wind) <b>External environment:</b> "macro-level societal, economic, ecological, and   | This article describes a slight variation/update on the original SEIPS model which it calls SEIPS 2.0. It is a very similar model, except it has included some new ideas from recent developments in the field of HFE. The major difference between the two is the change from physical environment to internal and external environments.  |   | Culture is certainly defined under the organization section of the work system. The policies and culture of an organization play a role in effectiveness of dissemination. The SEIPS 2.0 model explicitly states that "social environments" (similar to culture) should not be included in either internal or external environments, but rather under organization.  | Tasks is the term they use for processes in the SEIPS model. An important note is to recognize the adaptations portion of the model which occurs when workarounds need to be implemented.   | Both the tools and internal environment play into this category. SEIPS 2.0 considers physical layout and all physical aspects to be included in the internal environment.                         | Perhaps tasks is the only thing that could really be included in this section. It is kind of tangential, but the process could be one that involves continuous learning/disseminating knowledge.   | Holden, R. J., Carayon, P., Gurses, A. P., Hoonakker, P., Hundt, A. S., Ozok, A. A., & Rivera-Rodriguez, a J. (2013). SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. <i>Ergonomics</i> . Taylor & Francis. <a href="http://doi.org/10.1080/00140139.2013.838643">http://doi.org/10.1080/00140139.2013.838643</a> |
| M. Hoover                                  | Presentation                                   |                                 |   | This presentation highlights the attributes of the MAYO clinic dissemination model found above under Dilling et al.   |  | See Dilling et al.   | See Dilling et al.  | See Dilling et al.  | See Dilling et al.   | Hoover, M. (2012). Intermountain HEN Meeting: Mayo Clinic Model of Diffusion.  |
| Institute for Healthcare Improvement       | Report   | Likely Meta-analysis            |   | The spread planner worksheet is intended to be filled out before a dissemination project has even begun. It was informed by Don Berwick (president of IHI) and the work of Everett Rogers. Rogers' work is intimately related to the diagram seen right (pulled from slide 18 of the June 24th Dissemination Team Meeting Powerpoint).  |  | First topic addressed.   | The entire process is planned out by the questions asked in the spread planner. If any question goes unanswered the leader must answer it before  | Addressed in the pilot site section (more or less).   | The Measurement and Feedback system should do well to work as a continuous learning system.  | Institute for Healthcare Improvement. (2004). Spread Planner. Institute for Healthcare Improvement. Institute for Healthcare Improvement.  |

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| John Snow Inc.                          | Report/Case Study Series                      | Meta-analysis | <b>Scaling Up:</b> Similar to the terms dissemination, diffusion, and spread.   | Describes a variety of methods by which scale-up is achieved worldwide. The focus of this company seems to be on the dissemination of information in third world countries (specifically in Africa and related to AIDS). Similar in content to the M. Massoud, G Nielsen, C McCannon et al. report seen below.  |  | Some processes seem specifically linked to the leadership, these mostly include the political scaling up models.  | I find the role of the many people working for Jon Snow interesting because they are advocates for public health in places where they might not be welcomed (because of bringing about change).  | Not applicable  | Not applicable  | John Snow Inc. (2005). Best Practices in Scaling Up: Case Study Series.   |
| Kotter, John P.                         | Article                                       | Article       |   | This article (written by a professor of leadership) describes why transformation efforts fail in businesses worldwide. It is not healthcare specific, but it brings attention to the pivotal decisions senior leadership makes that can make or break a company (or health system).   |  | The entire article is focused on leadership and what leaders should/shouldn't do when they are trying to affect change within their company. There are eight, but a couple notable ones are "Not establishing a great enough sense of urgency" and "declaring victory too soon."  | The process of "anchoring change in the corporate culture" seemed to be a long term indicator of success. This obviously applies to <del>the and systems</del> <del>the four process</del> level factors are as follows: "benefits beyond helping patients," "credibility of the benefits," "adaptability of improved process," "senior leadership <del>and the feedback loop</del> ." | Not applicable  | It talks about declaring victory too soon as being the major barrier to long term sustainability of a transformation.   | Kotter, J. P. (1995). Leading Change: Why Transformation Efforts Fail.  |
| Maher, Gustafson, Evans                 | Presentation                                  |               |   | Goes through what the NHS have found to be the "ten key factors that increase the likelihood of sustainability and continuous improvement. They can be organized into the branches: process, organization, and staff.   |  | The two organization level factors are as follows: "fit with organization's strategic aims and culture" and "infrastructure for sustainability." It should be noted that both senior leadership engagement as well as clinical leadership engagement are mentioned in the staff level factors noted right.  | Tools/tech don't play a big role in these factors, but I will list the staff level factors: "staff involvement and training to sustain the process," "staff attitude towards sustaining the change," "senior leadership <del>and the feedback loop</del> ."  | Relevant factors include: infrastructure for sustainability, and effectiveness of the system to monitor progress.   | Maher, Gustafson, & Evans. (2003). The NHS Sustainability Model. In The NHS Sustainability Model (pp. 1-27). NHS Institute for Innovation and Improvement.  |   |
| M. Massoud, K. Donohue, C. McCannon     | Report  | Report        | Primarily uses spread for dissemination/implementation.   | This article is somewhat similar to the Jon Snow Inc. article listed above in that it too lists different models of dissemination that we see around the world. It is more USAID and WHO focused, however. It shows various graphs from different improvement collaboratives that have been successful in the past. It essentially gives a bunch of different "approaches for large-scale spread."  |   | There are an abundance of different strategies highlighted throughout this article. Some are rely heavily on senior leadership and culture change, others don't have any leadership involvement whatsoever.   | They recommend the "study, act, plan, do" method as a strong model for improvement.  | Reading through the case studies they did towards the end of the article showed how consolidating the tools at a health system can often lead to major improvements. This is what worked to reduce hypothermia (and therefore mortality) in | Massoud, M. R., Donohue, K. L., & McCannon, C. J. (2010). Options for Large-scale Spread of Simple, High-impact Interventions.  |   |
| M. Massoud, G. Nielsen, K. Nolan et al. | Report  | Report        | Primarily uses spread for dissemination/implementation.   | Tightly intertwined with the article above (same diagrams etc.). Again lists many different types of spread, but also has some FAQs about developing a spread plan. It also talks about execution/refinement of the spread plan, but overall didn't feel like this article added very much to my understanding.   |  | At one point in this report it states that "role of leadership cannot be emphasized enough in both initiating a plan for spread and being actively supportive once the plan is underway." I find it interesting that it doesn't remind us about how important leadership is for maintaining long-term goals in the audit/feedback process.  | Not applicable   | Not applicable  | Massoud, M. R., Nielsen, G. A., Nolan, K., Schall, M. W., & Sevin, C. (2006). A Framework for Spread: From Local Improvements to System-Wide Change. Spreading Improvement Across Your Health Care Organization. Retrieved from <a href="http://books.google.com/books?hl=en&amp;lr=&amp;oi=fnd&amp;pg=PA1&amp;dq=A+Framework+for">http://books.google.com/books?hl=en&amp;lr=&amp;oi=fnd&amp;pg=PA1&amp;dq=A+Framework+for</a> |   |
| R. Moynihan                             | Book Section                                  | Report        | Not applicable  | A consultation with Cassie after reading the first chunk of the report yielded the decision that this isn't relevant to the topic. It is a report on systematic reviews and their importance in medicine.   |  | Not applicable  | Not applicable   | Not applicable  | Not applicable  | Evaluating Health Sciences: A Reporter Covers the Science of Research Synthesis. Evaluating Health Sciences: A Reporter Covers the Science of Research Synthesis (Vol. 46). New York, NY: Millbank Memorial Fund. |
| J. Øvretveit                            | Book Section                                  | Meta-analysis | <b>Enabled Uptake:</b> Their words for the implementation spread to emphasize that most of what happens hinges on the buy-in of many parties. | This study provides a framework for spreading implementation it determined through studying various health systems' work at spreading implementation. It examined the John Hopkins project that informed the Keystone project, as well as various projects through Veteran's Affairs. In addition to its checklist, it also has an equation that show what goes into implementation results. It is as follows: initial idea/proven change + implementation actions + critical conditions = results implementation strategy. |  | Both a top-down and bottom-up approach are described in this framework. It says that in some cases one will work better and in others the other will work better (not very helpful). It says something similar about adapting different frameworks to different places.   | In many studies the process of dissemination and implementation require the adaptation of the general model to the specific hospital or even floor. This study says that sometimes this is   | Not applicable  | Not applicable  | Øvretveit, J. (2001). Implementing, Sustaining, and Spreading Quality Improvement (pp. 159-176).  |
| J. Ploeg, B. Davies, N. Edwards et al.  | Worldviews on Evidence-Based Nursing, 4, 2007 | Single Study  |   | This is another study of the facilitators and barriers to implementation and dissemination with a twist; it studies implementation in nursing. The results are similar to any studies of physicians and the facilitators are as follows: presence of champions, staff training and education, unit/organizational leadership, and collaboration with multidisciplinary teams. It should be noted that this is a study that results are from interviews with various participants.   |  | Leadership support was facilitator and was "closely linked with positive staff attitudes." The leaders were important because they supported the vision, provided staffing and resources, and embedded the guideline in policy and procedures. The culture of positive staff attitudes was another facilitator. When perceived changes are small as opposed to radical, the culture surrounding implementation remained positive. This was a top-down approach. | Group interaction "was emphasized as one of the most important facilitators/processes regarding implementation. According to this study the process of having someone learn from a powerpoint sent by a leader wasn't  | One of the biggest barriers for the nursing staff were time/resource constraints. This is intimately related to better technology because with better technology these problems could be reduced.   | Ploeg, J., Davies, B., Edwards, N., Gifford, W., & Miller, P. E. (2007). Factors Influencing Best Practice Guideline Implementation: Lessons Learned from Administrators, Nursing Staff, and Project Leaders. Worldviews on Evidence-Based Nursing, 4, 210-219.   |   |

# Integrated Delivery Network Region 1: Partnership for Integrated Care

|   |  |                 |  |   |  |   |   |  |   |   |
|---|--|-----------------|--|---|--|---|---|--|---|---|
| V. Prasad, A. Vandross, S. C. Toomey et al. | Mayo Clinic Proceedings, 88, 2013                                    | Meta-analysis   | <b>Medical Reversal:</b> when a current medial practice was found to be inferior to a lesser or prior standard.  | This review of 2,044 articles found 146 medical reversals in the last decade. That means that of the 363 articles that tested an established practice, 40.2% were found to be less effective than a previous best care practice. This has staggering implications for not only the reputation of the healthcare system, but for the finances as well.   |    | Not applicable  | Not applicable  | Often tools/technology/innovative processes aren't looking at literature from ten year span it seems like people will understand this has been going on for a while and requires long term change.           | Prasad, V., Vandross, A., Toomey, C., Cheung, M., Rho, J., Quinn, S., ... Cifu, A. (2013). A decade of reversal: An analysis of 146 contradicted medical practices. <i>Mayo Clinic Proceedings</i> , 88(8), 790-798. <a href="http://doi.org/10.1016/j.mayoc">http://doi.org/10.1016/j.mayoc</a>  |   |
| H. Rao, R. Sutton                           | McKinsey Quarterly   | Opinion article |  | Not a super pertinent article to our subject matter. The focus of this article is to provide leaders of private companies with ideas about how to increase employee productivity. Healthcare is mentioned briefly, but it doesn't add much to our knowledge base. Some of the ideas this articles had to improve productivity and behavior in their companies were as follows: nip it in the bud, focus on the mundane details, adequacy before excellence, use champions to squelch bad behavior, kill the thrill from bad behavior, try to have people focus on their future selves, focus on the highlights, lowlights, and ending to everything. Additionally, the four feelings that signal trouble in your organization are: fear of responsibility, feeling of injustice, helplessness, and anonymity. |  | This completely focuses on the leadership and what they must do to remove negative behaviors in their company. According to this article, negative behaviors are far more damaging than positive behaviors are constructive. Perhaps this can be used once we have a solid framework to work with, but I think it isn't very useful to the project at the moment.   | The responsibilities according to the article fall entirely on the senior leadership and the management to make decisions that correct bad behavior when a company is doing poorly.   | Not applicable   | They don't talk about long term processes or maintaining what a company might currently have. I did find one manager's system of reducing the millions of dollars of equipment stolen by employees to be interesting, however. They made everything borrowable which eliminated the thrill of stealing things and reduced the number of stolen goods by employees to nearly zero. | Rao, H., & Sutton, R. I. (2014). Bad to great: The path to scaling up excellence. <i>McKinsey Quarterly</i> , 1-11.   |
| L. Savitz, A. Kaluzny, D. Kelly             | Journal of Healthcare Management, 45, 2000                           | Single Study    | CPI: Clinical process innovation = generation, acceptance, and implementation of new ideas, tools, and/or support systems aimed at improving clinical processes and, ultimately, patient care. This is distinct from CQI | This study introduces the idea of life cycles into dissemination practices in healthcare institutions. There are four phases that an organization moves through in relation to their experience with innovations: emergence, growth, maturity, and critical crossroads. Great emphasis was placed on the critical crossroads as the place in the road where senior leadership needs to make decisions that advance, maintain, or decline the willingness of their organization to be open to change.  |    | This article explicitly focuses on the leadership (senior leadership for the most part) and the decisions they need to make as well as the need for them to have the ability to recognize where an organization is within the lifecycle model.  | To be frank, I was moderately confused by the lifecycle model itself. One of the things that they emphasized that I did want to draw attention to, however, was their statements regarding top-down and bottom-up                   | The life cycle model itself is a sort of tool that senior leadership can use to help make decisions. It draws leadership attention to the fact that promoting openness to change is of the highest priority. | It appears to me that the life cycle of the organization goes form its inception to the very longterm. In a sense, this is exactly a tool that senior leadership can use to promote long-term learning and goals.   | Savitz, L. A., & Kaluzny, A. D. (n.d.). Assessing the Implementation of Clinical Process Innovations: A Cross-case Comparison. <i>Journal of Healthcare Management</i> , 45, 366-379.   |
| L. Savitz, A. Kaluzny                       | Journal of Healthcare Management, 45, 2000                           | Single Study    | CPI: Clinical process innovation = generation, acceptance, and implementation of new ideas, tools, and/or support systems aimed at improving clinical processes and, ultimately, patient care. This is distinct from CQI | The second part in a series of two articles (the first one is listed above) that has a focus on determining the barriers and facilitating factors in dissemination of clinical process innovations. Three factors were listed and they are as follows: communication, financial, and organizational adaptation. Although other studies list many other factors, those other factors can often be put into at least one of the categories that are listed above. For example, Savitz et al. had training and education as well as feedback under the communications heading.   |   | In regards to the topic of top-down and bottom-up approaches, this article seems to state that most initiatives begin as a grassroots, bottom-up initiatives. The key appears to be that the management is able to respond to the grassroots learning and put strategic initiatives into place. The visibility barrier must be broken down/overcome between middle and senior leadership in order to produce system learning. | The process of having grassroots movements go through the visibility barrier to see how their efforts can benefit the entire health system is a difficult one. It takes   | Not applicable   | Not applicable  | Savitz, L. A., Kaluzny, A. D., & Kelly, D. L. (2000). A Life Cycle Model of Continuous Clinical Process Innovation. <i>Journal of Healthcare Management</i> , 45, 307-316.  |
| L. Schilling, A. Chase, S. Kehrl et al.     | The Joint Commission Journal on Quality and Patient Safety, 36, 2010 | Single Study    | PI: Performance Improvement  | This article identifies six factors which affected performance improvement efforts at Kaiser Permanente: leadership priority setting, a systems approach to improvement, measurement capability, a learning organizational, improvement capacity, a culture of improvement. The emphasis on the frontline in the study can hardly be overstated. "If PI is to occur, it must do so at the frontline."   |  | The culture section reminds us that "[t]o achieve systemwide improvement, ownership of quality and service performance needed to shift from quality-content experts . . . To operational leaders and managers and frontline staff."   | "Top-down, systemwide goal setting must be balanced against bottom-up learning and application." The top-down, bottom-up process is consistently mentioned as being the most important part of the process according to this study. | At Kaiser Permanente they implemented something called the Big Q data dashboard. This tool "provided consistent, timely, actionable data that could be view at national, regional, and facility levels."     | Something discussed was how they haven't yet "quantified the critical mass for creating a self-perpetuating improvement culture." Speculation about the square root of the total staff being the number was unfounded because Kaiser has that amount of staff buy-in.   | Schilling, L., Chase, A., Kehrl, S., Liu, A. Y., Stiefel, M., & Brentari, R. (2010). Kaiser Permanente's Performance Improvement System, Part 1: From Benchmarking to Executing on Strategic Priorities. <i>The Joint Commission Journal on Quality and Patient Safety</i> , 36(11), 482-498. |

