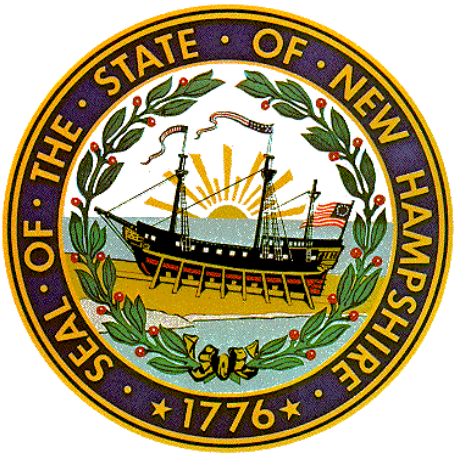


New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN 3 PROCESS MEASURES SEMI-ANNUAL REPORT

For July 31, 2017

IDN 3 Semi-Annual Report
July 2017

Table of Contents

DSRIP IDN Project Plan Implementation (PPI)

Process Milestone Number	Process Detail	Page Number
PPIa	DSRIP IDN Project Plan Implementation Narrative	8
PPIb	Project Plan Implementation Plan	12

Project A1: Behavioral Health Workforce Capacity Development

Process Milestone Number	Process Detail	Page Number
A1-1	Participation in Statewide BH Workforce Capacity Taskforce Strategic Plan Activity	27
A1-2a	IDN-level Workforce Gap Analysis Narrative	28
A1-2b	IDN Level Workforce Gap Analysis Table	30
A1-3a	IDN-level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan	33
A1-3b	Behavioral Health Workforce Capacity Implementation Plan	36
A1-4	Evaluation Project Targets	47
A1-5	IDN-level Workforce Staffing Targets	50
A1-6	IDN-level Workforce Capacity Budget	52
A1-7	IDN Workforce Key Organizational and Provider Participants	55

Project A2: IDN Health Information Technology (HIT)

Process Milestone Number	Process Detail	Page Number
A2-1	IDN Participation in Statewide HIT Taskforce	57
A2-2a	IDN HIT/HIE Assessment and Gap Analysis Narrative	58
A2-2b	IDN HIT/HIE Assessment and Gap Analysis Table	61
A2-3a	IDN HIT/HIE Implementation Plan and Timeline Narrative	82
A2-3b	IDN HIT/HIE Implementation Plan and Timeline Table	91
A2-4	Evaluation Project Targets	103
A2-5	IDN HIT Workforce Staffing	106
A2-6	IDN HIT Budget	107
A2-7	IDN HIT Key Organizational and Provider Participants	108
A2-8	IDN HIT Data Agreement Attestation by Organization	109

Project B1: Integrated Healthcare

Process Milestone Number	Process Detail	Page Number
B1-1a	IDN Integrated Healthcare: Assessment and Ongoing Reporting of Current State of Practice Against SAMHSA Framework for Integrated Levels of Care and Gap Analysis	111
B1-1b	List of completed baseline SSAs by Waves	113
B1-1c	Integrated Practice Site Self-Assessment Tool	115
B1-2a	IDN Integrated Healthcare: Implementation Plan Narrative, Timeline, Milestones and Evaluation Project Plan	124
B1-2b	Integrated Health Implementation Plan	133
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	140
B1-4	IDN Healthcare Integration Workforce Staffing	143
B1-5a	IDN Healthcare Integration: Budget Narrative	144
B1-5b	IDN Healthcare Integration: Detailed Budget	146
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	147
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	151
B1-8ai	CCSA Domains: Table of IDN Provider Practices	153
B1-8aii	CCSA Domains: Table of IDN Pediatric Practices	156
B1-8b	Multi-Disciplinary Teams: Table of IDN Practices with Roles of Team Members	158
B1-8ci	Multi-Disciplinary Core Team Training: Universal Screening	172
B1-8cii	Multi-Disciplinary Core Team Training: Co-Occurring Disorders	179
B1-8ciii	Multi-Disciplinary Core Team Training: Care Planning and Care Coordination Models	186
B1-8civ	Multi-Disciplinary Core Team Training: Cultural Competency and Adaptation	193
B1-8cv	Multi-Disciplinary Core Team Training: Understanding Addiction	200
B1-8cvi	Multi-disciplinary Core Team Training: BH Integration Core Competencies	207
B1-8d	Training for Non-Direct Care Staff	208

Process Milestone Number	Process Detail	Page Number
B1-8e	IDN 3 Cross-IDN Case Management Team Meetings Proposed Plan and Timeline	214
B1-8f	Secure Messaging Narrative	215
B1-8g	Closed Loop Referrals Narrative	216
B1-8h	IDN Member Entity Examples of Documented Work Flows and/or Protocols: Healthy at Home Client Admission Intake Form	217
B1-8hi	IDN Member Entity Examples of Documented Work Flows and/or Protocols: Dartmouth Hitchcock Behavioral Health Integration Guidelines	218
B1-8hii	IDN Member Entity Examples of Documented Work Flows and/or Protocols: Dartmouth Hitchcock Depression Pocket Guide for front-line providers	228
B1-8hiii	IDN Member Entity Examples of Documented Work Flows and/or Protocols: Student Assistance Program Guidelines	230
B1-9a	Progress Toward Coordinated Care Practice Designations	233
B1-9b	Additional Integrated Practice Designation Requirements	234
B1-9c	Table of IDN 3 Member Entities and Needs for Use of Technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	235
B1-9d	Documented work flows with community based social support service providers including joint service protocols and communication channels	237
B1-11	IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation	238

Project C1: Critical Time Intervention (CTI)

Process Milestone Number	Process Detail	Page Number
C1-1a	IDN Community Project Timeline Narrative, Key Milestones and Evaluation Project Plan	243
C1-1b	Critical Time Intervention (CTI) Implementation Plan	248
C1-2	IDN Community Project Evaluation Project Targets	251
C1-3	IDN Community Project Workforce Staffing	252
C1-4a	IDN Community Project Budget Narrative	253
C1-4b	IDN Community Project Budget Detail	254
C1-5	IDN Community Project Key Organizational and Provider Participants	256
C1-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	257
C1-7a	IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals	258
C1-7b	Sample CTI Referral Form	259
C1-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	261
C1-9a	CTI Training Plan Narrative	262
C1-9b	CTI Staff Training Plan Table	264
C1-9c	NC CTI Training Slides	267

Project D3: Expansion in Intensive Substance Use Disorder (SUD) Treatment Options

Process Milestone Number	Process Detail	Page Number
D3-1a	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan Narrative	276
D3-1b	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan Table	282
D3-2	IDN Community Project Evaluation Project Targets	285
D3-3	IDN Community Project Workforce Staffing	287
D3-4a	IDN Community Project Budget Overview	288

Process Milestone Number	Process Detail	Page Number
D3-4b	IDN Community Project Budget Detail	289
D3-5	IDN Community Project Key Organizational and Provider Participants	290
D3-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	291
D3-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	292
D3-8	IDN Community Project Roles and Responsibilities	295
D3-9	Training Topics by Staff	296

Projects E4: Integrated Treatment for Co-Occurring Disorders

Process Milestone Number	Process Detail	Page Number
E4-1a	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	200
E4-1b	Integrated Treatment of Co-Occurring Disorders Implementation Plan	306
E4-2a	IDN Community Project Workforce Staffing	309
E4-2b	IDN Community Project: Evaluation Project Targets	311
E4-3a	IDN Community Project Evaluation Project Targets Narrative	312
E4-3b	IDN Community Project Evaluation Project Targets Table	313
E4-4a	IDN Community Project Budget Overview	314
E4-4b	IDN Community Project Budget Detail	315
E4-5	IDN Community Project Key Organizational and Provider Participants	316
E4-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	317
E4-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	318
E4-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	319
E4-9a	IDDT Staff Training Plan	320
E4-9b	Case Western Reserve University IDDT Implementation Guide	325

DSRIP IDN Project Plan Implementation (PPI)

Soliciting Community Input

IDN Governance Structure and Full IDN Meetings

The IDN utilizes the Governance Committees and their work groups to solicit input into the project strategies, strategy development (including potential partners, communication/messaging, and workflows/protocols. Throughout the implementation planning process, the Governance Committees and their work groups examined the 2016 needs assessment and examined their own organization's experiences in the community to determine the specific strategies and funding needs for each of the IDN projects. This process timeline has been outlined in attachment_PPIb (*IDN 3 Project Plan Implementation).*

Behavioral Health Conference

The Community Engagement Governance Committee has set up work teams to solicit input and engage the community (in particular providers and other stakeholders) to understand the work of the IDN, as they will be critical to the operationalization of the strategies. This includes the support of a website for the IDN (https://greaternashuaidn.org/), elevator speech, and an annual conference, to be held in conjunction with the Nashua Department of Public Health. The first annual conference will be held in October 2017.

Network Development

The IDN has been holding quarterly Full IDN Member meetings, which enable all partners and their stakeholder members to attend to receive updates on progress, provide input into decision-making and ask questions about next steps, and stay engaged in the process as we move to operationalizing the implementation plan strategies.

These quarterly meetings will morph into monthly Full IDN meetings, held via webinar and phone using our ReadyTalk platform, which allows for a chat/Q & A section within the webinar, the ability to provide training, and the opportunity to provide more timely updates, especially related to our statewide projects (A1, A2, and B1).

Addressing the Opioid Crisis

The IDN has several strategies which will help address the opioid crisis, but especially as it relates to individuals within our attributed population with co-occurring disorders, such as physical or mental health conditions, as well as substance use disorder (SUD). These strategies will be supported by multi-disciplinary core teams with case management structures that address those complex patients through a cross-IDN provider approach, including our social service support organizations who are addressing the social determinants of health. We expect that we will have a better sense of the extent of the opioid and co-occurring complex patient needs as we better understand our target population and begin operationalizing our strategies. This will allow us to expand our thinking as a region for what strategies might best support the reduction in patients in the hospital Emergency Departments and those who fall through the gaps in care because of lack of information sharing and communication tools.

Opioid Crisis Update:

Hillsborough County (of which IDN 3 contains 13 of the 31 towns) did not see improvement in drug-related incidents.

EMS Narcan Administration:

- Hillsborough County had the most Narcan incidents with 66 in January, 80 in February and 92 in March 2017. (NH Bureau of Emergency Medical Services)

Opioid-Related Emergency Department Visits:

- Hillsborough County had the most opioid-related ED visits with 183 in January and 203 in February 2017. (NH Division of Public Health Services)

Opioid-Related Treatment Admissions:

- Hillsborough County had the most opioid/opiate treatment admissions with 67 in January and 62 in February, and 78 in March 2017. (NH Bureau of Drug and Alcohol Services)

Drug Overdose Deaths:

- Between January 2016 and April 2017, Hillsborough County had the highest suspected drug use resulting in overdose deaths per capita at 4.77 deaths per 10,000 population. (NH Medical Examiner's Office)

Nashua Safe Station:

As of February 15, 2017:

- Number of requests for Nashua Safe Station: 144
- Number of participants transported to hospitals: 18
- Number of participants taken to PSL facilities: 212
- Number of participants seen for ODs prior to seeking Safe Stations help: 26
- Number of unique participants: 121
- Number of repeat participants: 22
- Age range of participants: 18-61

As of March 16, 2017:

- Number of requests for Nashua Safe Station: 221
- Number of participants transported to hospitals: 33
- Number of participants taken to PSL facilities: 183
- Number of participants seen for ODs prior to seeking Safe Stations help: 34
- Number of unique participants: 183Number of repeat participants: 38
- Age range of participants: 18-66

As of April 14, 2017:

- Number of requests for Nashua Safe Station: 318
- Number of participants transported to hospitals: 45
- Number of participants taken to PSL facilities: 265
- Number of participants seen for ODs prior to seeking Safe Stations help: 56
- Number of unique participants: 247
- Number of repeat participants: 71
- Age range of participants: 18-65

Governance

The IDN Governance Committee structure is very sophisticated, with delegates and alternates from IDN Member Entity organizations each having a seat on at least one Governance Committee. The Governance Committees meet at least once a month and each representing organization attending receives a stipend for meeting attendance.

IDN 3 Work Team Structure:

In an effort to accomplish the many steps it will take to achieve the tasks associated with the project strategies, work teams have been formed to work under the oversight of the IDN Administrative Lead Team as well as the IDN Governance Committees.

These work teams include:

Clinical Committee Work Teams

- Provider Support toward Integrated Practice Designation
- Critical Time Intervention (CTI)
- Integrated Treatment of Co-Occurring Disorders (IDDT)
- Patient Privacy and Consent

Health Information Technology Work Teams

- HIT Infrastructure to Support Integration

Behavioral Health Workforce Work Teams

- Behavioral Health Workforce Recruitment, Hiring, and Retention
- Behavioral Health Conference Work Team

Community Engagement Committee Work Teams

- Social Media/Messaging Work Team
- Training and Community Education Work Team
- Data Collection and Resources Work Team

Cross-Committee Work Teams

- Provider and Workforce Training Work Team (Combo Clinical and Behavioral Health Workforce Work Team)
- Reporting Tools and Data Analysis for Monitoring and Managing Patient Outcomes (Combo IT and Clinical Work Team)
- Performance Metrics and Quality Monitoring (Combo IT and Clinical Work Team)

Budget

The IDN Governance Committees received proposals from the IDN Member Entities throughout the Spring 2017 related to the A1, B1, C1, D3, and E4 projects, which were vetted first for clinical soundness in reaching the identified project goals/milestones, as well as how they overlapped with the information secured through the Fall 2016 Community Needs Assessments. Then, the Clinical Governance

Committee made recommendations to the Finance Committee, who reviewed the proposals and budgets for financial soundness related to the project goals/milestones as well as the funding available for reimbursement. Finally, the Executive Governance Committee reviewed the proposals and budgets for both clinical and financial soundness, but also for the IDN in meeting its identified target goals and outcomes. This process concluded in July, with approval for the proposed project strategies and budgets made by the Executive Governance Committee to be submitted to DHHS for approval.

The A2 (Health Information Technology) strategies and budgets were vetted through the IT/Data Governance Committee throughout the Spring 2017 as part of the work of the Statewide HIT Taskforce minimum, desired and optional HIT capabilities and standards. The Committee engaged with HIT vendors to participate in demos of various HIT platforms to meet those HIT capabilities and standards and overlapped that research with the gaps/opportunities for the IDN Member Entities to move as far as possible toward achieving the optional capabilities and standards. Through the leadership of the IDN's IT Director, budgets were proposed with applicable vendors and submitted to the Finance Governance and finally the Executive Governance Committees for approval. This process concluded in July, with approval for the strategies, vendors and budgets made by the Executive Governance Committee to be submitted to DHHS for approval.

For more specific information related to the project budgets, please see the budget spreadsheets within each project implementation plan, as well as in attachment_PPIb.