# Integrated Delivery Network Region 1: Partnership for Integrated Care

| P. Sharek, C. Mullican, A. Lavanderos et al.   | The Joint Commission of Quality and Patient Safety, 33, 2007         | Single Study | <b>Partnership:</b> formal cooperative relationship between organizations that share responsibility for achieving a series of specific goals.<br><b>Collaborative:</b> collections of organizations | An analysis of the barriers to implementing best care practices specifically in partnerships (not collaboratives because they believe there is an abundance of studies of collaboratives already). Some results are shown in tables to the right where it appears partnership challenges were a big struggle for most organizations. Successful and unsuccessful intervention strategies were also listed. Ones that worked generally involved strong communication strategies and allowed for flexibility in the organizations. Interventions that didn't work had strict approaches, poor communication, or included incentives (those are ineffective apparently). | <p><b>Table 2: Implementation Submissions—Generated Major List of Potential Barriers to Implementation (Figure 14)</b></p> <p>Partnership: challenges<br/>Incentives: antitags/benefit ideas<br/>Trust: distrust for team-based methods<br/>Resources vs. quality improvement lesson<br/>Pilot/steer variables<br/>Blindness that QI is not<br/>Legal issues<br/>Regulatory issues<br/>Technical/data issues<br/>Financial challenges<br/>Time issues<br/>Communication<br/>Social confidence<br/>Evaluation<br/>Team issues<br/>Organizational<br/>No quality improvement</p> <p><b>Table 3: Prevalence of Categories for "Barriers to Implementation" (Items 1)</b></p> <table border="1"> <thead> <tr> <th>Category</th> <th>1 (n=10)</th> <th>2 (n=10)</th> <th>3 (n=10)</th> <th>Significance Score</th> </tr> </thead> <tbody> <tr> <td>Communication</td> <td>10</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Financial</td> <td>8</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Legal</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Organizational</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Regulatory</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Technical</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Trust</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Time</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> <tr> <td>Other</td> <td>7</td> <td>7</td> <td>7</td> <td>10</td> </tr> </tbody> </table> | Category   | 1 (n=10)   | 2 (n=10)   | 3 (n=10)   | Significance Score  | Communication                                   | 10   | 7     | 7     | 10    | Financial  | 8   | 7   | 7   | 10  | Legal  | 7   | 7   | 7   | 10  | Organizational                     | 7   | 7   | 7   | 10  | Regulatory   | 7   | 7   | 7   | 10  | Technical   | 7   | 7   | 7   | 10  | Trust | 7 | 7 | 7 | 10 | Time | 7 | 7 | 7 | 10 | Other | 7 | 7 | 7 | 10 | One of the challenges to intervention was the "ambiguity of guidelines and an inability to define actionable interventions that are easily operationalized at the practitioner/site level." This is something the leadership can address. Interestingly, the culture of these institutions made it so that interventions targeting doctors failed miserably. Targeting of a wider audience was required in order to be successful. | Processes suggested to overcome the barrier were as follows: formal QI coaching, internal benchmarking, establishment of a common database, internal success stories, and economies of scale | Although a lack of resources beyond the end of the grant was a tremendous barrier for organizations, nothing else seems to fit under tools/tech. | A long term barrier to sustaining the results of an implementation was the lack of financial resources after the grant ended. The authors made no suggestion about ways past this barrier. | Sharek, P. J., Mullican, C., Lavanderos, A., Palmer, C., Snow, V., Kmetik, K., ... Demby, L. M. (2007). Best Practice Implementation: Lessons Learned from 20 Partnerships. The Joint Commission Journal on Quality and Patient Safety, 33(12), 16–26. |
|--|--|--------------|---|---|---|--|--|--|--|---|---|------|-------|-------|-------|--|-----|-----|-----|-----|--|-----|-----|-----|-----|------------------------------------|-----|-----|-----|-----|--|-----|-----|-----|-----|---|---|---|---|---|-------|---|---|---|----|------|---|---|---|----|-------|---|---|---|----|--|--|--|--|--|
| Category   | 1 (n=10)   | 2 (n=10)     | 3 (n=10)  | Significance Score  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Communication  | 10   | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Financial  | 8  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Legal  | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Organizational   | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Regulatory   | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Technical  | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Trust  | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Time   | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Other  | 7  | 7            | 7   | 10  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Elizabeth Strutz   | Presentation   | Single Study | Uses term spread to represent dissemination   | Seven "spreadly" sins are the things they have found that organizations should not do in dissemination efforts. What an organization shouldn't do are as follows: start with large pilots, find one person to do it all, expecting hard work alone to solve the problems, spread the exact same pilot across all sites, require the innovator to be in charge of spreading the information, look at outcomes on a quarterly basis, expect improvement without attention to process reliability.   |   | Encourage working as a team in addition to reviewing data daily or weekly,   | Do not require the pilot team be in charge of spread the ideas to other member institutions.   | Not applicable   | Not applicable   | Strutz, E. (2013). A National Platform for Spurring Spread: The Permanent Foundation. In A National Platform for Spurring Spread: The Permanent Foundation (p. 10). |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| C. Tarrant, B. O'Donnell, et al.   | Report   | Report       |   | This report examined a QI collaborative in Scotland in an effort to determine how well collaboratives work generally. Their aims were to identify key positive components, describe the impact, describe local responses (to challenges and successes), and lastly to generate generalisable learning to optimize future projects.  | <p><b>Figure 1: Design of the SPP Sepsis VTE Collaborative</b></p> <p>Collaborative program objectives to meet requirements<br/>Specific aims for implementation<br/>Driver programs and change package<br/>National collaborative learning network (QI) model<br/>Monthly updates<br/>Programme website with repository for best practice and dissemination<br/>Annual site visits from faculty<br/>Measurement package - aims to collect evidence about delivery and outcomes<br/>Programme quality impact framework of activities<br/>Collaborative infrastructure to deliver the aims and driver results for 'best practice' sites</p> <p>Technical specifications for QI in the implementation<br/>Non-technical specifications for QI: Standardized and structured, shared and consistent, and consistent<br/>Helpdesk for patient management and performance review of change</p>  | "Local executive support was critical for helping to maintain momentum, and could help overcome problems, particularly those which required additional resources." Effective leadership "requires engagement and relationship skills, and facilitating the contribution of others." Culture of openness to failure emphasized. | Role of the champion includes: "championing the topic and the interventions at the local sites, working to gain local staff engagement, day-to-day work around modeling good practice, engaging in ongoing | WebExs (virtual meetings between participating groups) as well as an advanced central data repository were two tools reported as being highly effective for the collaborative. | "Encouraging organizations to find ways of resourcing staff time at the frontline to do ongoing improvement work (not just time-bounded projects) is more important for promoting sustainable change." | Tarrant, C., O'Donnell, B., Martin, G., & Bion, J. (2015). Evaluation of the Scottish Patient Safety Programme sepsis VTE collaborative: Short Report.              |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| UW Health  | Workflow   | Workflow     |   | This is a roadmap of what to do when a clinic doesn't meet the goals they were expected to. Although developed for diabetes projects at UW Health, it seems applicable to a much wider audience/set of projects.  |   | Not applicable   | The process goes through asking if the clinic understood the expectations, if they had the   | Tools and training are one of the first things asked about (presumably because it is one of the easier issues to fix).   | Not applicable   | UW Health. (n.d.). Diabetes Workflow.   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| UW Health  | Workflow   | Workflow     |   | Broadly goes through the process of disseminating improvements at UW Health system using the WD40 group.  |   | Not applicable   | The process starts with aligning the innovation with goals at UW Health, then moves to feasibility, then to  | Under sustaining the improvement they have "monitoring performance measures, set clear expectations" and "feedback on  | Not applicable   | UW Health. (2009a). Dissemination of Improvements at UW Health.   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| UW Health  | Chart  | Chart        |   | Intimately related to the above workflow. Gives descriptions of the different characteristics that promote dissemination within each of the broad topics seen in the above workflow.  |   | The perceived need for change is something so crucial culturally that is listed in the feasibility section. "Strong leadership role, visible support."   | "Who is responsible for the change?"   | Under sustaining improvement we have setting clear expectations as well as continuous monitoring and feedback.   | Not applicable   | UW Health. (2009b). Proposed Framework for WD-40 Dissemination of Improvements at UW H  |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| UW Health  | Workflow   | Workflow     |   | Describes the lifecycle of an improvement within an organization. Includes who is responsible for each step and places where a pause and reevaluate are needed.   |   | The leadership takes control of the visionary process according to this workflow.  | The six steps are as follows: visionary process, strategic priorities, tactics/strategies, program development   | Program development/packaging encompasses this topic.  | Not applicable   | UW Health. (2010). Organizational Improvement Life Cycle.   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| A. Whippy, M. Skeath, B. Crawford et al.   | The Joint Commission Journal on Quality and Patient Safety, 37, 2011 | Single Study | EGDT: Early Goal-Directed Therapy   | "The number of sepsis diagnoses per 1,000 admissions increased from a baseline value of 35.7 in July 2009 to 119.4 in May 2011. The percent of admitted patients who have blood cultures drawn who also have a serum lactate level drawn increased from a baseline of 27% to 97% in May 2011. The percent of patients receiving EGDT who had a second and lower lactate level within six hours increased from 52% at baseline to 92% in May 2011."  | <p><b>Table 2: Impact of a Sepsis Care Performance Improvement Initiative on Process of Care Measures, July 2009–May 2011</b></p> <table border="1"> <thead> <tr> <th>Process of Care Measure</th> <th>July 2009</th> <th>July 2010</th> <th>May 2011</th> <th>May 2012</th> </tr> </thead> <tbody> <tr> <td>Number of Sepsis Diagnoses per 1,000 Admissions</td> <td>35.7</td> <td>119.4</td> <td>119.4</td> <td>119.4</td> </tr> <tr> <td>Percent of Admitted Patients with Blood Cultures Drawn</td> <td>27%</td> <td>97%</td> <td>97%</td> <td>97%</td> </tr> <tr> <td>Percent of Patients with Blood Cultures Drawn who also had a Serum Lactate Level Drawn</td> <td>27%</td> <td>97%</td> <td>97%</td> <td>97%</td> </tr> <tr> <td>Percent of Patients Receiving EGDT</td> <td>52%</td> <td>92%</td> <td>92%</td> <td>92%</td> </tr> <tr> <td>Percent of Patients Receiving EGDT who had a Second and Lower Lactate Level within Six Hours</td> <td>52%</td> <td>92%</td> <td>92%</td> <td>92%</td> </tr> </tbody> </table>  | Process of Care Measure  | July 2009  | July 2010  | May 2011   | May 2012  | Number of Sepsis Diagnoses per 1,000 Admissions | 35.7 | 119.4 | 119.4 | 119.4 | Percent of Admitted Patients with Blood Cultures Drawn | 27% | 97% | 97% | 97% | Percent of Patients with Blood Cultures Drawn who also had a Serum Lactate Level Drawn | 27% | 97% | 97% | 97% | Percent of Patients Receiving EGDT | 52% | 92% | 92% | 92% | Percent of Patients Receiving EGDT who had a Second and Lower Lactate Level within Six Hours | 52% | 92% | 92% | 92% | "[T]he impact of senior leadership support cannot be overstated . . . [w]ithout it, even the most engaged, enthusiastic, and skilled champions will be unable to effect change." Because of the fact that ED and ICU needed to work together, needed senior leadership to bridge and also check on meeting of goals later in the process. | Process: "Four elements are engaged to propel organizational change — (1) leadership alignment; (2) standardization of evidence-based | Used EHR to help promote early sepsis detection. Bought a central venous catheterization simulator for EDs at hospitals in health system to ensure comfortability of ED physicians and nurses | Leadership continually checked in on progress for a while after the initiative. | Whippy, A., Skeath, M., Crawford, B., Adams, C., Marelich, G., Alamsahhi, M., & Borbon, J. (2011). Kaiser Permanente's Performance Improvement System, Part 3: Multistep Improvements in Care for Patients with Sepsis. The Joint Commission Journal on |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Process of Care Measure  | July 2009  | July 2010    | May 2011  | May 2012  |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Number of Sepsis Diagnoses per 1,000 Admissions  | 35.7   | 119.4        | 119.4   | 119.4   |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Percent of Admitted Patients with Blood Cultures Drawn                                       | 27%  | 97%          | 97%   | 97%   |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Percent of Patients with Blood Cultures Drawn who also had a Serum Lactate Level Drawn       | 27%  | 97%          | 97%   | 97%   |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Percent of Patients Receiving EGDT   | 52%  | 92%          | 92%   | 92%   |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| Percent of Patients Receiving EGDT who had a Second and Lower Lactate Level within Six Hours | 52%  | 92%          | 92%   | 92%   |   |  |  |  |  |   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |
| World Health Organization  | Report   | Report       | <b>Scaling up:</b> Deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to   | This report lists nine steps that might be helpful for various dissemination strategies. Overall, I didn't find this document to be very informative, but it could be a useful tool for an organization that is about to go through a dissemination process. Their model is shown right. "The purpose of this document is to provide precise, step-by-step guidance on how to develop a scaling up strategy.  | <p><b>Figure 1: The Expanded Framework for Scaling up</b></p>   | "Where political leaders are committed to the improvements tested in pilot or experimental projects and national health systems are strong, replicating the innovation on a large scale will be facilitated." Leadership and credibility is a crucial component to this model.   | Organizational process is one of the key components listed in the innovation (under step six).   | This document is a tool to help organization navigate the dissemination process. The "use of electronic media and site visits for peer to peer exchanges" are recommended.     | Not applicable   | World Health Organization. (n.d.). Nine steps for developing a scaling-up strategy.   |   |      |       |       |       |  |     |     |     |     |  |     |     |     |     |                                    |     |     |     |     |  |     |     |     |     |   |   |   |   |   |       |   |   |   |    |      |   |   |   |    |       |   |   |   |    |  |  |  |  |  |

## B1 Appendix C: B1 Application and Scope of Work Region 1 IDN Sub-Recipient Request for Proposal

*July 14, 2017*

### Overview

The Region 1 B1: Integrated Healthcare Project looks to support IDN Primary Care and Behavioral Health Organizations achieve the “Coordinated Care Designation” by December 31, 2018.