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Soliciting Community Input		243d	11/01/16	10/05/17
	Soliciting input on IDN 3 project strategies		193d	11/01/16	07/27/17
	A1		84d	04/03/17	07/27/17
	Form BH Workforce Work Team				
	RFP Process		50d	04/03/17	06/09/17
	Approve Budget		6d	07/20/17	07/27/17
	Finance		1d	07/20/17	07/20/17
	Executive		1d	07/27/17	07/27/17
	A2		193d	11/01/16	07/27/17
	Data/IT Governance Committee		163d	11/01/16	06/15/17
	Evaluate HIT platform vendors				
	Approve Budget		6d	07/20/17	07/27/17
	Finance		1d	07/20/17	07/20/17
	Executive		1d	07/27/17	07/27/17
	B1		84d	04/03/17	07/27/17
	RFP Process		54d	04/03/17	06/15/17
	Form Provider Integration Work Team				
	Approve Budget		6d	07/20/17	07/27/17
	Clinical				
	Finance		1d	07/20/17	07/20/17
	Executive		1d	07/27/17	07/27/17
	C1		149d	01/02/17	07/27/17
	Clinical Governance Committee Work		119d	01/02/17	06/15/17
	Form CTI Work Team				
	Approve Budget		6d	07/20/17	07/27/17
	Clinical				
	Finance		1d	07/20/17	07/20/17
	Executive		1d	07/27/17	07/27/17
	D3		149d	01/02/17	07/27/17
	Clinical Governance Committee Work		119d	01/02/17	06/15/17
	Form D3 Work Team				
	Approve Budget		6d	07/20/17	07/27/17
	Clinical				

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Finance		1d	07/20/17	07/20/17
	Executive		1d	07/27/17	07/27/17
	E4		149d	01/02/17	07/27/17
	Clinical Governance Committee Work		119d	01/02/17	06/15/17
	Form E4 Work Team				
	Approve Budget		6d	07/20/17	07/27/17
	Clinical				
	Finance		1d	07/20/17	07/20/17
	Executive		1d	07/27/17	07/27/17
	IDN presentations/workshops in the		91d	06/01/17	10/05/17
	IDN 3 Behavioral Health Conference		91d	06/01/17	10/05/17
	October 2017		91d	06/01/17	10/05/17
	Network Development		1191d	06/09/16	12/31/20
	Full IDN Meetings		1191d	06/09/16	12/31/20
	At Least Quarterly		1191d	06/09/16	12/31/20
	IDN presentations/workshops in the		91d	06/01/17	10/05/17
	IDN 3 Behavioral Health Conference		91d	06/01/17	10/05/17
	October 2017		91d	06/01/17	10/05/17
	IDN Career Fair		44d	08/01/17	09/29/17
	September 2017		44d	08/01/17	09/29/17
	Addressing the Opioid Crisis		1197d	06/01/16	12/31/20
	Review of existing data on regional trends		936d	06/01/16	01/01/20
	Needs Assessment conducted		305d	09/01/16	11/01/17
	Project strategies identified		206d	09/01/16	06/15/17
	Project partners identified		206d	09/01/16	06/15/17
	Strategies implemented		806d	11/30/17	12/31/20
	Governance		124d	07/10/17	12/28/17
	Inaugural Governance Committee		124d	07/10/17	12/28/17
	Executive Governance Committee		111d	07/17/17	12/18/17
	Bi-Monthly Meetings		111d	07/17/17	12/18/17

Project Plan Implementation (PPI)

Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
DONE	Governance Committee Meeting	- Michele Craig provided members with a progress update on projects A1, A2 and B1 - Lisa Madden shared the most updated draft of the A1 Budget, which allows for [redacted] a [redacted] positive potential variance -The administrative lead team will send information to be reviewed in advance of next meeting to make informed recommendations on final budgets	1d	07/17/17	07/17/17
DONE	Governance Committee Meeting	-Michele Craig shared a high level summary to include the total budget available, total budget requested, and funds remaining for each project -Vote to approve B1 Project Plan: All members were in favor -Vote to approve Projects A1, A2, C1, D3 and E4: All members were in favor	1d	07/27/17	07/27/17
DONE	Governance Committee Meeting	- Updates: SAR Submitted 07/31/17 Reminder about BH Conference Subcontracting clarification from Kate - Members agreed that the Committee only needs to meet monthly, instead of biweekly. This new meeting schedule will be used in the future.	1d	08/21/17	08/21/17
DONE	Governance Committee Meeting	- Michele Craig Shared the IDN 3 Website -Updates 09/26 Career Fair update from Scott Write Back Update from Lisa Madden -Compliance Update Compliance Presentation, 2018 work plan review and paperwork requirement for IDN partners -HIT Update Vendors Selected	1d	10/02/17	10/02/17

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
DONE	Governance Committee Meeting	-Members reviewed a high level DSRIP overview to refocus efforts on the Implementation Plans, IDN Reporting Requirements, approved budgets, subcontracting, Target Evaluation Goals and Performance Metrics/Outcomes. -Clarification was provided around the difference between the Performance Evaluation Targets and the Performance Metrics -Members reviewed upcoming IDN meetings	1d	10/16/17	10/16/17
	Governance Committee Meeting		1d	11/20/17	11/20/17
	Governance Committee Meeting		1d	12/04/17	12/04/17
	Governance Committee Meeting		1d	12/18/17	12/18/17
	Finance Governance Committee		104d	07/12/17	12/04/17
	Minimum of Monthly Meetings		104d	07/12/17	12/04/17
DONE	Governance Committee Meeting	- In response to a request from the Clinical Committee, members came to consensus on the following “caps” for standard budget line items: indirect costs/administrative overhead [redacted] cap for a computer and all required equipment. [redacted] cap on cell phone and associated costs. -Members reviewed the A1 budget and agreed on “caps” within the A1 Budget related to: Sign on bonuses Retention bonuses Staff referral Relocation Expenses Hiring/Recruiting CMEs/Professional Development Supervision Stipends	1d	07/12/17	07/12/17

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
DONE	Governance Committee Meeting	- Members considered the suggestion from the Clinical Committee to reduce the cap for indirect costs/administrative overhead to . Members agreed that it would put undue strain on organizations and agreed to recommend keeping the indirect costs/administrative overhead cap [redacted] - A1 and A2 budgets were approved by consensus - Members agreed that the B1 budget did not have a comfortable “cushion” and that there was a need to reduce the scope of the largest projects. Therefore, members agreed that the B1 budget was not ready to be approved at this time. -The E4 funding allocation had been approved by the Financial Governance at a previous meeting; members agreed by consensus that the circumstances did not necessitate a vote. - Members discussed the need to hold another vote to approve the A1 budget, the approval of A1 was withdrawn by consensus	1d	07/20/17	07/20/17
	Governance Committee Meeting		1d	11/13/17	11/13/17
	Governance Committee Meeting		1d	12/04/17	12/04/17
	Clinical Governance Committee		111d	07/10/17	12/11/17
	Bi-Monthly Meetings		111d	07/10/17	12/11/17
DONE	Governance Committee Meeting		1d	07/10/17	07/10/17
DONE	Governance Committee Meeting	-Members reviewed the results of the baseline SSA and were introduced to the "waves" concept. -Members reviewed the B1 budgetary asks and made the following recommendations: Cap overhead funding [redacted] DH should reconsider the need for positions to be RN level providers HH will submit updated proposal with [redacted] overhead PSL will absorb MRMS FTE SJH and GNMHC will decrease adult psychiatrist	1d	07/18/17	07/18/17

Project Plan Implementation (PPI)

Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
DONE	Governance Committee Meeting	-Members reviewed a high level DSRIP overview to refocus efforts on the Implementation Plans, IDN Reporting Requirements, approved budgets, subcontracting, Target Evaluation Goals and Performance Metrics/Outcomes. -The main focus of this committee going forward will be to define techniques to operationalize the IDN projects and to establish core teams.	1d	10/16/17	10/16/17
	Governance Committee Meeting		1d	10/23/17	10/23/17
	Governance Committee Meeting		1d	11/13/17	11/13/17
	Governance Committee Meeting		1d	11/27/17	11/27/17
	Governance Committee Meeting		1d	12/11/17	12/11/17
	IT/Data Governance Committee		121d	07/13/17	12/28/17
	Bi-Monthly Meetings		121d	07/13/17	12/28/17
DONE	Governance Committee Meeting	- Members received a demo from a secure messaging vendor - Members reviewed the draft A2 Budget and made several recommendations, including: [redacted] stipend to supplement cost of internet connectivity -Next Steps: a small work group will be formed to discuss the Service Agreement with	1d	07/13/17	07/13/17
DONE	Governance Committee Meeting	Check in with members with assigned apps: -Patrick Ulmen provided a update -Jebb Curelop provided a update -Jayne Emeneau was assigned as the point person for -Ellen Sorensen and Rebecca Williams were assigned as the points of contact for Shared Care Planning Vendors -Dr. Watt will look further into	1d	08/31/17	08/31/17

Project Plan Implementation (PPI)

Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
DONE	Governance Committee Meeting	-The points of Contact for the Shared Care Plan vendor shared their comparison of vs. - Members reviewed goals of upcoming Clinical/IT work session - Members reviewed the draft Attestation Form, to be used by agencies applying for HIT reimbursement stipends. Members are asked to provide feedback by 09/25/17	1d	09/07/17	09/07/17
DONE	Governance Committee Meeting	Members were updated on vendors: - Contracting progress - contracting progress -NIST vendor communications -Members were reminded that we still need a vendor for e-consent and e-referrals Members discussed the Attestation Form and agreed that vendor specific versions are needed	1d	09/28/17	09/28/17
	Governance Committee Meeting		1d	10/26/17	10/26/17
	Governance Committee Meeting		1d	11/09/17	11/09/17
	Governance Committee Meeting		1d	11/30/17	11/30/17
	Governance Committee Meeting		1d	12/14/17	12/14/17
	Governance Committee Meeting		1d	12/28/17	12/28/17
	Community Engagement Governance		66d	09/19/17	12/19/17
	Minimum of Monthly Meetings		66d	09/19/17	12/19/17
DONE	Governance Committee Meeting	- Members reviewed the agenda planned breakout sessions for the upcoming Behavioral Health Conference - Members reviewed the Statewide Learning Collaborative Website and were reminded how to log in - The IDN 3 regional website was also reviewed. Members were asked to think about how to make this website more accessible to a broad audience. this will be a focus of the next meeting	1d	09/19/17	09/19/17

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
DONE	Governance Committee Meeting	-Members debriefed from the BH conference on 10/05/17 and offered suggestions to consider for the next conference -Members reviewed the key points from the Public Health Community Health Needs Assessment and discussed the upcoming IDN Community Needs Assessment Surveys -Members reviewed the CEC work plan and made edits and additions. The administrative lead team will incorporate the edits and send out an updated working draft of the work plan	1d	10/17/17	10/17/17
	Governance Committee Meeting		1d	11/21/17	11/21/17
	Governance Committee Meeting		1d	12/19/17	12/19/17
	Governance Committee Meetings to Achieve Responsibilities		1d	10/02/17	10/02/17
	Executive Committee		1d	10/02/17	10/02/17
	Semi-Annual Compliance Report and Update on Work Plan		1d	10/02/17	10/02/17
	Attend all scheduled meetings either in person or by other means (as defined by the Nashua IDN's governance policies).				
	Proactively review policies and conduct decision making based on policies; policies are intended to establish the general and overall rules within which day-to-day community project operations of				
	Provide direction and oversight to the IDN as it relates to all governance matters.				
	Fulfill any specific requirements that are required by CMS or promised by the NH Department of Health and Human Services in the Waiver document				
	Projects that will be implemented by the IDN based on an analysis of data				
	Level and distribution of funding to be dispersed to various entities in order to meet the project goals and expectations				
	Metrics that will be required to demonstrate success in meeting goals				

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Final review of all budgets for program				
	Finance Committee				
	Attend all scheduled meetings either in person or by other means (as defined by the Nashua IDN's governance policies).				
	Proactively review policies and conduct decision-making based on polices; policies are intended to establish the general and overall rules within which day-to-day financial operations of the Nashua				
	Provide direction and oversight to the IDN as it relates to financial matters.				
	Provide oversight of performance of subcontractors.				
	Fulfill any specific requirements that are required by CMS or promised by the NH Department of Health and Human Services in the Waiver document.				
	Becoming familiar with the state payment process and ensure that programs are designed in a way that will meet all regulatory (state and federal)				
	Establishing rules for making financial				
	Defining roles and responsibilities of partnering organizations as it relates to				
	Making decisions on the distribution of				
	Establishing the budget for the IDN and IDN projects.				
	Monitor budgets and make necessary budget allocation adjustments as the				
	Developing and approving financial reporting for the IDN.				
	Exploring, understanding and developing alternative payment models.				
	Bringing all decisions to the Executive Steering Committee for ratification.				
	Clinical Committee				

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Attend all scheduled meetings either in person or by other means (as defined by the Nashua IDN's governance policies).				
	Proactively review policies and decision making based on policies; policies are intended to establish the general and overall rules within which day-to-day community project operations of the				
	Provide direction and oversight to the IDN as it relates to clinical matters.				
	Fulfill any specific requirements that are required by CMS or promised by the NH Department of Health and Human Services in the Waiver document.				
	Playing an integral role in project plan selection and development of clinical				
	Identifying and framing projects intended to address a variety of community needs.				
	Developing standard clinical pathways and strategies for monitoring and managing patient outcomes.				
	Developing guidance on implementing clinical improvements, including recommendations for relevant education for clinicians in participating agencies on the evidence-based practices or protocols				
	Developing and approving clinical reporting for the IDN.				
	Developing the strategies for monitoring the implementation Researching, developing and implementing outcome tools that will support the measurement				
	Monitoring IDN program performance and determine ways to support IDNs for enhancing outcomes.				
	Bringing recommendations for projects and measurements to the Executive Steering Committee for approval.				
	Data/IT				

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Attend at all scheduled meetings either in person or by other means (as defined by the Nashua IDN's governance policies).				
	Proactively review policies and conduct decision-making based on policy; policies are intended to establish the general and overall rules within which day-to-day data/IT operations of the Nashua Region				
	Provide direction and oversight to the IDN as it relates to data/IT matters.				
	Operate with a high degree of integrity and discretion; members will possibly be expected to review data of a sensitive nature for other member agencies.				
	Strictly adhere to industry standards of security and to handle data with the utmost of confidentiality using secure procedures as members may be asked to view data that contains personal or				
	Fulfill any specific requirements that are required by CMS or promised by the NH Department of Health and Human Services in the waiver document.				
	Determining the processes and standards for data sharing among the partners in the IDN, including the assessment and planning for				
	Providing guidance on the approach to drafting and executing data sharing agreements, including, the issue, review, and evaluation of RFI/RFP with technology providers, meeting with vendors of technology, and coordinating data requests and				
	Developing reporting and reporting processes for the IDN, including analyzing information from all members of the IDN and determining the types and frequency				

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Developing monitoring policies and procedures, including for assessing the status of compliance with the metrics and identifying areas of needed improvement and/or opportunity relative				
	Determining the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall				
	Community Engagement				
	Attend all scheduled meetings, either in person or by other means (as defined by the Nashua IDN's governance policies).				
	Proactively review policies and conduct decision-making based on polices; policies are intended to establish the general and overall rules within which operations of the Nashua Region 3 IDN				
	Provide direction and oversight to the IDN as it relates to community engagement				
	Fulfill any specific requirements that are required by CMS or promised by the NH Department of Health and Human Services in the Waiver document.				
	Determining how community input will be received and included in the strategic				
	Embracing the importance of keeping the entire community engaged, including those who did not meet the full				
	Connecting the community to the transformation process through multiple modalities and determining the channels and venues through which input is				
	Planning and implementing ongoing community forums to seek feedback from community leaders and from within the target population on the progress of the Transformation Waiver implementation, on areas of strength, and on areas that				