### Purpose

The purpose of this Sub-Recipient proposal is to distribute funds\* from the New Hampshire Delivery System Reform Incentive Program (DSRIP) to members of the Region 1\*\*. These funds will be used to meet the goals of the DSRIP demonstration project\*\*\*:

1. Deliver integrated physical and behavioral health care that better addresses the full range of the individual’s needs
2. Expand capacity to address emerging and ongoing behavioral health needs in an appropriate setting
3. Reduce gaps in care during transitions across care settings by improving coordination across providers and linking Medicaid beneficiaries with community supports

#### *Notes:*

*\*DSRIP funds are independent of current Medicaid patient reimbursement funds; these funds are to be used to create the infrastructure needed to implement the projects prescribed in the DSRIP demonstration project.*

*\*\*Region 1 includes the Upper Valley, Sullivan County and Monadnock Region.*

*\*\*\*The targeted population of the DSRIP demonstration project is only Medicaid beneficiaries.*

### Eligible Applicants

- All applicants must be existing members of Region 1 IDN and have completed a certificate of authorization
- Health and human service organizations
- Community-based organizations providing social and support services
- **Multiple organizations may apply under one application, with one organization identified as the primary organization that will maintain fiduciary and reporting responsibilities.**

## Evaluation Process & Selection Committees

Region 1 will employ a system to evaluate each proposal and select successful B1 proposals for implementation readiness by our multi-stakeholder Executive Committee which, represents all participants of Region 1.

- Tier 1 will entail the Administrative Lead team conducting a technical review of the proposal prior to submitting the proposal to the independent review panel.
- Tier 2, the Executive Committee will review the assessment and recommendations of the Independent Review Panel as it makes the final decision.

| Tier | Committee Name                | Committee Composition   | Evaluation Criteria   |
|------|-------------------------------|---|---|
| 1    | <b>Administrative Leaders</b> | <ul style="list-style-type: none"> <li>• Project Manager</li> <li>• Medical Director</li> </ul>   | <ul style="list-style-type: none"> <li>• Is the application complete?</li> <li>• <i>Solicit any additional information needed to make application complete through an iterative process with applicant.</i></li> <li>• Does this proposal align with the scope of work advanced by the B1 project team?</li> <li>• Is there a contract on file?</li> <li>• Are the necessary compliance and conflict of interest forms in place?</li> </ul> |
| 3    | <b>Executive Committee</b>    | <ul style="list-style-type: none"> <li>• 7 voting members</li> <li>• 7 non-voting members (IDN Administrative Leadership Team)</li> </ul> | <ul style="list-style-type: none"> <li>• Review all criteria and recommendations of Region 1 Admin Leads.</li> <li>• Ensure the proposals preclude biases and conflict of interests?</li> </ul>   |

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

Following the selection process, Administrative Leaders will complete the following:

- Prepare letters to applicants
- Prepare a summary report of grant awards to communicate to IDN membership
- Execute a sub-recipient contract with awardees outlining all responsibilities and accountability (in partnership with Legal and Finance)
  - Responsibilities for sub-recipients will also include signing a summary of agreement outlining specific expectations of Region 1 awardees, including the following:
    - Regular meetings among specified project/pilot team members (at least biweekly)

- Participation in project-specific Region 1 Knowledge Exchanges to share learnings with regional teams working on the same project implementation or preparing to implement the same project
- Mentorship for those organizations also planning to implement the same project or expanding program in their region
- Implementation of core technology systems to support care collaboration (note that technology subscription costs will be covered by the IDN for the duration of the waiver)
- Participation in quality reporting activities required of the 1115 waiver

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

## Region 1 IDN Sub-Recipient Application Form

Please concisely answer all of the below questions and submit no later than 5:00 p.m. on Monday, August 14, 2017. Please feel free to reach out to the Administrative Lead team at any point through the open application period. Additionally, the Administrative Lead team will connect directly with the primary contact listed with any questions or follow-up needs. The team strives to help applicants provide all of the information requested.

Date:

### *Organization Profile*

- a. Primary Applicant (Organization):
- b. Physical Address:
- c. Mailing Address:
- d. Telephone Number:
- e. Website:
- f. Tax ID:
- g. Organization Type (primary care, behavioral health, community service, etc.):
- h. Business Form (501 (c) 3) or LLC or Corporation):
- i. Completed Region 1 Certificate of Authorization (yes or no):
- j. Primary Organization Contact Person:  
Name:  
  
Title:  
  
Email:  
  
Telephone:
- k. Please list the names of all other organizations included on this application:

### *Project Overview*

*Note: Number of pages listed are meant to be a guide, not a requirement.*

- a. Budget Dollars Requested:
- b. Anticipated Project Start Date:

- c. Anticipated Project End Date:

## Region 1 IDN Sub-Recipient Application Form, continued

- a. Please provide a detailed description of the proposed project. Description should address project goal statement, project objectives, needs addressed, approach overview, participating partners, and targeted population. (1-2 pages)
- b. Please describe the collaborative approach taken in the proposed project, including established and future relationships with partners. Identify opportunities to strengthen the collaborative approach and any anticipated challenges to the proposed collaboration. If a collaborative approach is not needed for this project, please explain why. (1 page)
- c. Please describe how your organization, or collaboration of organizations, is positioned and ready to implement the proposed project. (2-3 pages; include attachments as necessary)
- i. *Please describe the operational strategy and infrastructure that will be employed to execute this proposal.*
  - ii. *Please include primary activities, proposed number of FTEs needed and how these positions will be supervised, mentored, trained, etc.*
  - iii. *Please include an implementation timetable with specific milestones and indicate when the organization(s) will be ready to begin implementation.*
  - iv. *Please indicate any evidence-based practices that will be incorporated as well as innovative techniques.*
  - v. *Please provide the appropriate/applicable data to demonstrate existing need and feasibility. Please contact the Administrative Lead team for available data from the Region 1 Behavioral Health Needs Assessment and/or the State.*
- d. Please describe the level of commitment by the applicant's executive leadership. Please also include a letter of commitment from each organization's executive leadership.
- e. Please describe how the requested funds will be used to meet the proposed project's established objectives and operational strategy. Please also describe those funds anticipated for start-up costs versus long-term costs. Additionally, please address how this investment is anticipated to generate long-term cost savings to the patient and the system. (1 page)
- i. *Please also submit a budget table or spreadsheet (include information for each year of the proposed project) providing the following information:*
    - Number of proposed FTEs
    - Salary
    - Benefits
    - Any supervision costs associated with new FTEs
    - Recruitment costs
    - Training costs

- Occupancy
- Technology costs (hardware, software, etc.)
- Administrative expenses (supplies, printing, etc.)
- Travel
- Other (please describe each in a separate line)
- Total budget

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

## Scope of Work

### B1: Integrated Healthcare Project Scope of Work

*April 2017*

Per the Delivery System Reform Incentive Payments (DSRIP) project regulations, all primary care and behavioral healthcare providers who are IDN 1 partners are required to participate in the Integrated Healthcare project. The Administrative Leadership team and Integrated Healthcare Project Team will work with the respective providers to determine the optimal time to implement this project in their practices. However, these organizations or collaboration of organizations must still submit applications for the B1: Integrated Healthcare project and align their proposals with the following scope of work:

***Disclaimer:*** *The following proposal requirements allow for some flexibility and customization to the current practice processes and systems. IDN 1 encourages leveraging current operational processes that achieve the same goals and aims as the proposed project requirements. Please feel free to contact the Region 1 Admin Leads via [Jessica.J.Powell@hitchcock.org](mailto:Jessica.J.Powell@hitchcock.org) for specific questions and comments.*

***Goal:*** Integrating behavioral health services across primary care.

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

***Target Population:*** Medicaid beneficiaries with behavioral health conditions or at risk for such conditions will be the primary sub-population expected to benefit from the project. From age 12 through adulthood.

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

***Note:*** *All primary care and behavioral providers are required to participate in this project.*

### ***Proposal Requirements***

- All proposals will demonstrate how the practice or collaboration of practices will achieve the Coordinated Care Practice Designation by December 2018. Required components of the Coordinated Care Practice Designation include the following (please see attached description for more details):
- Comprehensive Core Standardized Assessment Process and Shared Care Plan (*NOTE: 1 IDN Health Information Technology Workgroup has adopted a Shared Care Plan and supportive technologies that will be available to all IDN 1 Partners*)
  - Use of a Comprehensive Core Standardized Assessment framework that includes evidence-based universal screening for depression and SBIRT. The assessment process will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target population. The assessment will include the following domains: demographic, medical, substance use, housing, family and support services, education, employment and entitlement, legal, risk assessment including suicide risk, functional status (activities of daily living, instrumental activities of daily living, cognitive functioning).
  - Note: The Integrated Healthcare Project team has developed recommendations for evidence-based assessment components that capture the above domains. If an organization prefers to use a different assessment tool or to leverage existing tools that capture the above domain areas, please provide a copy of the assessment tool(s). Please see recommended assessment questions at the end of this section.
- Multi-Disciplinary Core Team
  - Development of a multi-disciplinary core team available to support individuals at risk for or with diagnosed behavioral health conditions or chronic conditions that includes PCPs, behavioral health providers (including a psychiatrist), and assigned care managers or community health worker. Teams may also include peer specialists, pharmacists, social support service providers and pediatric providers as appropriate.
  - Core team members are not required to be physically co-located or to be part of the same organization, although co-location is strongly encouraged where feasible given the size and volume of a particular practice.
  - Required basic educational program for core team members for training in management of chronic diseases, mental health disorders and substance use disorders to enable team members to recognize the disorders and act appropriately upon the information. Practice staff not involved in direct care should also receive training in the knowledge and beliefs about mental disorders.
  - Well-defined care manager/community health worker role which includes providing support to the patient in meeting care plan goals, providing support to core team members to ensure that the teams are coordinating care and communicating effectively.
  - Demonstrated care coordination through documented work flows, joint service protocols and communication channels with community-based social support service providers.
  - Demonstrated adherence to New Hampshire Board of Medicine guidelines on opioid prescribing.

- Information Sharing Demonstrated Through Care Plans, Treatment Plans and Case Conferences
  - Documented work flow that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment and management of care.
  - Regularly scheduled case conferences (minimum monthly) for those patients with significant behavioral health conditions or chronic conditions.
  - Documented workflows for communication protocols for how information is shared with treatment providers, community-based organizations and how privacy will be protected.
- Standardized Workflows and Protocols
  - Written roles, responsibilities and workflows for core team members.
  - Protocols to ensure safe care transitions from institutional settings back to primary care, behavioral health and social support services providers.
  - Intake procedures that include systematically solicit patient consent to confidentially share information among providers. (*NOTE: IDN 1 is working to develop these processes*)
- Proposals should include how the practice or collaboration of practices will operationalize the above requirements and how funding will be used to implement this plan. Executive leadership commitment and readiness and/or timing of desired implementation should be clearly addressed.
- Required FTEs:
  - Primary Care Physician
  - Behavioral Health Specialist (including psychiatrist when appropriate)
  - Care Manager or Community Health Worker

The IDN will fund an initial wave of 4-5 practices to pilot this project starting in July and plans to phase in the three additional waves in the next nine months to achieve designation for all practices by December 2018. All primary care and behavioral health providers/organizations are encouraged to speak directly with any member of the administrative lead team or the Integrated Healthcare project chairs or committee members about readiness and timing for implementing this project. Please contact Jessica Powell at [Jessica.J.Powell@hitchcock.org](mailto:Jessica.J.Powell@hitchcock.org) for more information.

### Recommended Core Standardized Assessment Screenings/Questions by Domain

Demographic: No particular tool or question chosen. Please report on the current screenings used to assess this domain area.

Medical: No particular tool or question chosen. Please report on the current screenings used to assess this domain area.

Substance Use: Some suggested screenings to include

- BAM
- AUDIT-C
- Addiction Severity Index
- DAST-10
- NM ASSIST

Housing: Health Leads Model



Are you worried that in the next 2 months, you **may not have stable housing?**

Y

N

Family and Support Services: No particular tool or question chosen. Please report on the current screenings used to assess this domain area.

Education: Institute of Medicine (IOM) Model



Risk Assessment: PHQ2->9

**Functional Status:** No particular tool or question chosen. Please report on the current screenings used to assess this domain area.

- Activities of Daily Living
- Instrumental Activities of Daily Living
- Cognitive Functioning

Uses of Funds

Allowable Expenditures

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

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

## Non-Allowable Expenditures

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

- Alcoholic beverages
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and Contributions
- Entertainment
- Capital expenditures for general purpose equipment, building and land, with the exception of costs associated with information technology requirements for the demonstration
- Fines and penalties
- Fund raising and investment management costs
- Goods or services for personal use
- Idle facilities and idle capacity
- Insurance and indemnification
- Interest expense
- Lobbying, as defined under NH law
- Memberships and subscription costs
- Patient costs

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

## Transformation Initiative Outcome Measures

The following outcome performance measures drive the incentive payments received each year by Region 1 from Centers for Medicaid and Medicare Services, CMS. For more information, please visit the Outcome Specification Metrics starting on page 175 in the DSRIP's Special Terms and Conditions: <https://www.dhhs.nh.gov/section-1115-waiver/documents/approval-protocols.pdf>.

| Measure Category                            | Measure   | B1: Integrated Healthcare |
|---|---|---------------------------|
| Follow-up After ED Visit or Hospitalization | <i>Readmission to Hospital for Any Cause (excluding maternity, cancer, rehab) at 30 days for Adults 18+ BH pop.</i>   | X                         |
| Follow-up After ED Visit or Hospitalization | <i>Follow-up after ED visit for alcohol and other drug dependence within 30 days</i>  | X                         |
| Follow-up After ED Visit or Hospitalization | <i>Follow-up after ED visit for mental illness within 30 days</i>   | X                         |
| Follow-up After ED Visit or Hospitalization | <i>Follow up after hospitalization for mental illness within 30 days</i>  | X                         |
| Follow-up After ED Visit or Hospitalization | <i>Follow up after hospitalization for mental illness within 7 days</i>   | X                         |
| Integration and Core Practice Competencies  | <i>% of patients screened for alcohol or drug abuse in the past 12 months using an age appropriate standardized alcohol and drug use screening tools AND if positive, a follow-up plan is documented on</i> | X                         |

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|   | <i>the date of the positive screen age 12+</i>  |                                  |
|---|---|----------------------------------|
| <b>Integration and Core Practice Competencies</b>                             | <i>Timely electronic transmission of transition record (discharges from an inpatient facility in IDN (including rehab and SNF) to other home/self-care or any other site of care)</i> | X                                |
| <b>Patient Reported Experience of Care</b>                                    | <i>Global Score for mini-CAHPS Satisfaction Survey at IND level for kids and adults</i>   | X                                |
| <b>Measure Category</b>   | <b>Measure</b>  | <b>B1: Integrated Healthcare</b> |
| <b>Physical Health/Primary Care clinical Quality/Screening and Assessment</b> | <i>Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers</i>                   | X                                |
| <b>Physical Health/Primary Care clinical Quality/Screening and Assessment</b> | <i>Global score for selected general HEDIS physical health measures, adapted for BH population</i>  | X                                |

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| <b>BH Care Clinical</b>   | <i>Global score for selected BH-focused HEDIS measures</i>  | X                                |
|---|---|----------------------------------|
| <b>Physical Health/Primary Care clinical Quality/Screening and Assessment</b> | <i>% of BH population with all recommended USPSTF A&amp;B Services</i>                                | X                                |
| <b>Physical Health/Primary Care clinical Quality/Screening and Assessment</b> | <i>Recommended Adolescent (age 12-21) Well Care visits</i>  | X                                |
| <b>Physical Health/Primary Care clinical Quality/Screening and Assessment</b> | <i>Smoking and tobacco cessation counseling visit for tobacco users</i>                               | X                                |
| <b>Population Level Utilization</b>   | <i>Frequent (4+ per year) ER visits users for BH population</i>                                       | X                                |
| <b>Population Level Utilization</b>   | <i>Potentially preventable ER visits for BH population and total population</i>                       | X                                |
| <b>Measure Category</b>   | <b>Measure</b>  | <b>B1: Integrated Healthcare</b> |
| <b>Population Level Utilization</b>   | <i>Rate per 1000 of people without cancer receiving a daily dosage of opioids greater than 120 mg</i> | X                                |

|                           |   |   |
|---------------------------|---|---|
|                           | <i>morphine equivalent dose (MED) for 90 consecutive days or longer</i>   |   |
| <b>Workforce Capacity</b> | <i>Engagement of alcohol and drug dependence treatment (initiation and 2 visits within 44 days)</i>             | X |
| <b>Workforce Capacity</b> | <i>Initiation of Alcohol and other drug dependence treatment (1 visit within 14 days)</i>                       | X |
| <b>Workforce Capacity</b> | <i>% of new patient call of referral from other provider for CMHC intake appointment within 7 calendar days</i> | X |
| <b>Workforce Capacity</b> | <i>% of new patients where intake to first follow-up visit was within 7 days after intake</i>                   | X |
| <b>Workforce Capacity</b> | <i>% of new patients where intake to first psychiatrist visit was within 30 days after intake</i>               | X |



B1 Appendix D. CCSA and DH Crosswalk (Attachment B1.2C)

|  |            |  |
|--|------------|--|
| Positioning                                      | don't know |  |
| Transferring                                     | don't know |  |
| Communicating                                    | don't know |  |
|  |            |  |
| Pregnancy Status (for women of childbearing age) | don't know |  |
| Military Service                                 | don't know |  |
|  |            |  |
| Risk for Infectious Disease                      | don't know |  |
| Not specified                                    | don't know |  |
| Not specified                                    | don't know |  |
| Not specified                                    | don't know |  |

## B1 Appendix E. CTC Job Description

Medicaid - Care Team Coordinator (CTC) Role:

### **Job Summary:**

The Medicaid - Care Team Coordinator (CTC) is responsible for a panel of patients and in collaboration with other members of an integrated behavioral health, primary care and community resources team, assists patients to meet their preventive, chronic and acute care needs.

The Care Team Coordinator's (CTC) primary responsibilities center on the coordination of the multidisciplinary team (MDT) for Medicaid patients who will benefit most from monthly core team care conferences.

Reporting to the clinical service line leader in the department of Psychiatry at DHMC, the CTC will take on specific organizational and operational responsibilities.

### **Duties and Responsibilities:**

The CTC will:

Help **collect and compile** the appropriate demographic and screening information necessary to complete the Common Core Shared Assessment (CCSA).

Be responsible for the **creation and maintenance** of an appropriate Shared Care Plan for Medicaid beneficiaries defined in the NH DSRIP Integrated Care Project.

**Identify** Medicaid patients meeting criteria for monthly core team review.

**Maintain a registry** of patients being assisted by the MDT and reviewed in monthly care meetings.

Coordinate the **schedules** of core team members for monthly review meetings.

**Facilitate** discussion of the MDT during monthly review meeting.

**Ensure** that the tasks needed to meet the patients' needs are appropriately aligned and assigned to team members and their institutions in keeping with the scope of services they are able to provide to the patient, and that there is agreement across the team on these tasks.

**Update documentation** of the Shared Care Plan based on discussion during the monthly review meeting.

**Track**, via the registry, implementation and follow through on the shared care plan elements.

**Assist** in implementation, outcomes measurement and process improvement related to this new role.

Participate in the **development and delivery** of educational and team building sessions.

The CTC will have limited direct patient contact, rather will be focused on facilitating the inter-organizational, multidisciplinary team's ability to deliver complex and coordinated care to patients and families.

Requirements:

Bachelor's level education

Interpersonal communication skills with exceptional listening abilities

Exceptional organizational skills

Compassionate, kind, and open-minded

Able to articulate the mission and values of WCBH and DHMC in relation to service and performance

Teamwork experience

Written communication skills

Clinical experience is a plus, such as EMT, MA, CNA, or Phlebotomy certification

Excited about joining a new team to work to improve the healthcare delivery of patients





B1 Appendix G. Evaluation Table (Attachment B1.3A)

| Project Name, Lead Organization   | Project Milestones:   | Deliverable:   | Met or Unmet | Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports) | Accountability of Time: Met or Unmet | Participation in IDN Activities: Baseline participation Met or Unmet |
|---|---|--|--------------|--|--------------------------------------|--|
| <b>Q1 Y1: July 1, 2017-September 30, 2017</b>   |   |  |              |  |                                      |  |
| Heater Road Practice Team: DH PC, DH Psych., WCBH   | Milestone 1 : Obtain Letters of Commitment from Primary Care at DH                                | Copy of Letters  |              |  |                                      |  |
|   | Milestone 2 : Demonstrate recurring team planning meetings with members of DH BH, DH PC, and WCBH | Share Meeting Schedules and Attendance                 |              |  |                                      |  |
|   | Milestone 3 : Update Proposal and Formalize Implementation Steps through 12/31/18                 | Share Updated Project Plan                             |              |  |                                      |  |
| <b>Q2 Y1: October 1, 2017- December 31, 2017</b>  |   |  |              |  |                                      |  |
| Heater Road Practice Team: DH PC, DH Psych., WCBH   | Milestone 1 :   | Adherence to Coordinated Care Designation Requirements |              |  |                                      |  |
| <b>Q3 Y1: January 1, 2018-March 30, 2018</b>  |   |  |              |  |                                      |  |
| Heater Road Practice Team: DH PC, DH Psych., WCBH   | Milestone 1 :   | Adherence to Coordinated Care Designation Requirements |              |  |                                      |  |
| <b>Q4 Y1: April 1, 2018-June 30, 2018</b>   |   |  |              |  |                                      |  |
| Heater Road Practice Team: DH PC, DH Psych., WCBH   | Milestone 1 :   | Adherence to Coordinated Care Designation Requirements |              |  |                                      |  |
| <b>Q1 Y2: July 1, 2018-September 30, 2018</b>   |   |  |              |  |                                      |  |
| <b>Q2 Y2: October 1, 2018-December 31, 2018</b>   |   |  |              |  |                                      |  |
| Additional Evaluation Targets for the project will be created in parallel with the 2nd year funding addendum ( To be completed in Q4 Y1). The Region 1 teams aims to support our project partners through allowing for flexibility in their planning at this early stage to facilitate inclusion of the continuous improvement work being supported by the project and quality improvement coaches. |   |  |              |  |                                      |  |

## B1 Appendix H. Evaluation Framework

### Region 1 IDN: Subcontract Awardee Evaluation Plan for Funding Year 1

Please review the following project evaluation guidelines and protocols. Address any questions or clarification needed with the Region 1 Project Manager, Jessica Powell.

Additionally, please note the IDN reserves the right to review progress on all components of the project core components, timelines, milestones, and adherence to specified model, assessments, or tools.

#### Timing of Evaluation:

- Quarterly evaluations will be conducted throughout the length of the project funding
  - Submissions will follow the NH FY Schedule-
    - Q1: July 1, 2017- September 30, 2017
    - Q2: October 1, 2017-December 31, 2017
    - Q3: January 1, 2018- March 30, 2018
    - Q4: April 1, 2018 – June 30, 2018
- All components of the evaluation will need to be received by the IDN Project Manager not later than 12pm on the due date.

#### Evaluation Measure Categories:

- **Project Milestones**
  - The IDN Admin team will review quarterly project milestones for adherence to the project plan
    - Quarterly funding disbursements will be contingent upon the milestone review (Please see Milestone Review Protocol Attachment)
      - In the initial quarter of funding a project will receive a passing evaluation based on the contract execution
      - Second quarter funding will follow the evaluation framework but no funding will be held back for non-compliance
      - Third quarter funding will be awarded based upon milestone development and the other evaluation measure categories
    - *Format: Submission in narrative format with supportive data as applicable*
- **Use of Funds**
  - On a monthly basis the lead project organization will submit actual budget expenditures and expenses
    - *Format: Submission in Budget Actuals and Expenses*
- **Accountability of Time**

- The project lead organization on a quarterly basis will need to document if the time as specified in the project plan is being met
  - *Format: Self-reported as Yes or No*
- **Participation in IDN Activities**
  - All project awardees ensure that they will maintain continued participation in IDN meetings and activities such as;
    - Completion of Implementation Plan for State Report by July 31, 2017
    - Monthly Knowledge Exchanges
    - Monthly Project Team Meetings
    - IDN Advisory Council Meetings
    - Any other IDN meetings or events as specified by the Admin Lead team
    - Sharing of process milestones and progress with all IDN partners as requested
    - *Format: Self-reported as Yes or No*

Remediation:

- In the event that that quarterly milestone review or evaluation produces significant non-compliance with the project plan, the IDN Admin Team will enlist the support of a project specialist and establish a remediation plan with the project lead organization.
  - Dependent on the nature of the issue and steps needed the remediation plan may vary and may or may not result in more stringent evaluation metrics for the remaining quarters of project implementation.
- Please note that in the event of multiple quarters of non-compliance and need for remediation a project Independent Review Panel will be convened to assess the continuation of the project pilot

B1 Appendix I. Education and Trainings (B1.8C.A)

### At A Glance 2016

## Nutrition, Physical Activity, and Obesity

Keeping Americans Healthy at Every Stage of Life



Good nutrition and regular physical activity are essential to keeping current and future generations of Americans healthy. People who eat a healthy diet and get enough physical activity live longer and have fewer chronic diseases, such as type 2 diabetes, heart disease, and obesity.

CDC leads our nation's fight against chronic diseases by promoting good nutrition, regular physical activity, and a healthy weight in places where people live, work, and play.

#### Public Health Problem

**Chronic Diseases Are Common, Costly, and Preventable**

Seven of the top 10 leading causes of death in the United States are due to chronic diseases, and treating people with chronic diseases accounts for 86% of our nation's health care costs. People with chronic diseases often have a lower quality of life. Almost 1 in 5 (12 million) children and more than 1 in 3 (78 million) adults in the United States struggle with obesity, causing \$147 billion in obesity-related health care costs each year. Young children with obesity tend to keep extra weight into adulthood. Fortunately, eating a healthy diet, getting enough physical activity, and not using tobacco help prevent most chronic diseases.

**Mothers Need Support to Breastfeed Their Babies**

Breastfeeding is the best method for early infant feeding and the healthiest option for most mothers and babies. Mothers and their children show short-term and long-term health benefits from breastfeeding. Although 80% of mothers start out breastfeeding, more than 50% stop before they intended. Only about 22% of infants are being exclusively breastfed as recommended by the time they are 6 months old. These low rates of breastfeeding add more than \$2 billion a year to direct medical costs in the United States.



National Center for Chronic Disease Prevention and Health Promotion  
Division of Nutrition, Physical Activity, and Obesity



### At A Glance 2016

## Heart Disease and Stroke

Preventing the Nation's Leading Killers



Heart disease and stroke—the first and fifth leading causes of death in the United States—are among the most widespread and costly health problems facing our nation today. They are also among the most preventable. About half (47%) of US adults have at least one of three major risk factors for cardiovascular disease (CVD), which includes heart disease, stroke, and related conditions: uncontrolled high blood pressure, uncontrolled high LDL (low-density lipoprotein) cholesterol, or current smoking. Controlling these factors could reduce a person's risk of heart attack or stroke by up to 80%.

CDC translates prevention research into public health practice and provides national leadership to help prevent heart disease and stroke. The agency has funded prevention programs in the United States since 1998 and also funds national data collection, applied research, and evaluation efforts.

#### Public Health Problem

**Staggering Costs of Cardiovascular Disease**

Every 40 seconds, an adult dies of a heart attack, stroke, or related disease. These deaths account for about 31% of all US deaths each year—more than 800,000 people in 2014. About 20% of these deaths were among people younger than 65. Heart disease and stroke kill roughly the same number of people in the United States each year as cancer and chronic lower respiratory diseases combined. Heart disease and stroke can also lead to serious illness, disability, and lower quality of life.