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Exchanging knowledge gained with the other governance committees to inform them of the perceptions, interests, and perceived needs of the community at				
	Determining how the communications strategies will continue throughout the duration of the demonstration project.				
	Governance Committee Work Teams		119d	05/15/17	10/26/17
	Clinical Committee		112d	05/15/17	10/17/17
	Privacy Work Team		1d	10/17/17	10/17/17
	Follow-up call for Boot		1d	10/17/17	10/17/17
	Provider Practice Integration Work Team		25d	05/15/17	06/16/17
	Baseline Integrated Practice Site Self-Assessment (SSA)		25d	05/15/17	06/16/17
	Meet with to plan who should be engaged in completing SSAs and				
	Send out email to practice managers to complete SSA		1d	05/15/17	05/15/17
	Reminder email to practice managers to complete SSA				
	Follow-up calls to practice managers to complete SSA				
	Baseline SSA completion deadline		1d	06/16/17	06/16/17
	Clinical/HIT Combo		34d	09/11/17	10/26/17
	work session to level set data aggregation and overlap with clinical		1d	09/11/17	09/11/17
	work session to identify elements of ENS and SCP	Two sessions: Oct 23 and 26	4d	10/23/17	10/26/17
	Budget		77d	07/12/16	10/26/16
	IDN 3 Capacity Building Budget Approval		2d	10/25/16	10/26/16
	Approved by Finance Committee		1d	10/25/16	10/25/16
	Approved by Executive Committee		1d	10/26/16	10/26/16
	IDN 3 2017 - 2020 Implementation Plan Preliminary Draft Budget Approval		12d	07/12/16	07/27/16
	A1: Behavioral Health Workforce Capacity Development	$3,365,889.57	12d	07/12/16	07/27/16

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Recruitment and Hiring	[redacted]	1d	07/12/16	07/12/16
	Retention	[redacted]	1d	07/12/16	07/12/16
	Preceptor/Licensing Supervision	[redacted]	1d	07/12/16	07/12/16
	Workforce Development and Training	[redacted]	1d	07/12/16	07/12/16
	Other Integrated Health Team Support	[redacted]	12d	07/12/16	07/27/16
DONE	Approved by Finance Committee		9d	07/12/16	07/22/16
DONE	Approved by Executive Committee		3d	07/25/16	07/27/16
	A2: Health Information Technology	$2,320,470.21	12d	07/12/16	07/27/16
	Data Extraction/Validation	[redacted]	1d	07/12/16	07/12/16
	Internet Connectivity	[redacted]	1d	07/12/16	07/12/16
	Secure Data Storage	[redacted]	1d	07/12/16	07/12/16
	Shared Care Plan and Event Notification	[redacted]	1d	07/12/16	07/12/16
	Transmit Event Notification	[redacted]	1d	07/12/16	07/12/16
	Direct Secure Messaging	[redacted]	1d	07/12/16	07/12/16
	Data Aggregation	[redacted]	1d	07/12/16	07/12/16
	Query Response/CCDA Exchange	[redacted]	1d	07/12/16	07/12/16
	Integrated Direct Secure Messaging	[redacted]	1d	07/12/16	07/12/16
	Closed Loop Referrals/Discrete Data	[redacted]	1d	07/12/16	07/12/16
	Secure Texting	[redacted]	1d	07/12/16	07/12/16
	E-Consents	[redacted]	1d	07/12/16	07/12/16
	Population Health Tools	[redacted]	1d	07/12/16	07/12/16
	Capacity Management Tools	[redacted]	1d	07/12/16	07/12/16
	Patient Engagement Tools	[redacted]	12d	07/12/16	07/27/16
DONE	Approved by Finance Committee		9d	07/12/16	07/22/16
DONE	Approved by Executive Committee		3d	07/25/16	07/27/16
	B1: Integrated Health	$5,519,483.00	12d	07/12/16	07/27/16
	Practice Integration Site Self-	[redacted]	1d	07/12/16	07/12/16
	Integrated Care Designation Practice	[redacted]	1d	07/12/16	07/12/16
	Coordinated Care Practice Teams	[redacted]	12d	07/12/16	07/27/16
	Approved by Finance Committee		9d	07/12/16	07/22/16
	Approved by Executive Committee		3d	07/25/16	07/27/16
	C1: Critical Time Intervention	$768,029.00	12d	07/12/16	07/27/16
	CTI Team Staffing	[redacted]	1d	07/12/16	07/12/16

Project Plan Implementation (PPI)
Implementation Plan

Status	Task Name	Details	Duration	Start Date	End Date
	Sub-contracts	[redacted]	1d	07/12/16	07/12/16
	Supplies	[redacted]	1d	07/12/16	07/12/16
	Mileage Reimbursement	[redacted]	1d	07/12/16	07/12/16
	Overhead	[redacted]	12d	07/12/16	07/27/16
DONE	Approved by Finance Committee		9d	07/12/16	07/22/16
DONE	Approved by Executive Committee		3d	07/25/16	07/27/16
	D3: Expansion in SUD Treatment	$794,026.37	12d	07/12/16	07/27/16
	Student Assistance Program in Nashua Middle Schools	[redacted]	1d	07/12/16	07/12/16
	Detox and Non-Detox Nurses for Inpatient Treatment	[redacted]	1d	07/12/16	07/12/16
	Spirituality Non-Treatment Community	[redacted]	1d	07/12/16	07/12/16
	Community-Based Pre-Treatment	[redacted]	1d	07/12/16	07/12/16
	Recovery Care/Transitional Care Case Manager in Hospital Emergency	[redacted]	12d	07/12/16	07/27/16
DONE	Approved by Finance Committee		9d	07/12/16	07/22/16
DONE	Approved by Executive Committee		3d	07/25/16	07/27/16
	E4: Integrated Dual Diagnosis Treatment	$735,839.00	12d	07/12/16	07/27/16
	IDDT Staffing	[redacted]	1d	07/12/16	07/12/16
	Sub-contracts	[redacted]	1d	07/12/16	07/12/16
	Travel	[redacted]	1d	07/12/16	07/12/16
	Supplies	[redacted]	1d	07/12/16	07/12/16
	Overhead	[redacted]	12d	07/12/16	07/27/16
DONE	Approved by Finance Committee		9d	07/12/16	07/22/16
DONE	Approved by Executive Committee		3d	07/25/16	07/27/16

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	Yes
Participation in taskforce meetings - 1 SUD representative	Yes
Participation in assessment of current workforce gaps across the state	Yes
Participation in the creation of the statewide gap analysis	Yes
Participation in the creation of the Statewide Workforce Capacity Strategic Plan	Yes
Completion of the Statewide Workforce Strategic Plan	Yes

A1-2a. IDN-level Workforce: Gap Analysis

The IDN conducted a gap analysis in February 2017 with its Member Entities through focus groups, interviews and email. We got responses from a majority of our members, allowing us to compile a spreadsheet that included:

- the types of positions by role and title
- licenses/certification and degree
- pay scale range

We were also able to ascertain from that list of roles and titles:

- how many positions they currently had filled
- how many were open and
- how many they would like to have filled, including what would help them achieve the goals of the IDN.

The participants in the focus groups and interviews provided feedback related to the lack of preceptors for LADCs and APRNs, as well as the lack of engagement of our region's providers with the educational institutions where we could be building the pipeline at the middle and high school level as well as at the undergraduate level for integrated health workforce. We determined that this would be a priority in our implementation plan, which included:

- The Youth Council and Greater Nashua Mental Health Center (GNMHC) partnering to build a Master's level intern cohort to work for 8 months between the two agencies to build a pipeline of clinicians who could address adolescent/youth mental health and substance use disorders (8 Master's Level clinicians over the demonstration period, with the potential for second 8-month cohort).
    - Stipends will be provided to the interns and a supervision stipend will be provided to clinicians at both The Youth Council as well as GNMHC.
    - Stipends will also be provided to offset staff time for both organizations to support outreach and relationship building with local educational institutions to build this intern program as well as future ones.
- Harbor Homes and Keystone Hall are being provided supervision stipends to support supervising LADC clinicians as they move to MLADCs (8 LADCs over the demonstration period).
- Greater Nashua Mental Health Center is being provided supervision stipends to support supervising Master's Level (non-LADC) clinicians (3 LMHC total) as well as LADC clinicians moving to MLADC (4 LADCs).

These programs, if successful, will net the IDN an additional 12 MLADCs over the demonstration period and 11 LMHC.

The IDN also determined in its budget development for the A1 project that it would be prudent to set aside funding to support recruitment and hiring, training and retention for the workforce in order to attract positions such as psychiatrists and psychiatric APRNs, nurses, therapists and substance use

treatment providers, as well as behavioral health counselors and specialists. More information is outlined in Table A1-4, as well as in section A1-3.

Finally, there was great concern about the lack of available workforce in the region in general. The IDN is having conversations with to complete development of its website in preparation for their support in implementing a concerted recruitment and marketing effort for IDN-funded positions. We plan to hold an IDN job fair, house a job board on our region's website and utilize provider networks as an opportunity to have IDN Member Entity providers write blogs and share position information widely with their networks.

attachment_A1.2b

IDN Level Workforce Gap Analysis Table

Role	Title	License and/or Certification	Degree	Pay Scale Range	Current Staffing Level	Current # of Open Positions	Needed to Hire to Support IDN Strategies	X Waiver Eligible	Billable Services	Unbillable Services	Notes
BH (MH and SUD) Clinician	Social Worker	LICSW	Master's	[redacted]	[redacted]	[redacted]			outpatient program--individual and group counseling	intake services; administrative paperwork; administrator	
	Counselor	LMHC		[redacted]	[redacted]		10		outpatient program--individual and group counseling	in residential program, all of the services are all-	
	Counselor Under Supervision		Master's			[redacted]	11				
	Divinity Counselor Under Supervision		Master's in Divinity	[redacted]	[redacted]						
	LADC working toward MLADC (under supervision)	LADC			[redacted]		12				
	Substance Use Disorder (SUD) Counselor	LADC	Bachelor's		[redacted]				outpatient program--individual and group counseling	in residential program, all of the services are all-	
	Substance Use Disorder (SUD) Counselor	MLADC	Master's	[redacted]	[redacted]	[redacted]	10				
	Clinical Psychologist		MA, PsyD, PhD		[redacted]						
	Pastoral Psychotherapist		Doctorate in Ministry	[redacted]	[redacted]						
	Pastoral Psychotherapist	LPP	Doctorate in Ministry	[redacted]	[redacted]						
Psychiatric Clinician	Psychiatrist	MD		[redacted]	[redacted]		2				*higher end of range if prescribing suboxone
	Psychiatric Advanced Practice Nurse	APRN		[redacted]	[redacted]	[redacted]	0.8				
	Psychiatrist/Psychiatric APRN	MD/APRN					3				
	Advanced Registered Nurse Practitioner	ARNP					0.5				
	Psychiatric Certified Nurse	RN		[redacted]	[redacted]		1				
	Psychiatric Physician Assistant	PA			[redacted]		1				
Care Coordinator	Social Worker		BSW	[redacted]		[redacted]			outpatient program--individual and group counseling		
	Social Worker	LICSW	MSW		[redacted]						
	Clinical Care Coordinator		Master's		[redacted]		1				
	Behavioral Health Specialist/Embedded Consultant/Case Manager	LICSW	Master's		[redacted]		5				
	Behavioral Health Case Manager		Bachelor's				8				
	Behavioral Health Coordinator		Bachelor's		[redacted]	[redacted]	5				
	Family Specialist		Bachelor's				0.1				
	Housing Specialist		Bachelor's				0.1				
	Supportive Employment Specialist		Bachelor's		[redacted]		0.5				
	Recovery Care Case Manager/Acute Care Case	LADC (preferred)	Bachelor's		[redacted]		1				

attachment_A1.2b

Role	Title	License and/or Certification	Degree	Pay Scale Range	Current Staffing Level	Current # of Open Positions	Needed to Hire to Support IDN Strategies	X Waiver Eligible	Billable Services	Unbillable Services	Notes
	Nurse	RN	Bachelor's				1.2				
	Nurse	RN	Associates				1.5			part of day rate in residential services; sometimes this staff	
	Nurse	LPN									
	Nurse	LNA									
	Care / Case Manager		Bachelor's				5.5				Some case managers work across sites in different locations
	Case Manager		MSW								
	Nurse Case Manager		Associates				1				
	Medical Assistant										
	Spiritual Care Education		MA Teaching								
	Staff Development Coordinator/Trainer						0.5				
	Maternal Child Health										
Care Enhancer	Community Health Worker						8				
	Patient Educator										nutritionist
	Health (or other) Navigator	Certified	Bachelor's								
	Certified Application Counselor	Federal Certification									
	Peer Recovery Coaches (MH/SUD)	CRSW							For some, BDAS pays for enhanced services		
	Peer Specialists	Pending State Certification									
	Peer Specialist/Case Manager		Bachelor's				1				Family Education and Peer Support Specialist for NAMI
	Peer Support/Crisis Respite Staff						0.5				
Primary Care Clinician	Physician	MD, OD									
	Advance Practice Nurse	APRN									
	Physician's Assistant	PA									
	TeleNurse	RN									
	Geriatrician						1				
	Medical Assistant	MA/LNA									

attachment_A1.2b

Role	Title	License and/or Certification	Degree	Pay Scale Range	Current Staffing Level	Current # of Open Positions	Needed to Hire to Support IDN Strategies	X Waiver Eligible	Billable Services	Unbillable Services	Notes
	Functional Support Worker		Bachelor's	[redacted]	[redacted]						
	Nurse	LNA			[redacted]						
	Intake Staff	RN		[redacted]	[redacted]						
	Intake Staff	LPN		[redacted]	[redacted]						
	Support Staff				[redacted]	[redacted]	2			in residential program, all of the services are all-inclusive	
	Total				[redacted]	[redacted]	94				

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

While the IDN is awaiting approval from DHHS of the IDN's implementation plans and distribution of funds, we will be drafting the sub-contracts with each of the IDN Member Entities, as well as garnering approval from DHHS for subcontractors outside of the state of NH. We expect that this process will take some time and negotiation as we work through invoicing structure, reporting requirements and time frames for deliverables. However, by doing this work while we are waiting for DHHS approval of the plans, we will be ready to implement the project strategies right away.

Goals for Recruiting, Hiring, Training and Retaining the Workforce

As noted in section A1-3, there was substantial concern about recruiting and sustaining the workforce needed to accomplish the goals of the IDN. As noted in Table A1-4, the following funding amounts were provided to support these categories of workforce support to enable the IDN to fund efforts to address these concerns:

Recruitment/Hiring: $242,500

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Retention: $189,400

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Preceptor/Licensing Supervision: $262,000

- [redacted]
- [redacted]

Workforce Development and Training: $452,231.72

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Behavioral Health Workforce Training

The IDN determined that it would set aside funding [redacted] over the course of the demonstration to support training for physicians, behavioral health providers, and non-direct care staff. The *Behavioral Health Workforce Capacity Development Work Team* will work in conjunction with the IDN Administrative Lead team and other IDNs around the state to identify vendors with expertise in required training for the core multi-disciplinary team and non-direct care staff, using its due diligence to share training opportunities where possible.

Training will "required" training for Multi-disciplinary Core Team members for practices as well as training for specific roles. The areas of training by role include:

Physicians:

- Universal Screening
    - SBIRT
    - PHQ 2 & 9
    - MAT
    - Social Determinants of Health
- Core Team Training
    - Working in care teams
    - Co-occurring disorders, including diabetes hyperglycemia, dyslipidemia, hypertension and the nature of mental health disorders and substance use disorders
    - Cultural competency
    - Spirituality in patient care
    - Other topics, as determined by the IDN Clinical Committee, DHHS and Myers and Stauffer

Behavioral health providers:

- Core Team Training
    - Co-occurring disorders, including diabetes hyperglycemia, dyslipidemia, hypertension and the nature of mental health disorders and substance use disorders
    - Cultural competency
    - Other topics, as determined by the IDN Clinical Committee, DHHS and Myers and Stauffer
- Integrated Care Core Competencies
    - Interpersonal communication
    - Collaboration and teamwork
    - Screening and assessment
    - Care planning and care coordination
    - Intervention
    - Cultural competence and adaptation
    - Systems-oriented practice
    - Practice-based learning and quality improvement
    - Informatics

Non-Direct Care Staff:

- Mental Health First Aid
- Addressing challenges with coding
- Cultural competency

General IDN training:

- Integrated Health 101
- Mental Health First Aid
- Change Management
- LEAN
- Patient Privacy, Confidentiality and IDN Compliance
- Other topics, as determined by Myers and Stauffer, the IDN Administrative Lead and IDN members

A1: Behavioral Health Workforce Capacity Implementation Plan

July 2017

Status	Task Name	Notes	Duration	Start Date	End Date
DONE	Participation in Formation and Kick-off of Statewide Behavioral Health Workforce Capacity Taskforce		1066d	12/01/16	12/31/20
DONE	Participation in monthly statewide All-IDN member meetings		1066d	12/01/16	12/31/20
DONE	IDN Workforce Gap Analysis Conducted		6d	03/03/17	03/10/17
DONE	Conduct focus groups and interviews with IDN Member Entities to identify filled, open and expected new positions that support the IDN's goals		6d	03/03/17	03/10/17
DONE	Finalize IDN Workforce Gap Analysis		5d	03/03/17	03/09/17
DONE	Submit to DHHS		1d	03/10/17	03/10/17
	Participation in development of Statewide Workforce Capacity Strategy Plan		1065d	12/01/16	12/30/20
DONE	Consensus Meetings Held		125d	12/01/16	05/24/17
DONE	Strategic Plan completed and submitted to DHHS		1d	06/30/17	06/30/17
	Work Committees created to begin work on identified goals		892d	08/01/17	12/30/20
	Statewide Meetings (Quarterly)		892d	08/01/17	12/30/20
	Recruitment Hiring	IDN 3 is Chair of this committee	859d	09/15/17	12/30/20
	Recruit members and hold monthly meetings to work toward achieving goals		859d	09/15/17	12/30/20
	Education/Training	IDN 3 will have reps on this committee	853d	09/25/17	12/30/20
	Attend monthly meetings to work toward achieving goals		853d	09/25/17	12/30/20
	Retention/Sustainability	IDN 3 will work to have reps on this committee	853d	09/25/17	12/30/20
	Attend monthly meetings to work toward achieving goals		853d	09/25/17	12/30/20
	Policy	IDN 3 will have reps on this committee	892d	08/01/17	12/30/20
	Attend monthly meetings to work toward achieving goals		892d	08/01/17	12/30/20
	Development, Submission, and Approval of IDN Workforce Capacity Development Implementation Plan		71d	04/24/17	07/31/17

A1: Behavioral Health Workforce Capacity Implementation Plan
July 2017

DONE	Convene IDN Behavioral Health Workforce Capacity Development and Retention Work Team		50d	04/24/17	06/30/17
DONE	Develop RFP for IDN Member Entity Submissions		13d	04/24/17	05/10/17
DONE	Release RFP to IDN Members		1d	05/19/17	05/19/17
DONE	Collect IDN Member proposals		17d	05/19/17	06/12/17
	A1 Budget Development		31d	06/19/17	07/31/17
DONE	Compile A1 IDN submissions		3d	06/19/17	06/21/17
DONE	Send requests for revisions and additional information		3d	06/21/17	06/23/17
DONE	Submit budget for review and recommendations by Clinical Committee		1d	07/10/17	07/10/17
DONE	Submit budget for review and approval by Finance Committee		9d	07/12/17	07/24/17
DONE	Set IDN budget caps for specific funding requests	Submit budget for review and approval by Finance Committee	9d	07/12/17	07/24/17
DONE	Submit budget for review and approval by Executive Committee		1d	07/27/17	07/27/17
	Submission to and Approval of Plan to DHHS		1d	07/31/17	07/31/17
DONE	Submission of plan and budget		1d	07/31/17	07/31/17
	Approval of budget and plan to DHHS				
	Implementation of IDN Workforce Capacity Development Plan; Ongoing Semi-Annual Reporting Against Targets Identified in Plan		1023d	01/31/17	12/31/20
	Recruitment and Hiring of Workforce		356d	08/21/17	12/31/18
	Increased knowledge through broadening the geographic area of reach for potential workforce to support the work of the IDN.	With sub-goal of filling existing open positions with IDN Member Entities that support the goals of the IDN strategies	356d	08/21/17	12/31/18

	Up to 100 individuals will participate in the efforts related to the IDN's Career Fair, including attending the event(s), inquiring about posted jobs, and engaging with IDN Member Entities regarding IDN-funded positions by December 31st 2018.	Mass media marketing tools will be utilized, including sponsored ads on Facebook, LinkedIn, Indeed and other social media sites; radio ads on local stations; career postings provided on professional organizations who reach audiences with workforce interested in positions.	30d	08/21/17	09/29/17
	Up to 30 potential qualified applicants will provide their resumes, indicating interest in the available IDN-funded positions by December 31, 2018.	A Career Board will be created on the IDN 3 website where interested workforce will be driven to view and apply directly for open IDN-funded positions	30d	08/21/17	09/29/17
	Up to 10 IDN-funded positions will be filled through the efforts of the Career Fair(s) and IDN website's Career Board by December 31, 2018.		40d	08/21/17	10/13/17
	Up to 6 IDN Member Entities will utilize IDN funding to support dues or fees for recruitment sites, services and social/print media campaigns, resulting in the hiring of up to 6 positions to support IDN strategies by December 31, 2018.		356d	08/21/17	12/31/18
	Increased incentives for behavioral health workforce to work in NH (from both within and outside of the state).		347d	09/01/17	12/31/18
	Up to 9 IDN Member Entities will utilize IDN funding to provide sign-on bonuses for up to 9 newly hired staff to support IDN strategies by December 31, 2018.		347d	09/01/17	12/31/18
	IDN funding will be utilized to support an IDN Member Entity in their HR staffing capacity to develop job descriptions, and interview/onboard new staff, resulting in the hiring of up to 4 positions to support IDN strategies by December 31, 2018.		347d	09/01/17	12/31/18

	Up to 3 IDN Member Entities will utilize IDN funding to support reimbursement of relocation expenses, resulting in the recruitment and hiring of up to 4 positions to support IDN strategies by December 31, 2018.		347d	09/01/17	12/31/18
	Up to 2 IDN Member Entities will utilize IDN funding for staff referral bonuses to incentivize existing staff to refer potential new workforce members, resulting in the hiring of up to 2 positions to support IDN strategies by December 31, 2018.		347d	09/01/17	12/31/18
	Retention and Sustainability of Workforce		347d	09/01/17	12/31/18
	Increased perception of empowerment and value among existing behavioral health workforce for the work they are doing to support the IDN strategies.		347d	09/01/17	12/31/18
	Up to 15 staff (a combination of new and existing staff) will utilize IDN funding for CMEs/CEUs and/or professional development by December 31, 2018 to enable them to feel valued through the availability of opportunities to broaden their learning and expertise.	Lamprey Health, Southern NH Health, GNMHC, Harbor Homes, Healthy at Home and Keystone Hall will use funds to expand opportunities for staff who will the strategies funded by the IDN in B1, C1, D3 and E4.	347d	09/01/17	12/31/18
	A minimum of 6 staff working with consumers with intellectual/developmental disabilities will engage in clinical training, with a minimum of 3 (non IDN-funded) of those staff to utilize the new skills (where possible) to further the work of the IDN	Gateways 8-day training for Service Coordinators or Direct Service Providers being trained in Clinical Foundations	347d	09/01/17	12/31/18
	Up to 7 staff receiving financial support for association professional dues and/or medical licensure fees will be documented as staying in their positions with IDN Member Entities for a minimum of 24 months.		347d	09/01/17	12/31/18

	2 IDN Member Entities will utilize this financial incentive to retain up to 4 newly hired staff in their positions for a minimum of 24 months		347d	09/01/17	12/31/18
	1 IDN Member Entity will utilize this financial incentive to retain a minimum of 1 staff with a salary adjustment/bonus to retain them for a minimum of 24 months.		347d	09/01/17	12/31/18
	Preceptor/Licensing Supervision		347d	09/01/17	12/31/18
	Increased knowledge among educators and students about the workforce opportunities available in the physical health and behavioral health integrated care field.	Master's Level Child and Adolescent Intern Cohort Pilot	260d	01/02/18	12/31/18
	The Youth Council and Greater Nashua Mental Health Center will identify up to 3 new contacts at higher education institutions by 12/31/18 to reach out and engage them in the internship, preceptor and workforce opportunities in the IDN.	Provide support for a Master's Level Child and Adolescent Intern Cohort of 6 students, supervised by The Youth Council and Greater Nashua Mental Health Center, including supervision funding support, internship stipends, and	260d	01/02/18	12/31/18
	The Youth Council and Greater Nashua Mental Health Center will initiate opportunities to provide 8-month internships to up to 6 Master's Level interns by December 31, 2018 to engage them in the child and adolescent work of The Youth Council and GNMHC related to the IDN's work in the field of integrated behavioral health.	Provide support for The Youth Council and GNMHC to establish and sustain relationships with Rivier College, Antioch New England, UNH, Boston University and SNHU.	175d	05/01/18	12/31/18
	Master's Level Adult Internship Cohort Pilot		347d	09/01/17	12/31/18

	Up to 3 Master's Level interns will participate in an 8-month internship where they will support the adult programs of GNMHC, with up to 2 interns being hired by an organization in the IDN to support the strategies of the region.	Will provide a supervision stipend to support staff time to meet the supervision requirements of this work	347d	09/01/17	12/31/18
	Increase in the number of MLADCs who can provide substance use treatment in the IDN.		347d	09/01/17	12/31/18
	Up to 6 Licensed Alcohol and Drug Counselors (LADCs) will be supervised by IDN Member Entity organizations who will receive stipends from IDN funding to support their supervision requirements.	Supervision stipends provided to GNMHC, Harbor Homes and Keystone Hall	347d	09/01/17	12/31/18
	The Youth Council and Greater Nashua Mental Health Center will initiate opportunities to provide 8-month internships to up to 6 Master's Level interns by December 31, 2018 to engage them in the child and adolescent work of The Youth Council and GNMHC related to the IDN's work in the field of integrated behavioral health.				
	Community-Driven Project Training		413d	06/01/17	12/31/18
	Workforce Development Training for Providers and Non-Clinical Providers	Will be conducted in waves (Wave 1: Fall 2017/Winter 2018; Wave 2: Spring 2017; Wave 3: Summer 2018)	1023d	01/31/17	12/31/20
	Training strategies to build capacity of physical health providers		915d	07/01/17	12/31/20
	Universal Screening		282d	12/01/17	12/31/18
	Social Determinants of Health		282d	12/01/17	12/31/18
	Working in care teams		915d	07/01/17	12/31/20
	Co-occurring disorders, including diabetes hyperglycemia, dyslipidemia, hypertension and the nature of mental health disorders and substance use disorders		915d	07/01/17	12/31/20

	Cultural competency	Provided by Ascentria Care	915d	07/01/17	12/31/20
	Spirituality in patient care	Provided by The Emmaus	915d	07/01/17	12/31/20
	Other topics, as determined by the IDN Clinical Committee, DHHS and Myers and Stauffer		915d	07/01/17	12/31/20
	Training strategies to build capacity of behavioral health providers		392d	07/01/17	12/31/18
	Universal Screening		392d	07/01/17	12/31/18
	Social Determinants of Health		392d	07/01/17	12/31/18
	Working in care teams		392d	07/01/17	12/31/18
	Co-occurring disorders, including diabetes hyperglycemia, dyslipidemia, hypertension and the nature of mental health disorders and substance use disorders		392d	07/01/17	12/31/18
	Cultural competency	Provided by Ascentria Care	392d	07/01/17	12/31/18
	Understanding Addiction		392d	07/01/17	12/31/18
	Other topics, as determined by the IDN Clinical Committee, DHHS and Myers and Stauffer		392d	07/01/17	12/31/18
	Integrated Care Core Competencies		282d	12/01/17	12/31/18
	Interpersonal communication		282d	12/01/17	12/31/18
	Collaboration and teamwork		282d	12/01/17	12/31/18
	Screening and assessment		282d	12/01/17	12/31/18
	Care planning and care coordination		282d	12/01/17	12/31/18
	Intervention		282d	12/01/17	12/31/18
	Cultural competence and adaptation		282d	12/01/17	12/31/18
	Systems-oriented practice		282d	12/01/17	12/31/18
	Practice-based learning and quality improvement		282d	12/01/17	12/31/18
	Informatics		282d	12/01/17	12/31/18
	Training strategies to build capacity of non-direct care providers		805d	12/01/17	12/31/20
	Mental Health First Aid		282d	12/01/17	12/31/18
	Addressing challenges with coding		282d	12/01/17	12/31/18
	Cultural competency	Provided by Ascentria Care	783d	01/02/18	12/31/20
	General IDN/community training		1023d	01/31/17	12/31/20

	Integrated Health 101		1d	08/17/17	08/17/17
	Mental Health First Aid		21d	01/31/17	02/28/17
	Change Management		1d	09/28/17	09/28/17
	LEAN		1d	01/18/18	01/18/18
	Patient Privacy, Confidentiality and IDN Compliance		1d	10/19/17	10/19/17
	Other topics, as determined by Myers and Stauffer, the IDN Administrative Lead and IDN members	Held during our IDN monthly Full IDN webinars, Quarterly MSLC trainings and other opportunities	783d	01/02/18	12/31/20
	Conduct Annual Behavioral Health Conferences, open to the broader community, including professionals and stakeholders		915d	05/01/17	10/30/20
	IDN Monthly Full IDN Trainings		370d	08/01/17	12/31/18
	August 2017	Integrated Health 101	23d	08/01/17	08/31/17
	September 2017	Full IDN in-person meeting	21d	09/01/17	09/29/17
	October 2017	Statewide Projects: Process Metrics	23d	10/01/17	10/31/17
	November 2017	Change Management	22d	11/01/17	11/30/17
	December 2017		21d	12/01/17	12/29/17
	January 2018		22d	01/02/18	01/31/18
	February 2018		20d	02/01/18	02/28/18
	March 2018		22d	03/01/18	03/30/18
	April 2018		22d	04/01/18	04/30/18
	May 2018		23d	05/01/18	05/31/18
	June 2018		21d	06/01/18	06/29/18
	July 2018		23d	07/01/18	07/31/18
	August 2018		23d	08/01/18	08/31/18
	September 2018		21d	09/01/18	09/28/18
	October 2018		23d	10/01/18	10/31/18
	November 2018		22d	11/01/18	11/30/18
	December 2018		22d	12/01/18	12/31/18
	MSLC Quarterly Statewide Trainings		370d	08/01/17	12/31/18
	August 2017	Integrated Health	23d	08/01/17	08/31/17
	November 2017	Alternative Payment Models	22d	11/01/17	11/30/17
	Quarter 1 2018		65d	01/01/18	03/30/18