The economic costs of CVD are high—more than \$317 billion each year. Direct medical expenses were \$193.1 billion per year on average during 2011–2012, and another \$123.5 billion annually was attributed to lost productivity due to premature death from CVD. Treatment of CVD accounts for about \$1 of every \$6 spent on health care in this country.

#### Fast Facts

- Every 42 seconds, someone in the United States has a heart attack, and every 4 minutes, someone dies of stroke.
- About half of US adults have at least one major risk factor for cardiovascular disease (CVD).
- 1 in 3 deaths in the United States in 2014 were due to CVD.
- CVD cost the United States an average of \$317 billion annually during 2011–2012.
- CDC funds efforts in all 50 states and the District of Columbia to prevent heart disease and stroke.

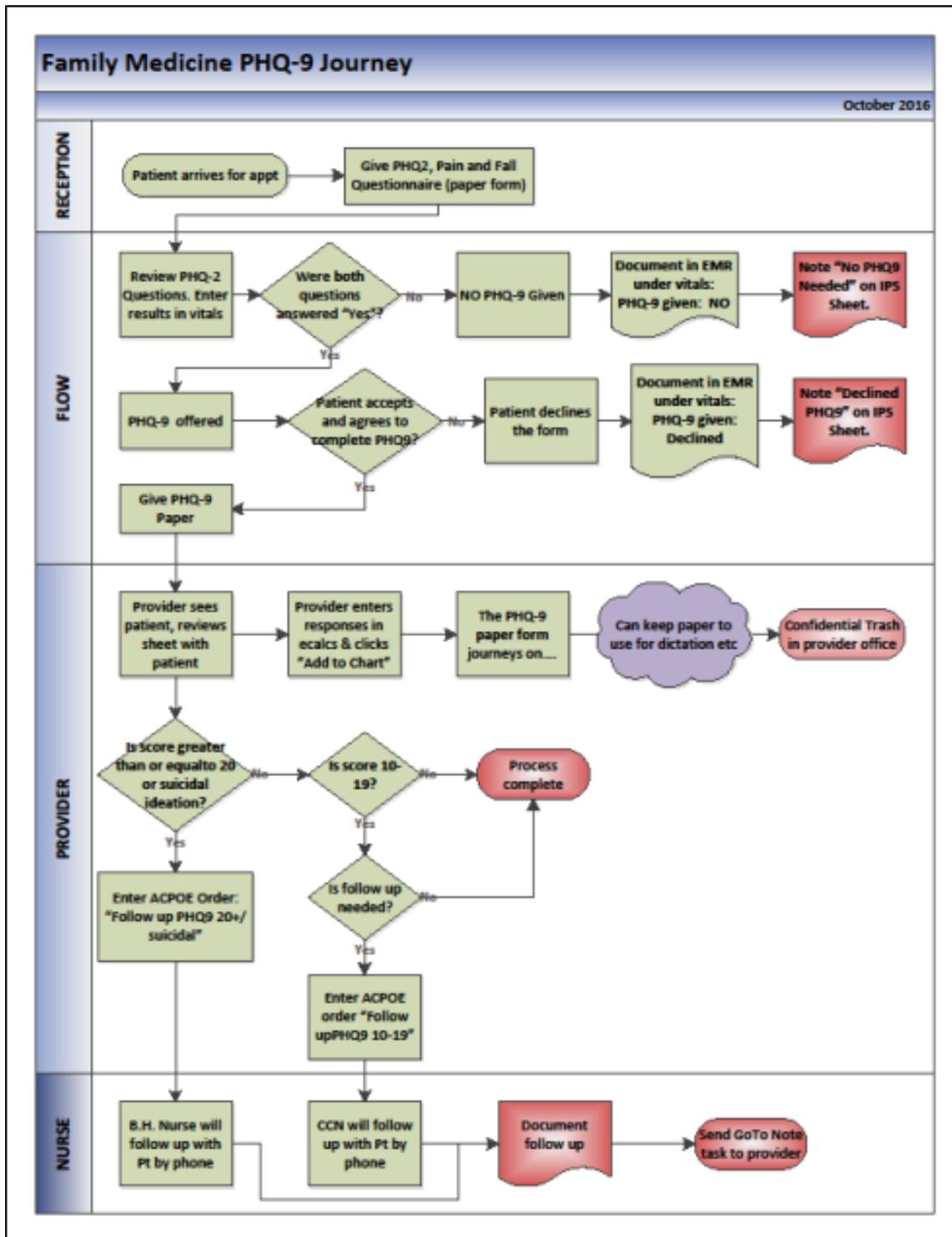


National Center for Chronic Disease Prevention and Health Promotion  
Division for Heart Disease and Stroke Prevention



\*Additional materials included in attachment

B1 Appendix J: Patient Management and Clinical Workflows (B1.8C.B)



\*Additional materials included in attachment

B1 Appendix K. SSA Report

**IDN Region: 1 Site Self-Assessment (SSA) Roll-Up Report**

**Average Scores: Domain One**

**Integrated Services and Patient and Family Centeredness**

|   | BL  |
|---|-----|
| 1. Level of integration: primary care and mental/behavioral health care   | 4.3 |
| 2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse) | 5.8 |
| 3. Treatment plan(s) for primary care and behavioral/mental health care   | 4.2 |
| 4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care                   | 4.2 |
| 5. Patient/family involvement in care plan  | 5.9 |
| 6. Communication with patients about integrated care  | 3.9 |
| 7. Follow-Up of assessments, tests, treatment, referrals and other services   | 5.7 |
| 8. Social support (for patients to implement recommended treatment)   | 4.1 |
| 9. Linking to community resources   | 5.0 |

**Average Scores: Domain Two**

**Practice/Organization**

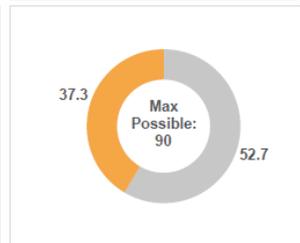
|   | BL  |
|---|-----|
| 1. Organizational leadership for integrated care                        | 5.4 |
| 2. Patient care team for implementing integrated care                   | 2.9 |
| 3. Providers' engagement with integrated care ("buy-in")                | 5.3 |
| 4. Continuity of care between primary care and behavioral/mental health | 4.4 |
| 5. Coordination of referrals and specialists                            | 4.3 |
| 6. Data systems/patient records   | 6.3 |
| 7. Patient/family input to integration management                       | 2.9 |
| 8. Physician, team and staff education and training for integrated care | 3.4 |
| 9. Funding sources/resources  | 2.4 |

**Domain One Average: Chosen SSA**



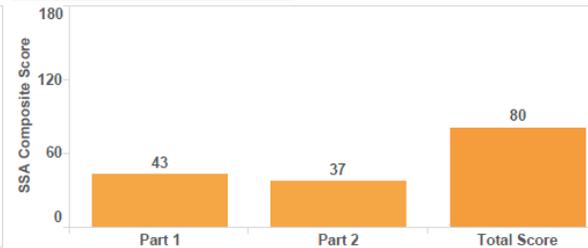
Legend:  
 Orange: Average Points Scored  
 Grey: Average Points Unmet

**Domain Two Average: Chosen SSA**



Note:  
 BL - Baseline Assessment  
 F/U 1 - First Follow-Up Assessment  
 F/U 2 - Second Follow-Up Assessment

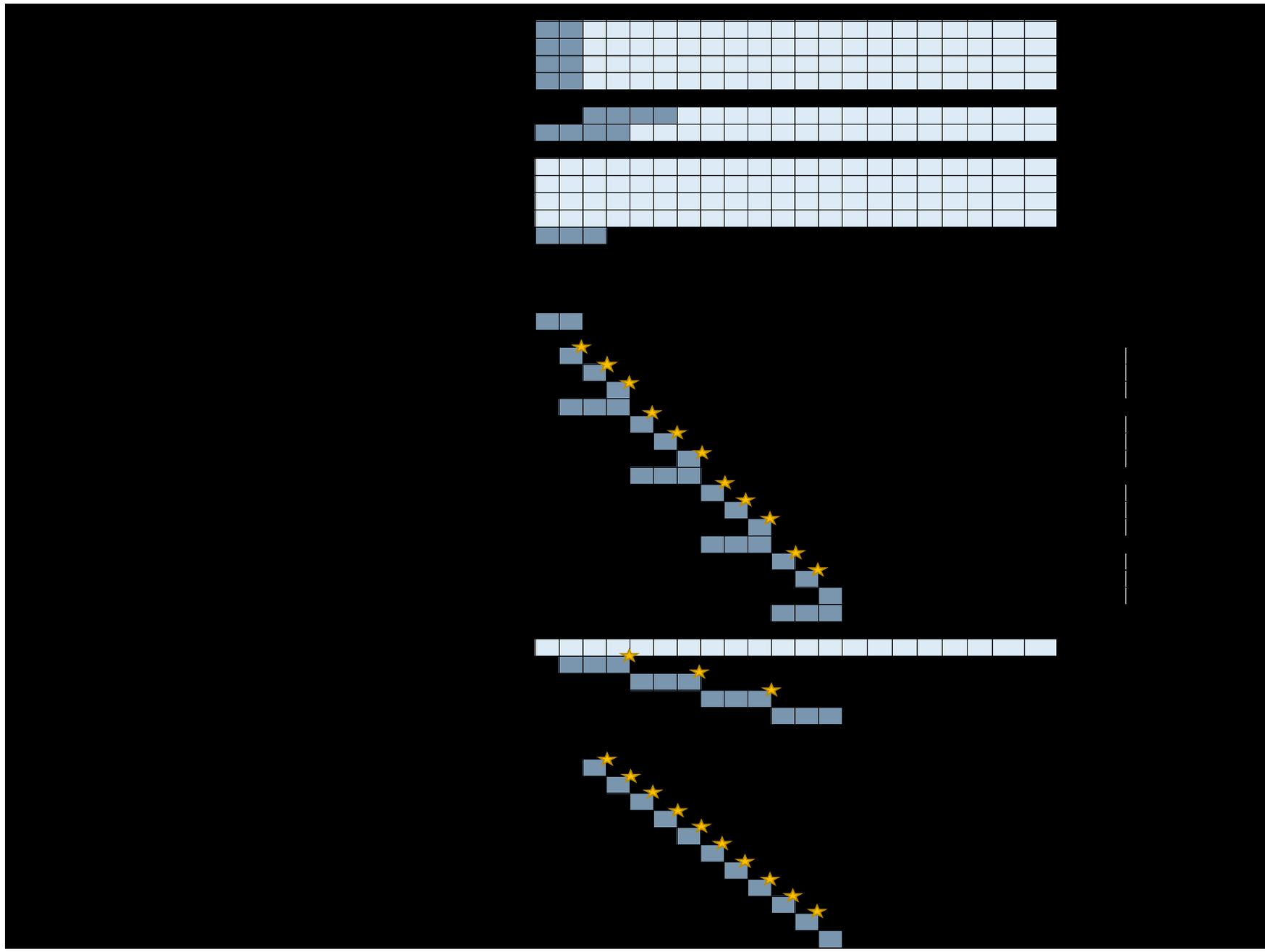
**Average Scores: Most Recent SSA**

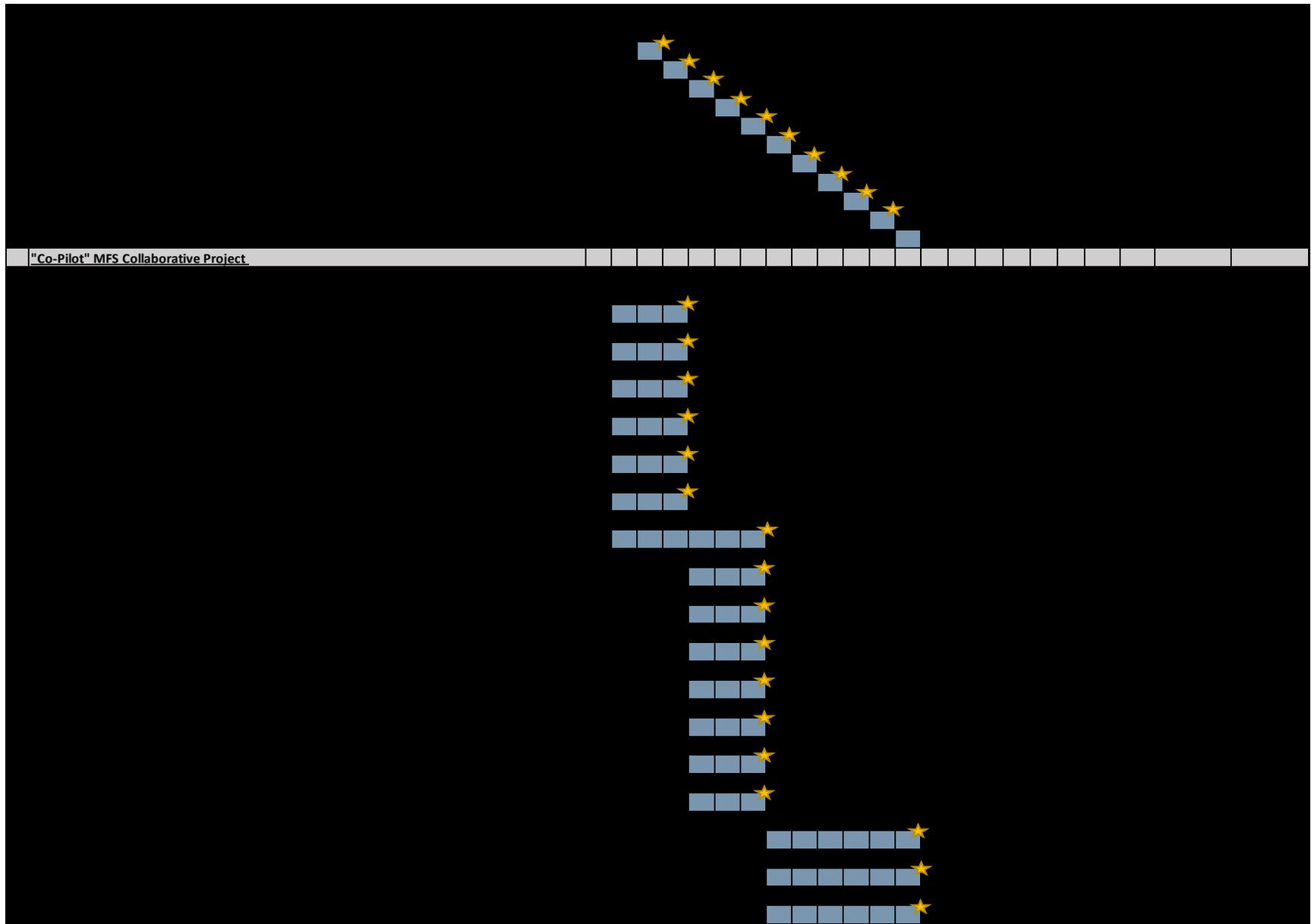


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C1: Appendix C: Evaluation Table (Attachment C1.2A)