	Quarter 2 2018		65d	04/02/18	06/29/18
	Quarter 3 2018		65d	07/02/18	09/28/18
	Quarter 4 2018		326d	10/02/17	12/31/18
	Other Integrated Health Team Support Services		870d	09/01/17	12/31/20
	IDN/DSRIP ProjectManager		781d	01/02/18	12/29/20
	IDN Administrative Lead Team	Manages overall goals of B1 project through identification and management of core training, identifying and sharing best practices related to workflows and protocols, and supporting clinical assessments	781d	01/02/18	12/29/20
	IDN Quality Manager		781d	01/02/18	12/29/20
	IDN Administrative Lead Team	Supports the clinical operations of the IDN, including the case managers, care coordinators, behavioral health coordinators/specialists and other integrated health team staffing to identify challenges and work to develop solutions	781d	01/02/18	12/29/20
	Student Assistance Program in Nashua Middle Schools		870d	09/01/17	12/31/20
	Two Master's Level Student Assistance Program (SAP) Counselors will each conduct assessments with up to 50 students per school year		870d	09/01/17	12/31/20
	Counselors will each provide supportive counseling to a minimum of 35 students per year		870d	09/01/17	12/31/20
	Counselors will screen each student for well-child visits and make referrals, as appropriate		870d	09/01/17	12/31/20
	Counselors will each build relationships with up to 5 primary care providers per year to educate about SBIRT		870d	09/01/17	12/31/20

	System of Care wraparound model for home and community settings to provide family education/peer recovery support		781d	12/18/17	12/14/20
	Family/peer support specialist will support a minimum caseload of patients/families of up to 15 at any given time with youth under the age of 26		781d	12/18/17	12/14/20
	Clinical support for case management for patients with intellectual/developmental disabilities		781d	01/02/18	12/29/20
	Clinician will support up to 5 case management sessions per year for cases that involve patients with intellectual/developmental disabilities		781d	01/02/18	12/29/20
	Spirituality therapy and case management support		781d	01/02/18	12/29/20
	Therapist will provide support to up to 5 case management sessions per year for cases that could benefit from spirituality counseling services/resources		781d	01/02/18	12/29/20
	Therapist will receive referrals from IDN partners and from patient self-referrals to provide individual therapy to up to 5 patients per year		781d	01/02/18	12/29/20
	Community Health Worker connecting refugees and immigrants to health services		781d	12/15/17	12/11/20
	Create connections with up to 40 refugees/immigrants per year, with a caseload of no more than 30 consumers per year, connecting them with the healthcare system.		781d	12/15/17	12/11/20
	Community Health Workers through Dartmouth AmeriCorps VISTA grant		260d	01/02/18	12/31/18

	Up to 5 trained AmeriCorps VISTA members will be located in 3-5 IDN Member Entities	Potential sites include Greater Nashua Mental Health Center, Nashua Department of Public Health, Foundation Medical Center Intensive Outpatient/Partial Hospital Program, Harbor Homes, or St.	260d	01/02/18	12/31/18
	Up to 90 attributed patients from the IDN will be served by the AmeriCorps VISTA staff as part of a coordinated care team		260d	01/02/18	12/31/18
	Closed loop screening and referral service		783d	12/15/17	12/15/20
	Up to 50 IDN attributed patients will utilize the services of the closed loop screening and referral service per year, once made available	Granite United Way 2-1-1 screening and referral system	783d	12/15/17	12/15/20

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

Below are targets the IDN intends to achieve for the A1 project intends achieve.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Workforce Recruitment and Hiring: Increased knowledge among educators and students about the workforce opportunities available in the physical health and behavioral health integrated care field.	The Youth Council and Greater Nashua Mental Health Center will identify up to 3 new contacts at higher education institutions by 12/31/18 to reach out and engage them in the internship, preceptor and workforce opportunities in the IDN.			
	The Youth Council and Greater Nashua Mental Health Center will initiate opportunities to provide 8-month internships to up to 6 Master's Level interns by December 31, 2018 to engage them in the child and adolescent work of The Youth Council and GNMHC related to the IDN's work in the field of integrated behavioral health.			
Workforce Recruitment and Hiring: Increased knowledge through broadening the geographic area of reach for potential workforce to support the work of the IDN.	Up to 100 individuals will participate in the efforts related to the IDN's Career Fair, including attending the event(s), inquiring about posted jobs, and engaging with IDN Member Entities regarding IDN- funded positions by December 31, 2018.			
	Up to 30 potential qualified applicants will provide their resumes, indicating interest in the available IDN-funded positions by December 31, 2018.			
	Up to 10 IDN-funded positions will be filled through the efforts of the Career Fair(s) and IDN website's Career Board by December 31, 2018.			
	Up to 6 IDN Member Entities will utilize IDN funding to support dues or fees for recruitment sites, services and social/print media campaigns, resulting in the hiring of up to 6 positions to support IDN strategies by December 31, 2018.			

Workforce Recruitment and Hiring: Increased incentives for behavioral health workforce to work in NH (from both within and outside of the state).	Up to 9 IDN Member Entities will utilize IDN funding to provide sign-on bonuses for up to 9 newly hired staff to support IDN strategies by December 31, 2018.			
	IDN funding will be utilized to support an IDN Member Entity in their HR staffing capacity to develop job descriptions, and interview/onboard new staff, resulting in the hiring of up to 4 positions to support IDN strategies by December 31, 2018.			
	Up to 3 IDN Member Entities will utilize IDN funding to support reimbursement of relocation expenses, resulting in the recruitment and hiring of up to 4 positions to support IDN strategies by December 31, 2018.			
	Up to 2 IDN Member Entities will utilize IDN funding for staff referral bonuses to incentivize existing staff to refer potential new workforce members, resulting in the hiring of up to 2 positions to support IDN strategies by December 31, 2018.			
Workforce Retention and Sustainability: Increase in the number of MLADCs who can provide substance use treatment in the IDN.	Up to 6 Licensed Alcohol and Drug Counselors (LADCs) will be supervised by IDN Member Entity organizations who will receive stipends from IDN funding to support their supervision requirements.			
	Up to 2 of the LADCs receiving supervision through the IDN-funded supervisors will have the opportunity to be hired by IDN Member Entities as newly licensed MLADCs by December 31, 2018.			
Workforce Retention and Sustainability: Increased perception of empowerment and value among existing behavioral health workforce for the work they are doing to support the IDN strategies.	Up to 15 staff (a combination of new and existing staff) will utilize IDN funding for CMEs/CEUs and/or professional development by December 31, 2018to enable them to feel valued through the availability of opportunities to broaden their learning and expertise.			
	Up to 7 staff receiving financial support for association professional dues and/or medical licensure fees will be documented as staying in their positions with IDN Member Entities for a minimum of 24 months.			

Workforce Training and Education: Increased knowledge of providers and other community stakeholders about the potential roles and opportunities to engage in the efforts of the IDN.	Up to 75 providers and community stakeholders will participate in the IDN's annual behavioral health conference, with at least 75% of completed surveys/evaluations reflecting an increase in knowledge about the roles and opportunities to engage in integrated health in the IDN.			
Workforce Training and Education: Increased knowledge about the stigma associated with behavioral health (mental health and substance use disorder) diagnoses.	Up to 30 providers and community stakeholders will be trained through IDN training opportunities, including Mental Health First Aid, by December 31, 2018			
Workforce Training and Education: Increased capacity to deliver evidence-based programs in multiple settings across the IDN to address Serious Mental Illness (SMI) and/or Substance Use Disorders (SUDs)	Up to 8 providers will participate in the Integrated Dual Diagnosis Treatment (IDDT) training provided by over 4 days (Winter 2017 and Spring 2018) to increase their skills for implementing the model's stages of change and treatment for those with co-occurring Serious Mental Illness (SMI) and Substance Use Disorder (SUD).			
	Up to 4 providers will participate in the Critical Time Intervention (CTI) training over 2 days (Fall 2017 and Spring 2018) to increase their skills for implementing the model's 9-month intensive case management strategy.			

A1-5. IDN-level Workforce: Staffing Targets

Below is the targeted number by full-time equivalent (FTE) staff needed to be hired to address the gaps identified in the IDN 3 Workforce Capacity Development Implementation Plan and the number of staff hired and trained by the date indicated. Included in these staff projections and baselines are the workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare and the IDN selected community-driven projects.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Psychiatrist/Psychiatric Advanced Practice Registered Nurse (APRN)	12.5	11			
Psychiatrist for IDDT	.5	3			
Psychiatric Certified Nurse	1	0			
Consulting Psychiatrist	.2	3			
Physician's Assistant (Certified)	.2	6			
Registered Nurse (Associate's Level)	3.5	73			
Consulting Pharmacist	.10	20			
Licensed Pastoral Psychotherapist	.75	2			
Mental Health Counselor (Master's Level LMHC)	10	85			
Counselor Under Supervision (Master's Level)	15	2			
LADC working toward MLADC under supervision (Substance Use Counselor)	12	18			
Behavioral Health Coordinator (Bachelor's)	5	5			
Behavioral Health Case Manager (Bachelor's)	8	12			
Behavioral Health Case Manager (Master's)	5	63			
Case Manager (RN Bachelor's Level)	1.7	90.6			
Clinical Operations	.20	9			
Master's Level Team Leader for IDDT and CTI (LICSW or LMHC)	2	98			
Master's Level Mental Health Therapist	1	85			
Master's Level Substance Use Disorder Therapist	1	16			
Bachelor's Level Case Manager for IDDT and Co-Located Pilot with GNMHC/Lamprey)	3	56			
Clinical Care Coordinator (Master's)	1	6			

Clinical Care Coordinator (RN Associate's)	.5	70.6			
Recovery Care Case Manager/Acute Care	1	.5			
CTI Case Manager/Specialist (Bachelor's)	2.5	56			
Criminal Justice Specialist/Liaison	.1	6			
Supportive Employment Specialist	.5	11			
Housing Specialist	.1	2			
Family Specialist	.1	2			
Community Health Worker	8	40			
Family Education and Peer Specialist	1	14			
Peer Support Specialist	.5	30			
Training Coordinator	.5	7			
DSRIP Practice Integration Project Manager	1	0			
DSRIP Quality Improvement Manager	1	0			
DSRIP Data Manager	1	.15			
Front Office/Billing Support Staff	2	290.5			
Administrative Assistant	.25	27			

attachment_A1.6

A1: Behavioral Health Workforce Capacity
2017 - 2020 Budget

Category and Item	Item Notes	Capacity Building Available	2017 - 2018 Budget Available	2019 - 2020 Budget Available	Sept 2017 - June 2018 (10 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	Total Requested 2017 - 2020	Total Available 2017 - 2020
Totals		**$825,000.00**	**$1,424,883**	**$1,214,694.00**	$1,090,640.43	$1,078,760.73	$761,039.01	$430,650.40	$3,361,090.57	**$3,464,577.00**
Recruitment/Hiring	[redacted]				$201,500.00	$41,000.00	0	0	$242,500.00	
Organizational HR support	[redacted]				$2,800				$2,800	
Dues or Fees for Recruitment Sites	[redacted]				$103,700	$22,500.00			$126,200	
Sign-on Bonus	[redacted]				$54,500	$15,000.00			$69,500	
Relocation Expenses	[redacted]				$37,000				$37,000	
Staff Referral Bonuses	[redacted]				$3,500.00	$3,500.00			$7,000.00	
Retention					$88,200.00	$78,700.00	$25,000.00	$10,000.00	$201,900.00	
CMEs/Professional Development	[redacted]				$25,900	$23,400.00			$49,300	
License Fees/Professional Dues	[redacted]				$5,300	$5,300			$10,600.00	
Stay Incentives/Retention Bonus	[redacted]				$15,000	$15,000.00	$10,000	$10,000.00	$50,000	
Loan Forgiveness	[redacted]				$35,000	$35,000.00	$15,000		$85,000	
Staff Recognition	[redacted]				$7,000				$7,000	
Preceptor/Licensing Supervision					$109,000.00	$153,000.00	$75,000.00	$75,000.00	$412,000.00	
Internship/Preceptor	[redacted]				$49,000.00	$93,000.00	$15,000.00	$15,000.00	$172,000.00	

A1: Behavioral Health Workforce Capacity
2017 - 2020 Budget

Category and Item	Item Notes	Capacity Building Available	2017 - 2018 Budget Available	2019 - 2020 Budget Available	Sept 2017 - June 2018 (10 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	Total Requested 2017 - 2020	Total Available 2017 - 2020
Supervision Stipends/Incentives	[redacted]				$60,000.00	$60,000.00	$60,000.00	$60,000.00	$240,000.00	
Workforce Development and Training					$162,615.95	$176,714.00	$62,384.00	$32,249.27	$433,963.22	
Patient Privacy and Consent IDN 3 Training and Technical Assistance	[redacted]				$5,500.00				$5,500.00	
Critical Time Intervention (CTI) Team Training	[redacted]				$11,027.38	$4,605.00			$15,632.38	
Integrated Dual Diagnosis Treatment (IDDT)	[redacted]				$36,315.00	$9,725.00			$46,040.00	
Spirituality in Patient Care Training for Providers, Faith Community Pastoral Specialist Training, and Mental Health Training for the Faith Community	[redacted]				$59,773.57	$62,384.00	$62,384.00	$32,249.27	$216,790.84	
Integrated Health Training for IDN	[redacted]				$50,000.00	$100,000.00			$150,000.00	
Other Integrated Health Team Support Services					$529,324.48	$629,346.73	$598,655.01	$313,401.13	$2,070,727.35	
[redacted] Staffing to achieve goals of demonstration (2 FTEs)	Quality Manager and Project Manager to support integrated health activities and the overall evaluation and monitoring of the metrics and outcomes associated with all of the DSRIP projects				$177,083.40	$212,500.00	$212,500.00	$106,250.04	$708,333.44	
[redacted] Intellectual Disabilities/Development Disabilities Clinical Support	Clinical consultation with case management/core teams to support links with services, as well as provide education about needs of population with intellectual developmental disabilities				$4,168	$5,000.00	$5,000.00	$2,499.96	$16,667.56	
[redacted] Spiritual Counseling and Consultation through Licensed Pastoral Psychotherapist (LPP) (.5 FTE)	Individual therapy via provider referrals (up to 32 patients/year) and up to 3 hours per week of consultation to care teams for case management (up to 144 hours)				$12,740.00	$15,288.00	$15,288.00	$7,644.00	$50,960.00	

A1: Behavioral Health Workforce Capacity
2017 - 2020 Budget

Category and Item	Item Notes	Capacity Building Available	2017 - 2018 Budget Available	2019 - 2020 Budget Available	Sept 2017 - June 2018 (10 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	Total Requested 2017 - 2020	Total Available 2017 - 2020
[redacted] CHW/Case Manager (1 FTE) and Training Coordinator (.5 FTE)	Create connections between refugees/immigrants and healthcare systems. CHW expected to serve up to 60 patients per year, with a case load of 30 at any time. Target of up to 100 IDN providers, support workers and community groups trained annually.				$108,350.17	$126,018.15	$126,018.15	$63,009.05	$423,395.52	
[redacted] Family Education/Peer Support Specialist (1 FTE)	Individual and group face-to-face work in various settings, including family's home, community sites, provider offices and schools in peer-to-peer wraparound model, with caseload of up to 15. Proposed to be housed at [redacted] upon Board approval.				$66,273.01	$80,081.08	$82,132.36	$43,165.80	$271,652.25	
[redacted] Student Assistance Program (2 FTEs)	Each position will conduct up to 3 assessments per day and work with guidance staff to build a collaborative plan to link the student to appropriate services for their needs with interim services provided to the students until they can connect with recommended services. Counselors will also communicate with primary care and school-based partners and parents.				$111,433.16	$133,716.50	$133,716.50	$66,832.28	$445,698.44	
[redacted] Psychiatric CAQ Certification for LHC primary care Physician Assistant	This psychiatric PA position will ultimately be sustained through billable patient activity, reimbursed by Medicaid and other insurers. Funding is sought for training time, supervision and psychiatric consultation which is not reimbursable.				$14,420.00	$27,600.00			$42,020.00	
[redacted]	Supplies for MSW/LICSW (2 FTEs)				$6,000				$6,000.00	

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

Below are a list of key organizations and providers participating in the IDN to support workforce development. Also included are workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community projects.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Foundation Medical Partners	Primary and Specialty Care Practices	A1, A2, B1, C1, D3, E4
St. Joseph Physician Practices	Primary and Specialty Care Practices	A1, A2, B1, C1, D3, E4
Dartmouth Hitchcock Nashua	Primary and Specialty Care Practices	A1, A2, B1, C1, D3, E4
Harbor Homes	FQHC	A1, A2, B1, C1, D3, E4
Lamprey Health	FQHC	A1, A2, B1, C1, D3, E4
Southern NH Medical Center	Acute Care Hospital	A1, A2, B1, C1, D3, E4
St. Joseph Hospital	Acute Care Hospital	A1, A2, B1, C1, D3, E4
Greater Nashua Mental Health Center	Community Mental Health Center	A1, A2, B1, C1, D3, E4
Ascentria Care Alliance	Home and Community-Based Provider	A1, B1
City of Nashua Division of Public Health	Public Health Organization	A1, B1
Gateways Community Services	Community-based Organization providing social and support services	A1, B1, C1
Merrimack River Medical Services	Substance Use Treatment Provider	A1, A2, B1, C1, D3, E4
Keystone Hall	Substance Use Treatment Provider	A1, A2, B1, C1, D3, E4
Healthy at Home	Home and Community-Based Provider	A1, A2, B1, C1, D3, E4
Hillsborough County Nursing Home	County Nursing Facility	B1
Hillsborough County Corrections Facility	County Corrections Facility	B1
Home Health and Hospice Care	Home and Community-Based Provider	B1
H.E.A.R.T.S. Peer Support Center	Community-based Organization providing social and support services	A1, A2, B1, C1, D3, E4

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Granite State Independent Living	Community-based Organization providing social and support services	B1
American Medical Response (AMR)	Other Organization Type	B1
NAMI NH	Community-based Organization providing social and support services	A1, A2, B1, C1, D3, E4
The Emmaus Institute	Community-based Organization providing social and support services	A1, A2, B1, C1, D3, E4
The Front Door Agency	Community-based Organization providing social and support services	B1
The Youth Council	Substance Use Treatment Provider	A1, A2, B1, C1, D3, E4
YMCA of Greater Nashua	Community-based Organization providing social and support services	B1

A2-1. IDN Participation in Statewide HIT Taskforce

Below is the affirmation of the IDN's participation in the statewide HIT Taskforce and Statewide HIT Plan activities.

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

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

Myers and Stauffer 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 client-focused entities. The results facilitated discussions on defining required, optional, and desired statewide HIT implementation priorities by the HIT Task Force and informed the IDN's HIT Implementation Plan.

The HIT Assessment tool was 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)[i] (and the Substance Abuse and Mental Health Services Administration's (SAMHSA) behavioral and mental health screening tools.[ii]

The 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 EMR systems, client 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.

See attachment_B1.9c for specific references to technologies that will support:

- The reduction of unnecessary use of inpatient and ED services, hospital readmissions and wait times.
- Support care transitions.
- Support Alternative Payment Models (APMs).

Electronic Medical Record (EMRs)

Based on the final version of the HIT Data Supplement for IDN 3, there was a total of twenty-seven (n=27) organizations that completed the assessment. Nine (n=9) organizations attested to having a Certified EMR system and nine (n=9) organizations attested to having a non-certified EMR system. To be noted, nine (n=9) organizations stated that they had no EMR system at all. Organizations with no EMR systems were important to identify as we later determined what further assistance they needed to meet the State's DSRIP objectives and our region's goals.

NHHIO Connectivity

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, nine (n=9) organizations are connected to NHHIO with an additional four (n=4) organizations that are in the process of connecting. Fourteen (n=14) organizations are not connected or are not planning on connecting to NHHIO. While progressing through the demonstration, we will ensure organizations that are not connected to NHHIO adopt a basic sharing protocol, such as Direct Secure Messaging (DSM), which is a minimum HIT standard/capability identified by the Statewide HIT Taskforce.

Since NHHIO will no longer function in the same capacity, the IDN 3 member entities will secure a contract with for direct secure messaging for IDN member entities that have a need for DSM.

Patient Engagement Tools

In the assessment, 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 three (n=3) 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 twenty-two (n=22) organizations that do not provide a patient portal at all and provide limited access to their patient's information. As the demonstration progresses, a goal of the IDN will be to create an infrastructure to allow patients with complex health issues, as well as their caregivers, providers and case managers, shared access to their health information, keeping in mind patient confidentiality while ensuring care coordination.

Patient Consents

Another critical area for care coordination 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, three (n=3) organizations capture patient consent information entirely electronically in an EMR system. Eleven (n=11) 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 Statewide 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. It was determined that 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. As part of that process, the IDN contracted with to participate in technical assistance and education through a series of webinars and in-person boot camp sessions to

better understand the patient flow between providers for the projects being implemented, keeping in mind the updated rules related to Substance Use Disorder (SUD) through 42 CFR Part 2.

The IDN is working with Southern NH Health's Privacy and Compliance Officer as well as with the Compliance Officers of the other IDN providers to develop an IDN 3 patient education and consent/disclosure packet that will include the applicable patient privacy, consent and disclosure forms necessary for the patient to share treatment information with IDN providers. Work on this packet is underway with the IDN Privacy and Consent Work Team, which is expected to be completed no later than October 30 2017, as outlined in the B1 Implementation Plan.

---

[i] https://www.healthit.gov/standards-advisory/2016

[ii] http://www.integration.samhsa.gov/clinical-practice/screening-tools

Overview
The HIT data supplements are to inform IDNs about their members who have or plan to have health information technologies to support their specific project goals and objectives and those members who need to adopt additional technology features and/or functionality.

Sheet Descriptions	
Sheet	**Description**
Participation	Shows what organizations have completed the HIT Assessment based on the previously submitted IDN Project Plan 4A organization list.
Data Capturing & Sharing	Displays all organizations high level current health IT capabilities including EHR adoption, HIE connections, and HIT Adoption Score.
Key Data Elements for Exchange	Provides more granular information on the interoperability capabilities of the organizations such as ePrescribing, care summaries, patient referrals, and patient consents.
Consumer Tools	Focuses on the organizations ability to share health information with their patients.
EHR Software	Lists all the EHR systems that organizations use within the region including a summary of the most common EHR vendors.
Other Software	Lists all other systems that organizations use within the region.
Social Determinants	Provides data on what social determinants each organization currently has the ability to capture or share electronically.
Behavioral Health Assessment	Summarizes the most common behavioral and mental health assessments for each IDN region.
HIT Initiatives	Identifies those projects both near and long-term that organizations are planning to design and implement to support a health IT infrastructure as well what interoperability standards are in use by those organizations.

Definitions		
Notation	**Term**	**Description**
*	HIT Score	Provides an organization with an overall HIT maturity score which includes HIT standards, interoperability capabilities, quality measurement capabilities, and data governance. The scores range between 0 and 5, with a 5 being higher maturity
**	Inter-Vendor Connection	EHR vendor is a participant in Commonwell and/or Carequality, an actual inter-vendor connection has not been verified

Created by: Myers & Stauffer
Date of update: 03/13/2017

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Assessment Participation

Organizations With HIT Assessment Received	Expected	Completion %
42	45	93%

Organization Name	Organization Name from HIT Assessment	Provider Type	Received	Count IDNs
American Medical Response of MA, Inc.	American Medical Response of MA, Inc.	Other Organization Type	Yes	2
Area Agency for Developmental Services DBA Gateways Community Services	Gateways Community Services	Community-Based Organization providing social and support services	Yes	1
Ascentria Care Alliance	Ascentria Care Alliance	Home and Community-Based Care Provider	Yes	4
Bridges: Domestic & Sexual Violence Support Services, Inc	Bridges: Domestic & Sexual Violence Support Services, Inc.	Community-Based Organization providing social and support services	Yes	1
City of Nashua Division of Public Health and Community Services	Division of Public Health and Community Services	Public Health Organization	Yes	1
Dartmouth Hitchcock Nashua		Primary Care Practice (including hospital-based, independent, etc.)	No	
Emmaus Institute Counseling Services	The Emmaus Institute, Inc.	Home and Community-Based Care Provider	Yes	1
Foundation Medical Partners	Southern New Hampshire Medical Center	Hospital Facility	Yes	1
Granite State Independent Living	Granite State Independent Living	Home and Community-Based Care Provider	Yes	7
Greater Nashua Council on Alcoholism, Inc. d/b/a Keystone Hall	Nashua Council on Alcoholism/Keystone Hall	Other Organization Type	Yes	1
Greater Nashua Mental Health Center	Greater Nashuia Mental Health Center	Community Mental Health Center	Yes	1
H.E.A.R.T.S. Peer Support & Crisis Respite Centers	H.E.A.R.T.S. Peer Support Center Of Greater Nashua	Community-Based Organization providing social and support services	Yes	1
Harbor Homes, Inc.	Harbor Homes (Harbor Care Health & Wellness Center)	Federally Qualified Health Center	Yes	1
Healthy at Home	Healthy At Home	Home and Community-Based Care Provider	Yes	1
Hillsborough County	Hillsborough County	County Nursing Facility	Yes	2
Hillsborough County		County Nursing Facility	No	
Home Health & Hospice Care	Home Health & Hospice Care	Home and Community-Based Care Provider	Yes	1
Lamprey Health Care, Inc.	Lamprey Health Care, Inc.	Federally Qualified Health Center	Yes	2
Life Coping, Inc.	Life Coping Inc.	Home and Community-Based Care Provider	Yes	6
Merrimack River Medical Services	Health Care Resource Centers/Merrimack River Medical Services	Substance Use Disorder (SUD) Provider	Yes	1
NAMI New Hampshire	NAMI New Hampshire	Community-Based Organization providing social and support services	Yes	7
Southern New Hampshire Medical Center - Acute Behavioral Health Unit	Southern New Hampshire Medical Center	Hospital Facility	Yes	1
Southern New Hampshire Medical Center- Acute Medical	Southern New Hampshire Medical Center	Hospital Facility	Yes	1

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Assessment Participation

Organization Name	Organization Name from HIT Assessment	Provider Type	Received	Count IDNs
Southern New Hampshire Medical Center- Behavioral Health Professional Fee	Southern New Hampshire Medical Center	Hospital Facility	Yes	1
Southern New Hampshire Medical Center- Emergency Department Professional Fee	Southern New Hampshire Medical Center	Hospital Facility	Yes	1
Southern New Hampshire Services	Southern New Hampshire Services	Community-Based Organization providing social and support services	Yes	3
St. Joseph Community Services, Inc.	St Joseph Community Services	Community-Based Organization providing social and support services	Yes	2
St. Joseph Hospital Adult Medicine	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Family Medicine Hudson	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Family Medicine Merrimack	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Family Medicine Milford	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Family Medicine Nashua	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Family Medicine South Nashua	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Internal Medicine	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Midwifery, Full circle Midwifery	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital OBGYN Associates	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Pediatrics, Merrimack Valley Pediatrics	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Pediatrics, Nashua Pediatrics	St Joseph Hospital	Hospital Facility	Yes	1
St. Joseph Hospital Primary Care Practices (see list below)	St. Joseph Hospital Primary Care Practice Network	Primary Care Practice (including hospital-based, independent, etc.)	Yes	1
St. Joseph Hospital, Nashua New Hampshire	St Joseph Hospital	Hospital Facility	Yes	1
The Courville at Nashua	The Courville at Nashua	Other Organization Type	Yes	1
The Front Door Agency, inc.		Community-Based Organization providing social and support services	No	
The Youth Council	The Youth Council	Substance Use Disorder (SUD) Provider	Yes	1
United Way of Greater Nashua	United Way of Greater Nashua	Other Organization Type	Yes	1
YMCA of Greater Nashua	YMCA of Greater Nashua	Community-Based Organization providing social and support services	Yes	1

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Electronic Data Collection and Exchange

Organization Name	Count IDNs	Provider Type	HIT Score*	EHR Type	Inter-Vendor Connection**	HIE Connection - Assessment	HIE Connection - NHHIO	HIE Connection -No Opt-Out Disclosure
American Medical Response of MA, Inc.	2	Other Organization Type	2.60	Certified EHR		Not Connected	Not Connected	
Ascentria Care Alliance	4	Home and Community-Based Care Provider	1.55	No EHR		Not Connected	Pending	X
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services	1.25	No EHR		Not Connected	Not Connected	
Division of Public Health and Community Services	1	Public Health Organization	1.50	No EHR		Not Connected	Not Connected	
Gateways Community Services	1	Community-Based Organization providing social and support services	2.15	EHR		Not Connected	Not Connected	
Granite State Independent Living	7	Home and Community-Based Care Provider	1.45	EHR		Not Connected	Pending	
Greater Nashuia Mental Health Center	1	Community Mental Health Center	3.55	Certified EHR		EHR Integrated with HIE	Yes	X
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services	1.20	EHR		Not Connected	Not Connected	
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	3.10	Certified EHR		Connected to HIE	Not Connected	
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	2.65	Certified EHR		Connected to HIE	Yes	X
Healthy At Home	1	Home and Community-Based Care Provider	1.15	No EHR		Not Connected	Pending	
Hillsborough County	2	County Nursing Facility	3.15	Certified EHR	X	Not Connected	Not Connected	
Home Health & Hospice Care	1	Home and Community-Based Care Provider	2.75	EHR		Connected to HIE	Yes	X
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR		EHR Integrated with HIE	Yes	X
Life Coping Inc.	6	Home and Community-Based Care Provider	1.50	EHR		Not Connected	Not Connected	
NAMI New Hampshire	7	Community-Based Organization providing social and support services	0.20	No EHR		Not Connected	Not Connected	
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type	2.26	EHR		Not Connected	Yes	
Southern New Hampshire Medical Center	1	Hospital Facility	3.50	Certified EHR	X	EHR Integrated with HIE	Yes	
Southern New Hampshire Services	3	Community-Based Organization providing social and support services	0.00	No EHR		Not Connected	Yes	
St Joseph Community Services	2	Community-Based Organization providing social and support services	0.75	EHR		Not Connected	Not Connected	
St Joseph Hospital	1	Hospital Facility	3.30	Certified EHR	X	Not Connected	Yes	X
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	3.70	Certified EHR		Not Connected	Yes	X
The Courville at Nashua	1	Other Organization Type	2.45	EHR		Not Connected	Pending	X
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider	0.85	No EHR		Not Connected	Not Connected	
The Youth Council	1	Substance Use Disorder (SUD) Provider	1.30	No EHR		Not Connected	Not Connected	
United Way of Greater Nashua	1	Other Organization Type	0.25	No EHR		Not Connected	Not Connected	
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services	0.95	EHR		Not Connected	Not Connected	