| Project Name, Lead Organization                  | Project Milestones:  | Deliverable:   | Met or Unmet | Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports) | Accountability of Time: Met or Unmet | Participation in IDN Activities: Baseline participation Met or Unmet |
|--|--|--|--------------|--|--------------------------------------|--|
| <b>Q1 Y1: July 1, 2017-September 30, 2017</b>    |  |  |              |  |                                      |  |
| <b>"Co-Pilot" Monadnock Family Services</b>      | <i>Milestone 1:</i> Establish Governance Structure                               | Meeting Minutes, Agenda                                |              |  |                                      |  |
|  | <i>Milestone 2:</i> Completed MOU with all Referral Partners                     | Documented Materials                                   |              |  |                                      |  |
|  | <i>Milestone 3:</i> Finalized Job Descriptions, Begin Recruit to Hire Activities | Documented Materials                                   |              |  |                                      |  |
|  | <i>Milestone 4:</i> Formalize Training Plan                                      | Training Plan Draft                                    |              |  |                                      |  |
|  | <i>Milestone 5:</i> Formalize Referral Process                                   | Referral Process Draft                                 |              |  |                                      |  |
|  | <i>Milestone 6:</i> Review of Outcome Measures                                   | Documented Addition or Changes to the Outcome Measures |              |  |                                      |  |
| <b>Q2 Y1: October 1, 2017- December 31, 2017</b> |  |  |              |  |                                      |  |

|  |   |  |  |  |  |  |
|--|---|--|--|--|--|--|
| <b>"Co-Pilot" Monadnock Family Services</b>  | <i>Milestone 1:</i> Staff participation in CTI Training                       | Documented Materials                     |  |  |  |  |
|  | <i>Milestone 2:</i> Finalize Outcome Measures                                 | Updated Evaluation Plan                  |  |  |  |  |
|  | <i>Milestone 3:</i> Staff participation in CTI Supervisor Training            | Documented Materials                     |  |  |  |  |
|  | <i>Milestone 4:</i> Draft of Operational Plan                                 | Operations Plan                          |  |  |  |  |
|  | <i>Milestone 5:</i> Sustainability Plan Development - Ongoing                 | Sustainability Plan Draft                |  |  |  |  |
|  |   |  |  |  |  |  |
| <b>Q3 Y1: January 1, 2018-March 30, 2018</b> |   |  |  |  |  |  |
| <b>"Co-Pilot" Monadnock Family Services</b>  | <i>Milestone 1:</i> End of Hiring Period                                      | Full Staffing Documentation              |  |  |  |  |
|  | <i>Milestone 2:</i> Assess Patient Centered Programming                       | Review of Patient Satisfaction Responses |  |  |  |  |
|  | <i>Milestone 3:</i> 80% targeted Patient Caseloads                            | Documented Patient Caseloads             |  |  |  |  |
|  | <i>Milestone 4:</i> Document PDSA and Continuous Improvement Measures to Date | Review work with QI Coach                |  |  |  |  |
|  | <i>Milestone 5:</i> Sustainability Plan Development - Ongoing                 | Sustainability Plan Draft                |  |  |  |  |

| Q4 Y1: April 1, 2018-June 30, 2018  |   |                              |  |  |  |  |
|---|---|------------------------------|--|--|--|--|
| <b>"Co-Pilot" Monadnock Family Services</b>   | <i>Milestone 1: Creation of Year 2 Funding Addendum and Milestones</i>  | Year 2 Addendum              |  |  |  |  |
|   | <i>Milestone 2: Conduct Year 1 Review of Program Structure</i>          | Evidence of review measures  |  |  |  |  |
|   | <i>Milestone 3: Continuous demonstration of QI work, implementation</i> | Documented QI Implementation |  |  |  |  |
|   | <i>Milestone 4: Sustainability Plan Development - Ongoing</i>           | Sustainability Plan Draft    |  |  |  |  |
| Q1 Y2: July 1, 2018-September 30, 2018  |   |                              |  |  |  |  |
| Q2 Y2: October 1, 2018-December 31, 2018  |   |                              |  |  |  |  |
| <p>Additional Evaluation Targets for the project will be created in parallel with the 2nd year funding addendum (To be completed in Q4 Y1). The Region 1 teams aims to support our project partners through allowing for flexibility in their planning at this early stage to facilitate inclusion of the continuous improvement work being supported by the project and quality improvement coaches.</p> |   |                              |  |  |  |  |

## C1: Appendix D: Care Support Coordinator – CTI Job Description

\*Please note this job description is still under review by the C1 team and is not yet final

Job Title: Care Support Coordinator

Grade:

Employee:

Anniversary Date:

Department:

Review Date:

Reports to: Co Pilot Program Team Leader

---

### Job Summary:

The Care Support Coordinator (CSC) provides case management and coordinates services in the community as part of a psychosocial rehabilitation services for Medicaid recipients with complex needs, particularly individuals with severe or persistent mental illness. Utilizing the Critical Time Intervention and Enhanced Care Coordination criteria (strategies, model?), the CSC will assist clients and their families with navigating community resources while ensuring integration with healthcare services in order to improve patient care and outcomes. They help clients to address social and behavioral determinants of health needs that can be a barrier to them achieving better overall health and wellbeing. They empower the patient/caregiver to become an active participant in their care and assist in developing lasting self-management skills.

---

### Responsibilities:

1. Accept client referrals from clinical staff at Cheshire Medical Center, Dartmouth Hitchcock primary care teams, New Hampshire Hospital and other locations provide informal client counseling, support, and follow-up; making home and community visits when appropriate.
2. Establish a trusting relationship with clients and their families, using approaches such as basic motivational interviewing and goal setting to help clients overcome barriers and achieve better health.
3. Conduct person centered planning activities that seek to maximize recipient engagement and involvement in the plan of care, interventions, referrals and the access of community resources.
4. Follow up with clients via telephone, email, home visits, and meetings in other appropriate settings. Record client interactions in the electronic medical record and other secured Health Information Technology (HIT) to facilitate integration of activities with clinical staff.
5. Work closely with healthcare teams to address social and behavioral needs by connecting clients to community resources and services, social service agencies, and environments that will enhance health. Coordinate care across health-care and community-care delivery systems with client, caregivers, providers and others; participate with acute care discharge

- teams.
6. Deliver 'critical time intervention' and enhanced care coordination to recipients making the transition back to the community from inpatient physical or psychiatric levels of care or from primary care, particularly those with complex health needs that may jeopardize the individual's adherence to the plan of care.
  7. Develop an agreed upon plan of care and individualized treatment plan and goals with the patient and appropriate care teams.
  8. Identify barriers to effective utilization of community assets and healthcare resources and assist clients with accessing services such as helping to complete forms, providing client encouragement and advocacy, and ensuring clients attend appointments. Revise plan of care as circumstances demand, with input from key stakeholders and communicate those changes with all necessary partners.
  9. Facilitate and coordinate the individualized care plan to allow for maximum impact of services and treatments provided.
  10. Develop individualized crisis plans that allow the patient to manage emerging crisis, identify resources for maintain the individual within the community during a time of crisis.
  11. Manage escalated behaviors in a therapeutic manner during times of crisis and assess the effectiveness and efficiency of services provided to a client.
  12. Assess the client engagement and satisfaction throughout the time of services.
  13. Maintain the client case record information and documentation in an accurate, timely, and professional manner.

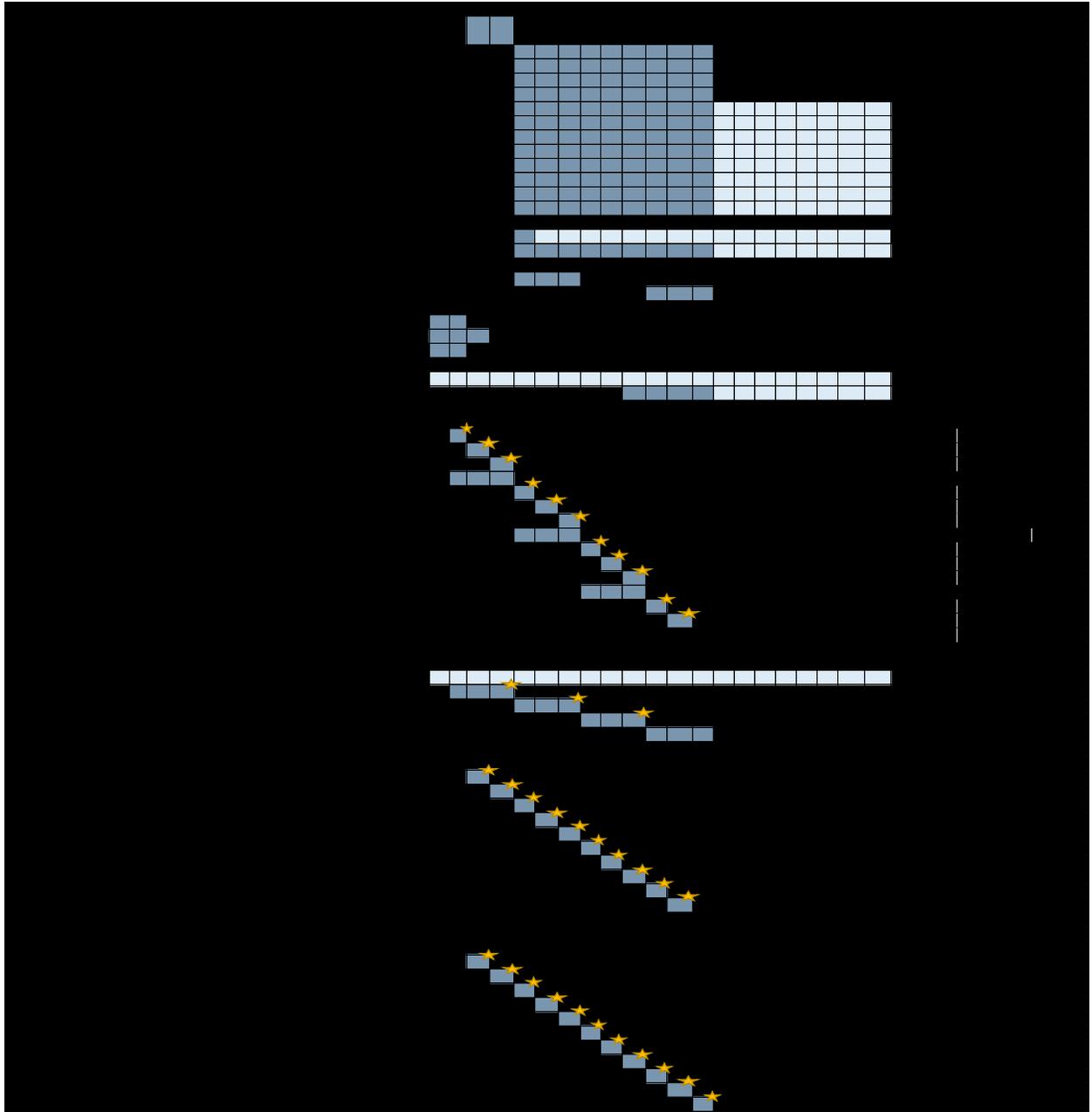
Other Expectations:

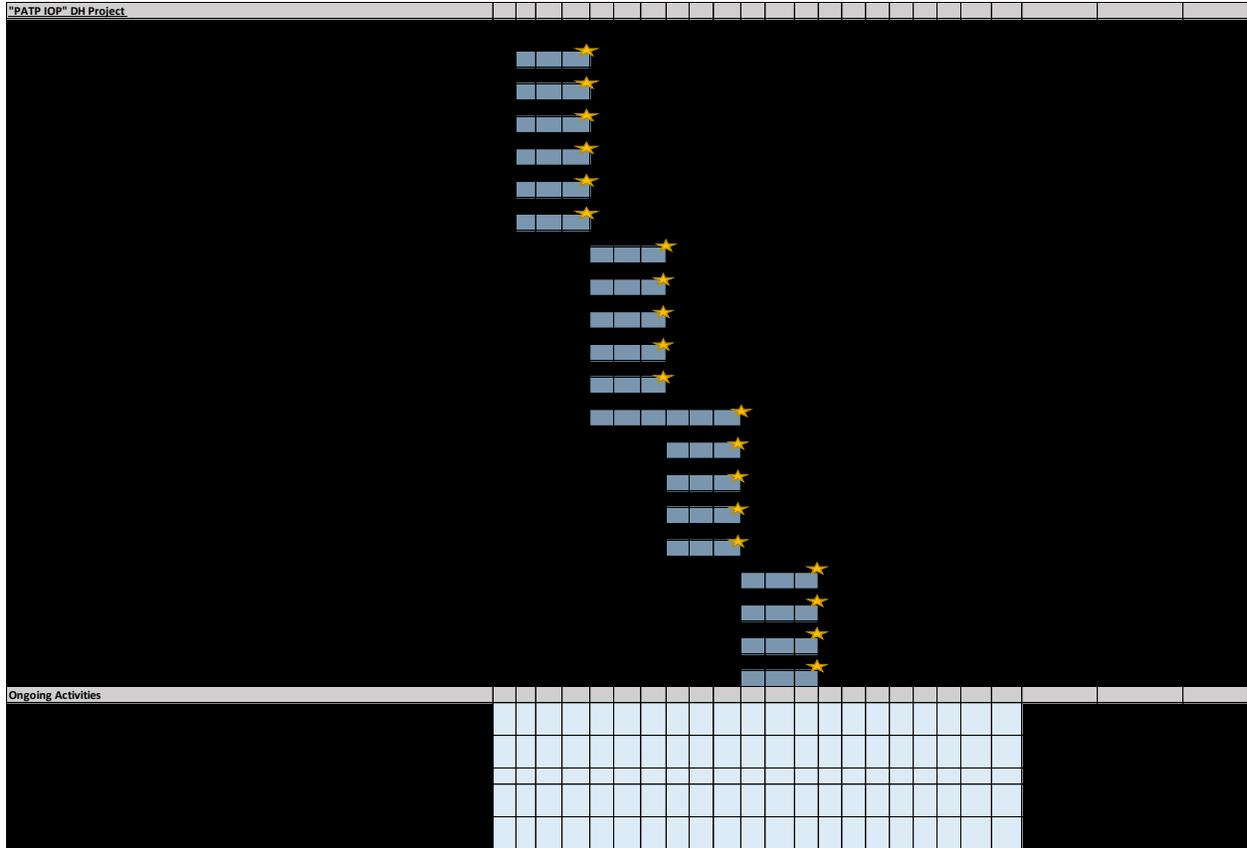
1. At times, it may be appropriate and necessary to transport the patient in the employee's personal vehicle.
2. Maintain appropriate auto insurance coverage (as determined by the agency) for use of a personal vehicle for accomplishing job duties, and protecting themselves in the event of an accident during the performance of these duties.
3. Attend regular staff meetings, trainings, and meetings as requested.
4. Collect and analyze data that will aid in measuring both individual and programmatic progress and outcomes and contribute to continuous quality improvement.
5. Maintain all net learning competencies with area agencies such as Dartmouth Hitchcock Keene/Cheshire Medical Center, Service Link, and others as needed.
6. Jobs as otherwise assigned.