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Patient Dataset

Organization Name	Count IDNs	Provider Type	eRX	Lab Results Exchange	Care Summary Exchange	Patient Assessments	Patient Referrals	Patient Consent Tracking
American Medical Response of MA, Inc.	2	Other Organization Type	No eRx	Captured & Shared Electronically	Not shared	Captured & Shared Electronically	No Referrals	Electronically
Ascentria Care Alliance	4	Home and Community-Based Care Provider	No eRx	Not Captured	Manual	Not Captured	Manually	Paper Consents
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services	No eRx	Not Captured	Manual	Not Captured	Manually	Paper Consents
Division of Public Health and Community Services	1	Public Health Organization	No eRx	Not Captured	Manual	Captured on Paper	Manually	Paper Consents
Gateways Community Services	1	Community-Based Organization providing social and support services	No eRx	Not Captured	DSM	Not Captured	Unsecure Email	Scanned Consents
Granite State Independent Living	7	Home and Community-Based Care Provider	No eRx	Not Captured	Manual	Not Captured	Manually	Paper Consents
Greater Nashuia Mental Health Center	1	Community Mental Health Center	eRx	Not Captured	DSM	Captured Electronically	Manually	Scanned Consents
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services	No eRx	Not Captured	Not shared	Not Captured	Manually	Paper Consents
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	eRx	Captured & Shared Electronically	Manual	Captured Electronically	Manually	Scanned Consents
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	No eRx	Not Captured	Manual	Captured Electronically	Manually	Electronically
Healthy At Home	1	Home and Community-Based Care Provider	No eRx	Not Captured	Manual	Captured on Paper	Manually	Paper Consents
Hillsborough County	2	County Nursing Facility	eRx	Captured & Shared Electronically	Other Electronic Means	Not Captured	Unsecure Email	Scanned Consents
Home Health & Hospice Care	1	Home and Community-Based Care Provider	No eRx	Not Captured	Manual	Captured Electronically	Manually	Scanned Consents
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	eRx	Captured & Shared Electronically	Other Electronic Means	Captured & Shared Electronically	DSM	Scanned Consents
Life Coping Inc.	6	Home and Community-Based Care Provider	No eRx	Not Captured	DSM	Captured Electronically	Manually	Scanned Consents
NAMI New Hampshire	7	Community-Based Organization providing social and support services	No eRx	Not Captured	Not shared	Not Captured	No Referrals	Not Tracked
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type	No eRx	Captured & Shared Electronically	Manual	Captured & Shared Electronically	Manually	Scanned Consents
Southern New Hampshire Medical Center	1	Hospital Facility	eRx	Captured & Shared Electronically	Manual	Captured Electronically	DSM	Electronically
Southern New Hampshire Services	3	Community-Based Organization providing social and support services	No eRx	Not Captured	Not shared	Not Captured	No Referrals	Not Tracked
St Joseph Community Services	2	Community-Based Organization providing social and support services	No eRx	Not Captured	Not shared	Captured Electronically	Manually	Not Tracked
St Joseph Hospital	1	Hospital Facility	No eRx	Captured & Shared Electronically	Manual	Captured Electronically	Manually	Scanned Consents
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	eRx	Captured & Shared Electronically	Other Electronic Means	Captured & Shared Electronically	DSM	Scanned Consents
The Courville at Nashua	1	Other Organization Type	eRx	Not Captured	Manual	Captured Electronically	Manually	Paper Consents
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider	No eRx	Not Captured	Manual	Captured on Paper	Manually	Paper Consents

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Patient Dataset

Organization Name	Count IDNs	Provider Type	eRX	Lab Results Exchange	Care Summary Exchange	Patient Assessments	Patient Referrals	Patient Consent Tracking
The Youth Council	1	Substance Use Disorder (SUD) Provider	No eRx	Not Captured	Manual	Captured on Paper	Manually	Paper Consents
United Way of Greater Nashua	1	Other Organization Type	No eRx	Not Captured	Not shared	Not Captured	No Referrals	Not Tracked
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services	No eRx	Not Captured	Manual	Captured on Paper	No Referrals	Scanned Consents

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Consumer Tools

Organization Name	Count IDNs	Provider Type	Patient / Consumers Tools
American Medical Response of MA, Inc.	2	Other Organization Type	None or Limited Access
Ascentria Care Alliance	4	Home and Community-Based Care Provider	None or Limited Access
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services	None or Limited Access
Division of Public Health and Community Services	1	Public Health Organization	None or Limited Access
Gateways Community Services	1	Community-Based Organization providing social and support services	None or Limited Access
Granite State Independent Living	7	Home and Community-Based Care Provider	None or Limited Access
Greater Nashuia Mental Health Center	1	Community Mental Health Center	None or Limited Access
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services	None or Limited Access
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	Patient Portal
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	None or Limited Access
Healthy At Home	1	Home and Community-Based Care Provider	None or Limited Access
Hillsborough County	2	County Nursing Facility	None or Limited Access
Home Health & Hospice Care	1	Home and Community-Based Care Provider	None or Limited Access
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	Patient Portal with 3+ Features

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Consumer Tools

Organization Name	Count IDNs	Provider Type	Patient / Consumers Tools
Life Coping Inc.	6	Home and Community-Based Care Provider	None or Limited Access
NAMI New Hampshire	7	Community-Based Organization providing social and support services	None or Limited Access
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type	None or Limited Access
Southern New Hampshire Medical Center	1	Hospital Facility	Patient Portal
Southern New Hampshire Services	3	Community-Based Organization providing social and support services	None or Limited Access
St Joseph Community Services	2	Community-Based Organization providing social and support services	None or Limited Access
St Joseph Hospital	1	Hospital Facility	Patient Portal with 3+ Features
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	Patient Portal with 3+ Features
The Courville at Nashua	1	Other Organization Type	None or Limited Access
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider	None or Limited Access
The Youth Council	1	Substance Use Disorder (SUD) Provider	None or Limited Access
United Way of Greater Nashua	1	Other Organization Type	None or Limited Access
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services	None or Limited Access

Separate into sections_IDN 3 DATA SUPPLEMENT v2: EHR Software

Vendor		Organizations Using
GE Healthcare		4
SureScripts		3
Cerner Corporation		2
PointClickCare		2

Organization Name	Count IDNs	Provider Type	HIT Score	Attested EHR Usage	Application	Vendor	Year	Version	CHPL	Description
American Medical Response of MA, Inc.	2	Other Organization Type	2.60	Certified EHR	[redacted]	[redacted]	[redacted]			internal EMR product
Ascentria Care Alliance	4	Home and Community-Based Care Provider	1.55	No EHR						
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services	1.25	No EHR						
Division of Public Health and Community Services	1	Public Health Organization	1.50	No EHR						
Gateways Community Services	1	Community-Based Organization providing social and support services	2.15	EHR						
Granite State Independent Living	7	Home and Community-Based Care Provider	1.45	EHR						
Greater Nashuia Mental Health Center	1	Community Mental Health Center	3.55	Certified EHR	[redacted]	[redacted]	[redacted]		CHP-025733	Organizational EMR, primary operational system
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services	1.20	EHR						
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	3.10	Certified EHR	[redacted]	[redacted]	[redacted]	[redacted]	unknown	Use for medical, behavioral health records documentation
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	2.65	Certified EHR	[redacted]	[redacted]	[redacted]		None	Medication Assisted Treatment Software
Healthy At Home	1	Home and Community-Based Care Provider	1.15	No EHR						
Hillsborough County	2	County Nursing Facility	3.15	Certified EHR	[redacted]	[redacted]		[redacted]		Rehabilitation Point of Care
Hillsborough County	2	County Nursing Facility	3.15	Certified EHR	[redacted]	[redacted]				Electronic Health (Medical) Records
Home Health & Hospice Care	1	Home and Community-Based Care Provider	2.75	EHR	[redacted]	[redacted]		[redacted]		
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]	[redacted]			integrated faxing
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]	[redacted]	[redacted]		electronic health system
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]	[redacted]	[redacted]		practice management system
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]	[redacted]	[redacted]		HIE import/export
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]		[redacted]		electonic prescribing
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]	[redacted]	[redacted]		secure patient email
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	3.85	Certified EHR	[redacted]	[redacted]	[redacted]			document indexing system

Separate into sections_IDN 3 DATA SUPPLEMENT v2: EHR Software

Organization Name	Count IDNs	Provider Type	HIT Score	Attested EHR Usage	Application	Vendor	Year	Version	CHPL	Description
Life Coping Inc.	6	Home and Community-Based Care Provider	1.50	EHR						
NAMI New Hampshire	7	Community-Based Organization providing social and support services	0.20	No EHR						
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type	2.26	EHR	[redacted]	[redacted]	[redacted]	[redacted]	unknown	use as an electronic health record
Southern New Hampshire Medical Center	1	Hospital Facility	3.50	Certified EHR	[redacted]	[redacted]		[redacted]	CHP-025542	Electronic medical record
Southern New Hampshire Medical Center	1	Hospital Facility	3.50	Certified EHR	[redacted]	[redacted]		[redacted]	CHP-025535	Document management
Southern New Hampshire Medical Center	1	Hospital Facility	3.50	Certified EHR	[redacted]	[redacted]		[redacted]	CHP-022837	Patient education
Southern New Hampshire Medical Center	1	Hospital Facility	3.50	Certified EHR	[redacted]	[redacted]			CHP-021745	Lab information system
Southern New Hampshire Services	3	Community-Based Organization providing social and support services	0.00	No EHR						
St Joseph Community Services	2	Community-Based Organization providing social and support services	0.75	EHR						
St Joseph Hospital	1	Hospital Facility	3.30	Certified EHR	[redacted]	[redacted]	[redacted]		CHP-019212	
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	3.70	Certified EHR	[redacted]	[redacted]	[redacted]		1314E01RMAHWEA5	EMR
The Courville at Nashua	1	Other Organization Type	2.45	EHR	[redacted]	[redacted]	[redacted]	[redacted]	14.04.04.2180.Open.12.0.1.160609	
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider	0.85	No EHR						
The Youth Council	1	Substance Use Disorder (SUD) Provider	1.30	No EHR						
United Way of Greater Nashua	1	Other Organization Type	0.25	No EHR						
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services	0.95	EHR						

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Other Software

Organization Name	Count IDNs	Provider Type	Application	Software Type	Vendor	Year	Version	Description
Ascentria Care Alliance	4	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Ascentria Care Alliance	4	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Ascentria Care Alliance	4	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Ascentria Care Alliance	4	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Ascentria Care Alliance	4	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Ascentria Care Alliance	4	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Bureau of Dev. Services client and Medcaid billing
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Wait list client tracking tool
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]		[redacted]	Case Management data base
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]			Health risk screenings and service agreements
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Billing software
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Bureau of Dev. Services client and Medcaid billing/Prior Authorization
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]			Bureau of Elderly and Adult Services
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Customized report building

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Other Software

Organization Name	Count IDNs	Provider Type	Application	Software Type	Vendor	Year	Version	Description
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]			Attendance and billing software
Gateways Community Services	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Electronic document management software
Granite State Independent Living	7	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Home grown Consumer Data Collection System
Granite State Independent Living	7	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	SQL reporting
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]			Participants in Drug Court
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]			Participants in Mental Health Court
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]			Data for Servicce Recipients of Community Mental Health Services
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]			Assessment for Eligibility for State Funded Services
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]			Elders State Assessment
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]	[redacted]		
Greater Nashuia Mental Health Center	1	Community Mental Health Center	[redacted]	[redacted]	[redacted]	[redacted]		
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]			
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	[redacted]	[redacted]	[redacted]	[redacted]		Use for reports

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Other Software

Organization Name	Count IDNs	Provider Type	Application	Software Type	Vendor	Year	Version	Description
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	[redacted]	[redacted]	[redacted]			Tracks Patient/Client Demographics
Healthy At Home	1	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			Home Health billing system
Hillsborough County	2	County Nursing Facility	[redacted]	[redacted]	[redacted]		[redacted]	Document Management
Hillsborough County	2	County Nursing Facility	[redacted]	[redacted]	[redacted]			Resident Fund Management Service
Home Health & Hospice Care	1	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	meaningful use, quality and dashboard reporting
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	practice management reporting system
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	meaningful use and quality reporting
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	[redacted]	[redacted]	[redacted]	[redacted]		secure patient portal
Life Coping Inc.	6	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Life Coping Inc.	6	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Life Coping Inc.	6	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Life Coping Inc.	6	Home and Community-Based Care Provider	[redacted]	[redacted]	[redacted]			
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	use as an electronic health record for clients eligible for BDAS
Southern New Hampshire Medical Center	1	Hospital Facility	[redacted]	[redacted]	[redacted]		[redacted]	Reporting system

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Other Software

Organization Name	Count IDNs	Provider Type	Application	Software Type	Vendor	Year	Version	Description
Southern New Hampshire Medical Center	1	Hospital Facility	[redacted]	[redacted]	[redacted]		[redacted]	Patient portal
Southern New Hampshire Medical Center	1	Hospital Facility	[redacted]	[redacted]	[redacted]		[redacted]	Interface to State Syndromic Surveillance
St Joseph Hospital	1	Hospital Facility	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
St Joseph Hospital	1	Hospital Facility	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	[redacted]	[redacted]	[redacted]		[redacted]	reporting tool for quality and MU
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	[redacted]	[redacted]	[redacted]		[redacted]	Automated messaging for lab results and visit summaries
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	[redacted]	[redacted]	[redacted]			Secure Messaging and Patient Portal
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	[redacted]	[redacted]	[redacted]		[redacted]	scheduling
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	[redacted]	[redacted]	[redacted]		[redacted]	patient demographics, insurance and billing
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	[redacted]	[redacted]	[redacted]		[redacted]	reporting tool for quality
The Youth Council	1	Substance Use Disorder (SUD) Provider	[redacted]	[redacted]				
The Youth Council	1	Substance Use Disorder (SUD) Provider	[redacted]	[redacted]	[redacted]			
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services	[redacted]	[redacted]	[redacted]	[redacted]		Allows us to track DPP participants progress; shares with Y-USA