Requirements:

1. Bachelor's degree in Psychology, social work, psychosocial rehabilitation or related human services field is preferred.
2. Master's degree preferred in Psychology, social work, psychosocial rehabilitation or related human services field accepted.
3. 2 plus years of experience in a community based psychosocial rehabilitation treatment, Case Management services, health and human services or related field.







D3: Appendix B. Evaluation Table Milestones (Attachment D3.2A)

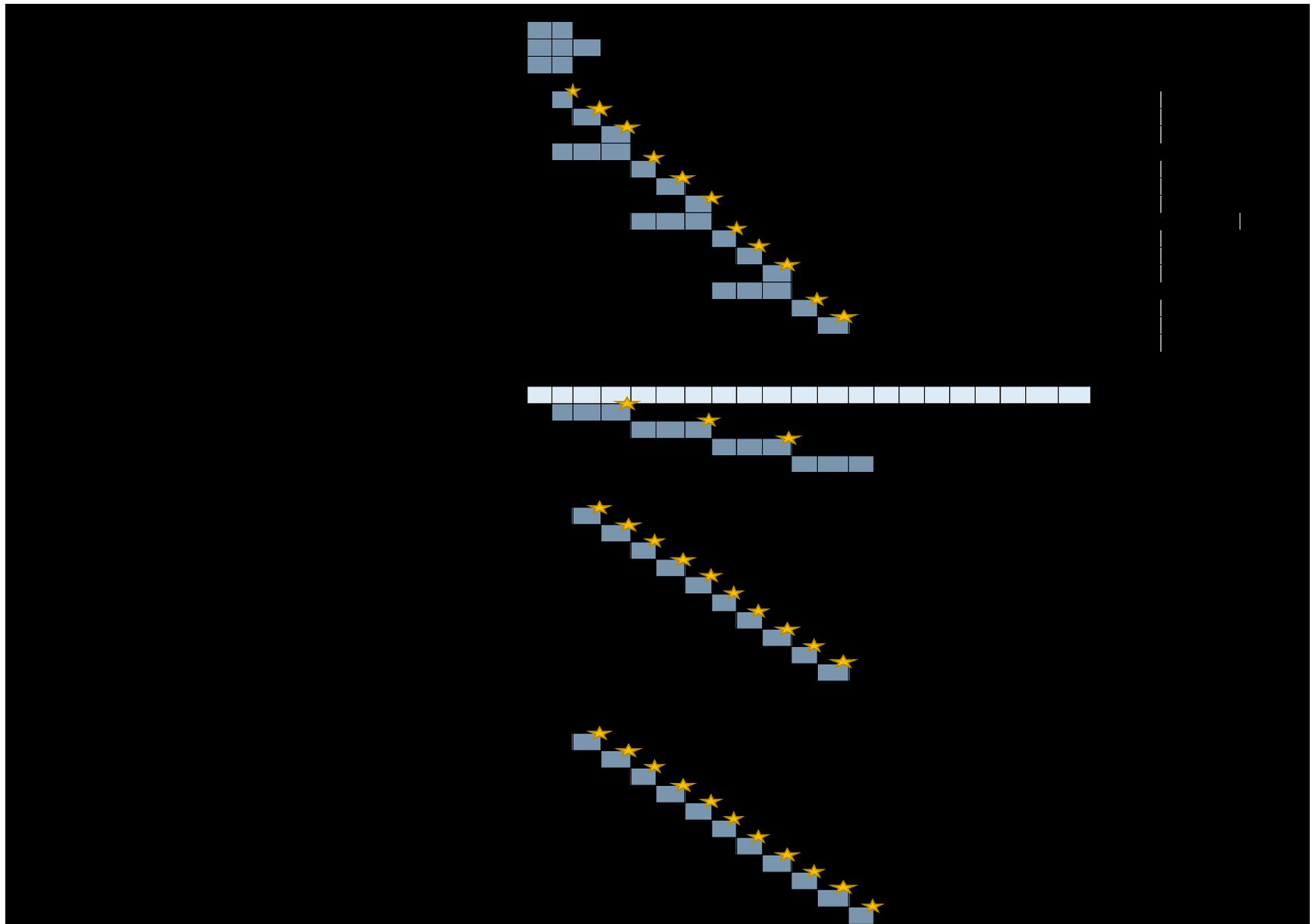
| Project Name, Lead Organization               | Project Milestones:   | Deliverable:                                   | Met or Unmet | Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports) | Accountability of Time: Met or Unmet | Participation in IDN Activities: Baseline participation Met or Unmet |
|---|---|--|--------------|--|--------------------------------------|--|
| <b>Q1 Y1: July 1, 2017-September 30, 2017</b> |   |  |              |  |                                      |  |
| <b>"PATP-IOP" Dartmouth Hitchcock</b>         | <i>Milestone 1: New Staff Recruitment, Credentialing</i>                                  | Hiring Documents                               |              |  |                                      |  |
|   | <i>Milestone 2: Budget Revisions to Reflect Partial Funding and Other Funding Streams</i> | Updated Budget                                 |              |  |                                      |  |
|   | <i>Milestone 3: Process For PATP Outpatient and IOP Integration Drafted</i>               | Draft Document                                 |              |  |                                      |  |
|   | <i>Milestone 4: Creation of Patient Advisory Board</i>                                    | Draft Document                                 |              |  |                                      |  |
|   | <i>Milestone 5: Ongoing Curriculum Development</i>  | Draft Documents                                |              |  |                                      |  |
|   | <i>Milestone 6: Begin outreach/public information campaign to inform about PATP/IOP</i>   | Campaign Materials and Outreach Methods Shared |              |  |                                      |  |

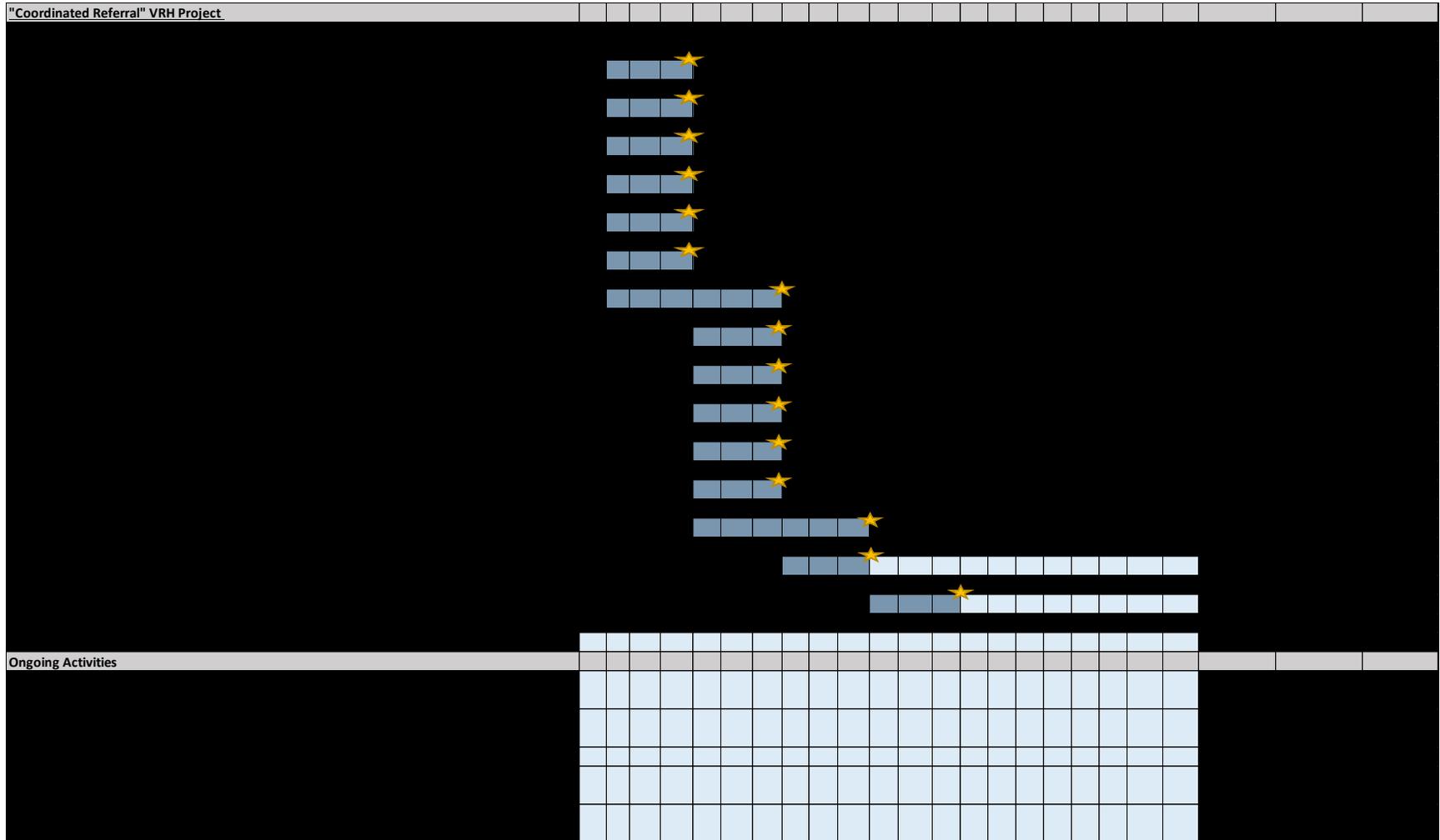
| Q2 Y1: October 1, 2017- December 31, 2017 |  |                                     |  |  |  |  |
|---|--|-------------------------------------|--|--|--|--|
| <b>"PATP-IOP" Dartmouth Hitchcock</b>     | <i>Milestone 1:</i> New Hires Orientation to Dept. and Program                 | Orientation Documents               |  |  |  |  |
|   | <i>Milestone 2:</i> Case management role fully integrated into PATP OP and IOP | Details of % effort in PATP and IOP |  |  |  |  |
|   | <i>Milestone 3:</i> PATP and IOP Integration Underway                          | Project Team Self Report            |  |  |  |  |
|   | <i>Milestone 4:</i> Childcare Program Operational                              | Share Childcare Schedule            |  |  |  |  |
|   | <i>Milestone 5:</i> Begin Assessments of new referrals to IOP                  | Project Team Self Report            |  |  |  |  |
|   | <i>Milestone 6:</i> PATP-IOP Groups Begin                                      | Project Team Self Report            |  |  |  |  |
| Q3 Y1: January 1, 2018-March 30, 2018     |  |                                     |  |  |  |  |
| <b>"PATP-IOP" Dartmouth Hitchcock</b>     | <i>Milestone 1:</i> Continuous Improvement of PATP-IOP                         | Documented QI work                  |  |  |  |  |
|   | <i>Milestone 2:</i> Continual Updates to Curriculum                            | Updated Curriculum Draft            |  |  |  |  |
|   | <i>Milestone 3:</i> Formal Documented Processes and Protocols                  | Draft Documents                     |  |  |  |  |



|   |  |                             |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|
|   | <i>Milestone 4: Collect and Interpret Outcome Data</i>     | Data Reports                |  |  |  |  |
| <b>Q4 Y1: April 1, 2018-June 30, 2018</b>   |  |                             |  |  |  |  |
| <b>"PATP-IOP" Dartmouth Hitchcock</b>   | <i>Milestone 1: Formal Documented Curriculum</i>           | Curriculum Document         |  |  |  |  |
|   | <i>Milestone 2: Ongoing Sustainable Funding Efforts</i>    | Documented Efforts          |  |  |  |  |
|   | <i>Milestone 3: Collect and Interpret Outcome Data</i>     | Data Reports                |  |  |  |  |
|   | <i>Milestone 4: Establish 2018/2019 Program Objectives</i> | Project Objectives Document |  |  |  |  |
| <b>Q1 Y2: July 1, 2018-September 30, 2018</b>   |  |                             |  |  |  |  |
| <b>Q2 Y2: October 1, 2018-December 31, 2018</b>   |  |                             |  |  |  |  |
| <p>Additional Evaluation Targets for the project will be created in parallel with the 2nd year funding addendum (To be completed in Q4 Y1). The Region 1 teams aims to support our project partners through allowing for flexibility in their planning at this early stage to facilitate inclusion of the continuous improvement work being supported by the project and quality improvement coaches.</p> |  |                             |  |  |  |  |





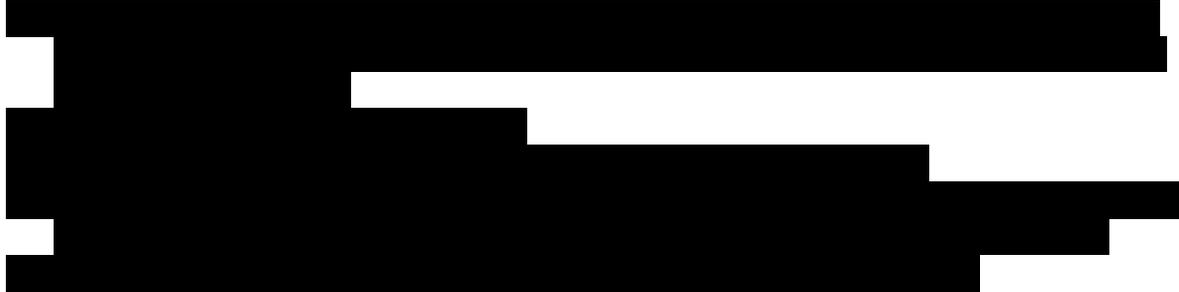


## E5: Appendix B. Coordinated Referral Partnership Agreement

### *I. Name:*

- Coordinated Referral Partnership (referred to as the “Partnership”)

### *II. Members of the Partnership Agreement:*



### *III. Purpose*

- The purpose of this Agreement is to specify what the Partners agree to as members of the Coordinated Referral Partnership. The members agree to participate in the Partnership. The goal of the Partnership is to provide and improve information, referral, assistance and access to services for high need adults and child Medicaid populations with multiple physical health and behavioral health chronic conditions.
- This is achieved as a result of improved partner collaboration through a robust Continuum of Care, which a grant-funded community-based complex case manager will serve. Referrals to the Case Manager will come through the Continuum of Care referral process outlined in this agreement. All partners in this agreement will be able to make referrals, and this agreement is open ended to encourage the ongoing

### *IV. Guiding Principles & Strategies*

1. **Reorient service provision**, creating a more client-focused environment.
2. **Identify which strategies are best for each household** based on knowledge of and access to a full array of available services.
3. **Link households to the most appropriate program** that will assist the household to quickly resolve their needs.
4. **Provide timely access and appropriate referrals** to programs and support services.
5. **Shorten the time** between identification of an eligible individual and referral to appropriate services.
6. **Focus on improving and maintaining functional status** of eligible individuals and increase the ability and capacity of individuals to self-manage their condition(s).
7. **Streamline identification and referral** for eligible individuals in crisis, especially in accessing acute care services.
8. **Establish consistent referral protocols and uniform assessment** so that no matter where a person or family presents in need, they can have access to programs and support services using a no wrong door approach.

### *V. Description of Coordinated Referral*

The Coordinated Referral Partnership will include the following:

1. The Household Screening & Referral Tool to obtain basic information related to need;
2. Screening for safety issues related to domestic/sexual violence or abuse, and appropriate referrals according to the agreed protocol;
3. The Continuum of Care Coordinated Referral Release of Information;
4. The Confidentiality Agreement for Partner staff;
5. HIPAA-compliant referral processes;
6. Initial and ongoing training of Partner staff to ensure uniform application of screening, assessment and referral protocols;
7. A local inventory of services and resources;
8. Outreach to potential new partner organizations in the Continuum of Care;
9. Regular Partnership meetings to evaluate the success of the Partnership Achieving goals, analyzing data, and making changes in referral protocols and processes, as needed. A commitment by Partners to engage in problem solving with mutual respect;
10. Community-wide lists of persons and/or households that are in crisis for the purpose of referral and enrollment in appropriate Partner projects and programs;
11. Agreement to only accept clients into Continuum of Care case management (as outlined in Attachment A) through the processes established by the Coordinated Referral Partnership; and

#### **VI. Core Components**

**A. Access:** Partners will use a triage screening tool to refer households for crisis help. This initial **Screening** will help determine what referral is appropriate.

**B. Assessment:** A **Barriers Assessment** will be conducted as soon as possible, for all households in order to identify linkage to appropriate intervention. The Assessment will inform the case plan by looking at history, barriers and personal goals, skills and assets. All assessments will be conducted by a trained assessor in the lead agency or assessment partner agency.

**C. Referrals:** Linkages to appropriate services will be based on assessment, prioritization, eligibility and written programs standards. Tools for assessment and written program standards will provide transparent, planned and fair process for case management waitlist and prioritization.

**D. Evaluation:** Coordinated Referral will include an evaluation of patient outcome and system performance to: increase effective use of resources (both staff and fiscal), improve quality of service to clients, and to proactively identify and plan services. Partners will promote and review system-wide performance standards. Additionally, an annual review of Coordinated Referral tools and processes will be conducted with feedback from patients and Partners.

#### **VII. Term of the Agreement**

The effective date of this Agreement shall be the date of 1 September 2017 and shall continue in effect until modified or terminated by the Partnership. The agreement will be reviewed annually and may be amended as stipulated in Section XVI.

The following are the responsibilities of all Partners:

**A.** Make Coordinated Referral Partnership processes, including those related to access, assessment and referral to programs and services, well-known to all clients.

- B.** Agree to make appropriate staff available for the training on protocols and procedures to follow for Coordinated Referral in their agency. To the extent possible, the training will focus on standardizing the level of information and understanding that Partners staff have, in order to give consistent and accurate information through Coordinated Referral.
- C.** Agree to distribute information to the public regarding how to access assistance. Brochures, fliers, websites, public services announcements may be created by the Partnership for this purpose.
- D.** Agree to have a representative on the Continuum of Care committee, to provide input into the operations and continuous refinements and evaluation of the Coordinated Referral processes. When issues arise, agree to joint problem solving with individual Partners, the Lead Agency, and the Partnership committee.
- E.** Partners shall agree to follow guidelines for referring clients in a manner that is compliant with HIPAA (Public Health Information) and 42 CFR Part 2 (Substance Abuse Treatment Information). This includes informing households that they are receiving intake and referral under the Partnership, completing the authorized Referral Form, signing a compliant release of information form, and forwarding any information to agencies in a compliant manner. **Attachment B** is a HIPAA and 42 CFR Part 2 Confidentiality Agreement that accompanies this Agreement, which outlines the agreements between and amongst agencies that work as Partners to ensure that all privacy, security and confidentiality standards under HIPAA and 42 CFR Part 2 are being met by participating agencies.
- F.** Agree to use established Coordinated Referral protocols and processes to refer and accept clients into projects and programs named in Attachment A. Agree to communicate with partner's when/if a referred household is not accepted into a project/program.

#### ***VIII. Shared Responsibilities***

the following are the responsibilities of all Partners:

- A.** Make Coordinated Referral Partnership processes, including those related to access, assessment and referral to programs and services, well-known to all clients.
- B.** Agree to make appropriate staff available for the training on protocols and procedures to follow for Coordinated Referral in their agency. To the extent possible, the training will focus on standardizing the level of information and understanding that Partners staff have, in order to give consistent and accurate information through Coordinated Referral.
- C.** Agree to distribute information to the public regarding how to access assistance. Brochures, fliers, websites, public services announcements may be created by the Partnership for this purpose.
- D.** Agree to have a representative on the Continuum of Care committee, to provide input into the operations and continuous refinements and evaluation of the Coordinated Referral processes. When issues arise, agree to joint problem solving with individual Partners, the Lead Agency, and the Partnership committee.
- E.** Partners shall agree to follow guidelines for referring clients in a manner that is compliant with HIPAA (Public Health Information) and 42 CFR Part 2 (Substance Abuse Treatment Information). This includes informing households that they are receiving intake and referral under the Partnership, completing the

authorized Referral Form, signing a compliant release of information form, and forwarding any information to agencies in a compliant manner. **Attachment B** is a HIPAA and 42 CFR Part 2 Confidentiality Agreement that accompanies this Agreement, which outlines the agreements between and amongst agencies that work as Partners to ensure that all privacy, security and confidentiality standards under HIPAA and 42 CFR Part 2 are being met by participating agencies.

F. Agree to use established Coordinated Referral protocols and processes to refer and accept clients into projects and programs named in Attachment A. Agree to communicate with partner's when/if a referred household is not accepted into a project/program.

***IX. Lead Agency Responsibilities***

A. Provide leadership, coordination and oversight of Coordinated Referral processes.

B. Ensure that all Partners are involved in and informed of evaluation and reporting aspects of this Agreement.

C. Seek out funding to help with costs associated with the continued development and implementation of this Partnership.

D. Ensure that all requirements (programmatic and fiscal) for grant funds received to underwrite any part of expenses associated with the continued development and implementation of this Partnership.

E. Provide training to Partners to ensure standardization of information, assistance and referral offered to potential households.

F. Provide training to all Partner staff administering the Screening & Referral Tool, and the Barriers Assessment Tool.

G. Promote the process and outcomes of Coordinated Referral to the public; local officials; state and federal agencies, officials and other interested parties.

H. Convene local CoC Partnership meetings.

I. Follow up with clients referred by Referral Partners within 3 days.

J. Complete Barriers Assessment for referred households.

K. Ensure that all Agreements and Partner Staff Confidentiality Agreements are signed and kept in a secure central location; to be kept on file for a minimum of five years.

***X. Assessment Partners' Responsibilities***

A. Complete Barriers Assessment for households in crisis.

B. Maintain high level of communication and coordination with Lead Agency and other Assessment Partners, e.g. participation on a Case Review Team.

C. Share assessment information, as needed, to coordinate referrals and ensure that clients are not completing the assessment multiple times.

***XI. Referral Partners' Responsibilities***

A Referral Partner may be a service agency, or business or organization that provides services to the public, who have elected to become a part of the Continuum of Care; and has agreed to the following:

**A.** Complete the Screening & Referral tool for households they identify as in crisis.

**B.** Submit completed Screening & Referral tool to the Lead Agency within one business day

***XIII. Grievance Policy and Rights***

Coordinated Referral includes a Client Grievance Policy and Rights. Each Partner agrees to inform and help track that Partners assure the following:

1. Give clients the opportunity to be empowered about the services they choose to receive;
2. Hold partners accountable to responding to calls for available services or housing units;
3. Explain the Coordinated Referral processes to clients so that they understand their responsibilities and those of the Coordinated Referral Partnership; and
4. Inform clients of both their agency and the Coordinated Referral grievance process at intake.

***XIV. Confidentiality***

The Partnership agree that by virtue of entering into this Agreement they will have access to certain confidential information regarding each other's operations related to this Partnership. The Partners agree that they will not disclose confidential information and/or material without consent of the affected party unless such disclosure is authorized by this Agreement or required by law. Unauthorized disclosure of confidential information shall be considered a breach of this agreement. At all times client Releases of Information (HIPAA and 42 CFR Part 2 compliant) will be secured before confidential client information is exchanged. Confidential client information will be handled with the utmost discretion and judgment. Partner staff participating in this Partnership will sign a Confidentiality Agreement related to sharing client information.

***XVI. Amendment of the Agreement***

This Agreement may be amended at any time by mutual agreement of the Partners, as determined by the Partnership.

***XVII. Termination of Agreement***

Any party may terminate their participation in this agreement with written notification to the project manager of the Coordinated Referral Partnership.

***XVIII. Costs***

Unless otherwise specified by grant funds that may become available during the duration of this Agreement, any and all expenses incurred by the participants of this Partnership are the responsibility of the Partner.

***XIX. Conformance***

If any provisions of this Agreement violates any statute or rule of law of the State of New Hampshire, or Federal statutes, it is considered modified to conform to that statute or rule of law.

***XX. Approval***

This Agreement shall be subject to the written approval of the Partnership. This agreement may be altered, amended or waived only by a written amendment executed by all parties

E5: Appendix C: Evaluation Table (Attachment E5.2A)

| Project Name, Lead Organization                        | Project Milestones:   | Deliverable:                    | Met or Unmet | Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports) | Accountability of Time: Met or Unmet | Participation in IDN Activities: Baseline participation Met or Unmet |
|--|---|---------------------------------|--------------|--|--------------------------------------|--|
| <b>Q1 Y1: July 1, 2017-September 30, 2017</b>          |   |                                 |              |  |                                      |  |
| <b>"Coordinated Referral" Valley Regional Hospital</b> | <i>Milestone 1:</i> Identify Coordinated Referral Core Team               | Document Membership             |              |  |                                      |  |
|  | <i>Milestone 2:</i> Recruit to Hire Coordinator Staff                     | Copy of Hiring Paperwork        |              |  |                                      |  |
|  | <i>Milestone 3:</i> Identify and Finalize Assessment Partners             | Copy of Assessment Partner List |              |  |                                      |  |
|  | <i>Milestone 4:</i> Identify and Finalize Referral Partners               | Copy of Referral Partner List   |              |  |                                      |  |
| <b>Q2 Y1: October 1, 2017- December 31, 2017</b>       |   |                                 |              |  |                                      |  |
| <b>"Coordinated Referral" Valley Regional Hospital</b> | <i>Milestone 1:</i> Screening and Barriers Tool Development               | Documented Materials            |              |  |                                      |  |
|  | <i>Milestone 2:</i> Formalize Coordinator Training Plan                   | Documented Materials            |              |  |                                      |  |
|  | <i>Milestone 3:</i> Formalize Program Guidelines                          | Documented Materials            |              |  |                                      |  |
|  | <i>Milestone 4:</i> Formalize Implementation Plan and Share with Partners | Documented Materials            |              |  |                                      |  |

Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  | <i>Milestone 5: Begin CoC Network Meetings</i>   | Documented Schedule and Attendance               |  |  |  |  |
| <b>Q3 Y1: January 1, 2018-March 30, 2018</b>           |  |  |  |  |  |  |
| <b>"Coordinated Referral" Valley Regional Hospital</b> | <i>Milestone 1: Completion of all Coordinated Referral Partnership Agreements for Year 1</i> | Copy of Completed Agreements                     |  |  |  |  |
|  | <i>Milestone 2: Review and Adopt Screening and Barriers Tool with Partner Agencies</i>       | Copy of Final Tools                              |  |  |  |  |
|  | <i>Milestone 3: Formalize Patient Referral Processes Across Partners</i>                     | Copy of Referral Process                         |  |  |  |  |
|  | <i>Milestone 4: Provide Partner Training on updated Processes</i>                            | Share Training Curriculum and Attendance         |  |  |  |  |
| <b>Q4 Y1: April 1, 2018-June 30, 2018</b>              |  |  |  |  |  |  |
| <b>"Coordinated Referral" Valley Regional Hospital</b> | <i>Milestone 1: Review and Assess usage of Referral Process</i>                              | Share Assessment Process and Findings            |  |  |  |  |
|  | <i>Milestone 2: 6 Months of Project Implementation Data Analysis</i>                         | Share Data Analysis                              |  |  |  |  |
|  | <i>Milestone 3: Ongoing Sustainability Efforts</i>   | Demonstrate ongoing sustainable funding pursuits |  |  |  |  |

Integrated Delivery Network Region 1: *Partnership for Integrated Care*

|   |  |                                     |  |  |  |  |
|---|--|-------------------------------------|--|--|--|--|
|   | <i>Milestone 4: Create and Finalize Extended Contract Milestones</i> | Copy of Finalized Year 2 Milestones |  |  |  |  |
| <b>Q1 Y2: July 1, 2018-September 30, 2018</b>   |  |                                     |  |  |  |  |
| <b>Q2 Y2: October 1, 2018-December 31, 2018</b>   |  |                                     |  |  |  |  |
| <p>Additional Evaluation Targets for the project will be created in parallel with the 2nd year funding addendum (To be completed in Q4 Y1). The Region 1 teams aims to support our project partners through allowing for flexibility in their planning at this early stage to facilitate inclusion of the continuous improvement work being supported by the project and quality improvement coaches.</p> |  |                                     |  |  |  |  |

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<sup>1</sup> New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 65.

<sup>2</sup> New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 68.

<sup>3</sup> New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 67.

<sup>4</sup> <https://www.healthit.gov/standards-advisory/2016>

<sup>5</sup> <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

<sup>6</sup> <http://www.rwjf.org/en/library/research/2010/01/a-new-way-o-talk-about-the-social-determinants-of-health.html>

<sup>7</sup> New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 63.