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Social Determinants

			Captured Electronically				Shared Electronically			
			9	11	8	12	4	4	2	3
Organization Name	Count IDNs	Provider Type	Economic stability	Education	Food	Community and social context	Economic stability	Education	Food	Community and social context
American Medical Response of MA, Inc.	2	Other Organization Type					X	X	X	X
Ascentria Care Alliance	4	Home and Community-Based Care Provider								
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services								
Division of Public Health and Community Services	1	Public Health Organization		X	X	X				
Gateways Community Services	1	Community-Based Organization providing social and support services								
Granite State Independent Living	7	Home and Community-Based Care Provider	X	X		X				
Greater Nashuia Mental Health Center	1	Community Mental Health Center	X	X						
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services								
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	X		X	X	X	X		
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	X	X	X	X				
Healthy At Home	1	Home and Community-Based Care Provider	X			X				
Hillsborough County	2	County Nursing Facility			X	X			X	X

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Social Determinants

			Captured Electronically				Shared Electronically				
			9	11	8	12	4	4	2	3	
Organization Name	Count IDNs	Provider Type	Economic stability	Education	Food	Community and social context	Economic stability	Education	Food	Community and social context	
Home Health & Hospice Care	1	Home and Community-Based Care Provider			X	X					
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	X	X	X	X	X				
Life Coping Inc.	6	Home and Community-Based Care Provider	X	X	X	X					
NAMI New Hampshire	7	Community-Based Organization providing social and support services									
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type	X	X			X	X			
Southern New Hampshire Medical Center	1	Hospital Facility		X		X		X		X	
Southern New Hampshire Services	3	Community-Based Organization providing social and support services									
St Joseph Community Services	2	Community-Based Organization providing social and support services	X	X	X	X					
St Joseph Hospital	1	Hospital Facility		X							
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)									
The Courville at Nashua	1	Other Organization Type		X		X					
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider									
The Youth Council	1	Substance Use Disorder (SUD) Provider									
United Way of Greater Nashua	1	Other Organization Type									
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services									

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Behavioral Health Assessment

Notation: E= Using Electronically P=Using Paper

Note: Shows total number of organizations within IDN region using the behavioral or mental health assessment

Organization Name	Count IDNs	Provider Type	Patient Health Questionnaire (PHQ-9)	SBIRT: Screening, Brief Intervention, and Referral to Treatment	DAST-10 (Drug Abuse Screen Test)	AUDIT (Alcohol Use Disorders Identification Test)	GAD-7 (Generalized Anxiety Disorder)	AUDIT-C	The Mood Disorder Questionnaire (MDQ)	CAGE AID	Substance Use Screening and Assessment Database	DAST-28 (Drug Abuse Screen Test)
			9	4	3	3	2	2	2	2	4	2
American Medical Response of MA, Inc.	2	Other Organization Type										
Ascentria Care Alliance	4	Home and Community-Based Care Provider										
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services										
Division of Public Health and Community Services	1	Public Health Organization										
Gateways Community Services	1	Community-Based Organization providing social and support services										
Granite State Independent Living	7	Home and Community-Based Care Provider										
Greater Nashuia Mental Health Center	1	Community Mental Health Center	E		E	E		E			P	
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services										
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center	E	E	E	E				E		
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider										
Healthy At Home	1	Home and Community-Based Care Provider	P	P			P	P	P			P
Hillsborough County	2	County Nursing Facility										
Home Health & Hospice Care	1	Home and Community-Based Care Provider	E									
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	E	E	E	E	E		E	E		

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Behavioral Health Assessment

Notation: E= Using Electronically P=Using Paper

Note: Shows total number of organizations within IDN region using the behavioral or mental health assessment

Organization Name	Count IDNs	Provider Type	Patient Health Questionnaire (PHQ-9)	SBIRT: Screening, Brief Intervention, and Referral to Treatment	DAST-10 (Drug Abuse Screen Test)	AUDIT (Alcohol Use Disorders Identification Test)	GAD-7 (Generalized Anxiety Disorder)	AUDIT-C	The Mood Disorder Questionnaire (MDQ)	CAGE AID	Substance Use Screening and Assessment Database	DAST-28 (Drug Abuse Screen Test)
			9	4	3	3	2	2	2	2	4	2
Life Coping Inc.	6	Home and Community-Based Care Provider	E								E	

Separate into sections_IDN 3 DATA SUPPLEMENT v2: Behavioral Health Assessment

Notation: E= Using Electronically P=Using Paper

Note: Shows total number of organizations within IDN region using the behavioral or mental health assessment

Organization Name	Count IDNs	Provider Type	Patient Health Questionnaire (PHQ-9)	SBIRT: Screening, Brief Intervention, and Referral to Treatment	DAST-10 (Drug Abuse Screen Test)	AUDIT (Alcohol Use Disorders Identification Test)	GAD-7 (Generalized Anxiety Disorder)	AUDIT-C	The Mood Disorder Questionnaire (MDQ)	CAGE AID	Substance Use Screening and Assessment Database	DAST-28 (Drug Abuse Screen Test)
			9	4	3	3	2	2	2	2	4	2
NAMI New Hampshire	7	Community-Based Organization providing social and support services										
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type										P
Southern New Hampshire Medical Center	1	Hospital Facility	E									
Southern New Hampshire Services	3	Community-Based Organization providing social and support services										
St Joseph Community Services	2	Community-Based Organization providing social and support services										
St Joseph Hospital	1	Hospital Facility									E	
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)	E								E	
The Courville at Nashua	1	Other Organization Type	E									
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider										
The Youth Council	1	Substance Use Disorder (SUD) Provider		P								
United Way of Greater Nashua	1	Other Organization Type										
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services										

Separate into sections_IDN 3 DATA SUPPLEMENT v2: HIT Intiatives

Organization Name	Count IDNs	Provider Type	Current & Future HIT Initiatives	Data Interoperability Standards	HL7	CCD	CCDA	SNOMED
American Medical Response of MA, Inc.	2	Other Organization Type						
Ascentria Care Alliance	4	Home and Community-Based Care Provider						
Bridges: Domestic & Sexual Violence Support Services, Inc.	1	Community-Based Organization providing social and support services						
Division of Public Health and Community Services	1	Public Health Organization	The DPHCS is looking to invest in an EHR product for use in the clinic and on the mobile health van. The goal is to have this operable by April 2017.					
Gateways Community Services	1	Community-Based Organization providing social and support services						
Granite State Independent Living	7	Home and Community-Based Care Provider	Time and Attendance, fillable forms, donation software	ICD 10 only for billing only one code				
Greater Nashuia Mental Health Center	1	Community Mental Health Center	Implementation of and improvements to CQM (e.g. implemented PQRS measures), Clinical Registry Reporting, HIE Data Exchanges, Tele-Medicine, Document Management System Imporvements, Operational and Pratice Management systems, Reporting and Analytics Systems, Patient Portal solution.	ICD-10, CDA, HL7, SNOMED-CT	X			X
H.E.A.R.T.S. Peer Support Center Of Greater Nashua	1	Community-Based Organization providing social and support services	N/A	N/A				
Harbor Homes (Harbor Care Health & Wellness Center)	1	Federally Qualified Health Center		ICD-10				
Health Care Resource Centers/Merrimack River Medical Services	1	Substance Use Disorder (SUD) Provider	Transition to a different network wth greater bandwidth and failover. Deploy mjore monitoring tools to better resond to IT issues. Increasingly virtualize services for efficiency and to eliminate downtime due to equipment failure.					
Healthy At Home	1	Home and Community-Based Care Provider						
Hillsborough County	2	County Nursing Facility	Not Known	ICD-10				

Separate into sections_IDN 3 DATA SUPPLEMENT v2: HIT Intiatives

Organization Name	Count IDNs	Provider Type	Current & Future HIT Initiatives	Data Interoperability Standards	HL7	CCD	CCDA	SNOMED
Home Health & Hospice Care	1	Home and Community-Based Care Provider	Netsmart timeline to provide DSM is in 2017. If they cannot deliver, we are prepared to move to a new vendor who has this functionality.	None				
Lamprey Health Care, Inc.	2	Federally Qualified Health Center	1. Electronic signature capture. 2. Additional Business Intelligence/analytics capabilities (WEBI) 3. Automated/integration of patient intake process	Currently utilize SNOMED, DSM-5, ICD-10, HL7, and CCD-A.	X	X		X
Life Coping Inc.	6	Home and Community-Based Care Provider						
NAMI New Hampshire	7	Community-Based Organization providing social and support services						
Nashua Council on Alcoholism/Keystone Hall	1	Other Organization Type		IC D-10				
Southern New Hampshire Medical Center	1	Hospital Facility	Evaluating the transition to new EMR.	RxNorm, CPT4, ICD-9, ICD-10, HL7, CCD, SNOMED-CT, XML, Direct	X	X		X
Southern New Hampshire Services	3	Community-Based Organization providing social and support services						
St Joseph Community Services	2	Community-Based Organization providing social and support services						
St Joseph Hospital	1	Hospital Facility	Converting to Epic Nov '17	SNOMED-CT, ICD-10, HL7, CCDA	X	X	X	X
St. Joseph Hospital Primary Care Practice Network	1	Primary Care Practice (including hospital-based, independent, etc.)						
The Courville at Nashua	1	Other Organization Type						
The Emmaus Institute, Inc.	1	Home and Community-Based Care Provider						
The Youth Council	1	Substance Use Disorder (SUD) Provider						
United Way of Greater Nashua	1	Other Organization Type						
YMCA of Greater Nashua	1	Community-Based Organization providing social and support services	In January 2017 we will begin using AthenaNet. This will connect us to a large network of providers to receive referrals from.	We do not currently use an electronic system for exchanging health information. Participant information comes to us on a paper form and is put in the correct, secure mail box for the program coordinator to view.				

A2-3a. IDN HIT/HIE: Requirements and Timeline

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, 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. These include 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. These include more advanced technologies that may only apply to certain types of organizations and 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.

Desired standards apply, 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. These are 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.

IDN Region 3 will implement the following standards, as outlined by the Statewide HIT Taskforce.

Minimum: Data Extraction and Validation
Data extraction/validation is required to develop reports to meet DHHS and IDN metrics. We are contracting with (to have the ability to validate data for state outcome measures and sending to a single collector for all IDN 3 member entities. The seven IDN 3 member entities that are included in data extraction and validation are listed below. New Hampshire Hospital's level of participation is unknown at the time of this report.

- Dartmouth Hitchcock Nashua
- Foundation Medical Partners (FMP)
- Greater Nashua Mental Health Center (GNMHC)
- Harbor Homes
- Lamprey Health
- Southern NH Medical Center (SNHMC)
- St. Joseph Hospital (SJH) and Physician Practices
- New Hampshire Hospital *pending future discussions

These seven organizations will receive IT funding allocations [redacted] for the first 12 months of the demonstration to support the development of report templates to allow for data extraction and validation of IDN attributed patients. Throughout the remainder of the demonstration, these seven organizations will receive an additional [redacted] allocation annually to support IT staff as data extraction is underway and additional data needs are identified.

The implementation for data extraction and validation will consist of the IT milestones/steps listed below after securing a contract with

- Scoping session with representatives from IDN 3 member entities and ENS vendor,
- Building, testing and validating ADT feeds and data extracts
- Building and uploading historical data as necessary
- Identifying data import needs; i.e. from outside vendors/applications
- Building a data entry portal
- Provisioning staff/users
- Training staff/users
- Building reports
- Transitioning to support and reporting

IDN 3 will begin the first wave of setting up data feeds/extracts with the emergency departments at SNHMC and SJH and GNMHC with the goal of completing them by early January. The second wave of data feed set up will begin once the first wave has been completed and tested. This second wave will include FMP, St. Joseph Physician Practices, Harbor Homes and Lamprey Health. The IDN 3 Data/IT Committee will discuss the necessity of creating and retrieving flat files (Excel, CSV) from member entities which currently have no EMR (Division of Public Health & Community Services, Keystone Hall, NH Hospital and Merrimack River Medical Services) in late December 2017. This minimum HIT capability/standard will help the IDN meet the goal of the use of technology to identify at risk patients, as noted in attachment_B1.9c.

Minimum: Internet Connectivity

Internet connectivity is required to store or capture data and ensure it is secure. IDN 3 Member Entities are required to securely connect to the Internet and provide a recommended, but not required, speed. The IDN will provide one-time allocations for up to five organizations for business grade Internet routers ([redacted]). Additionally, the IDN will provide [redacted] for ISP services (30mbps) for the demonstration period for up to 5 organizations who in CY 2018 demonstrated a lack of Internet connection or a connection to the Internet only through:

1. A shared connection (e.g. provided by landlord to all building tenants)
2. A non-secure connection (e.g. public WiFi)
3. A connection speed of <9 mbps
4. Employees' personal connections or phones.

The IDN 3 Data/IT Committee has not yet identified which member entities need Internet connectivity. The committee will discuss at its mid-December meeting to identify member entities and assign staff from these entities to research available vendors and pricing. The goal is to have a report on the findings by the end of December 2017.

Minimum: Secure Data Storage

Secure data storage is required for all IDN Member Entities, as patient health information needs to be protected. The IDN will support each IDN organization in contracting with a vendor of their choosing to conduct a review and provide documentation of compliance with NIST secure PHI data storage standards. All 29 Member Entities will receive a [redacted] allocation for 2017-2018 and subsequently, all organizations without an EMR will receive an additional [redacted] allocation annually for the remainder of the demonstration to conduct annual reviews and provide documentation that they are data storage compliant.

A staff member from Home Health and Hospice was assigned to research NIST requirements and consultants. We expect to have a report on the findings at the October IDN 2 Data/IT Committee meeting. The committee will also discuss which entities store, or will store, PHI or other personal data to identify which entities will require secure data storage and therefore need to contract with a NIST security consultant.

Minimum: Shared Care Plan (SCP) and Event Notification Service (ENS)

On 6/14/17, all of the IDNs agreed to use for Event Notification Service (ENS) and Shared Care Plan (SCP). Contract negotiations are in progress, with the goal of having them in place upon approval of plans by DHHS. Once contracts are signed, work will begin with setting up IDN Member Entities that will have an ADT feed, data extraction upload or data entry portal. SCP and ENS will give IDN Member Entities the ability to access and/or contribute to a care plan for an individual patient and the ability to receive notifications of events such as hospital admissions, hospital discharges, and transfers between facilities, as a minimum.

will serve as the backbone for the SCP with (or other similar vendor) as the primary SCP vendor, pending decision by the IT/Data Committee.

Development of the care plan is underway and will serve the IDN in meeting its goal of the use of technology to identify the plan of care for attributed patients, as outlined in attachment_B1.9c. Upon DHHS approval of the implementation plans, contracting will move forward with which will support the development of the platform for the care plan, which will become part of the Shared Care Plan to be used by case managers/care coordinators to meet the IDN's goal of the use of technology to monitor/manage patient progress toward goals, as outlined in attachment_B1.9c.

The *HIT Infrastructure to Support Integration* and the *Information Sharing and Standardized Workflow Protocols Work Teams* will collaborate with the Clinical Governance Committee and in next steps, which include:

- Within 1-2 weeks of contract signing:
  - IDN sharing with which providers will be on the SCP network, with providing an email intro to each provider
  - Completing the Provider milestones/steps:
    - Viewing video demo of (SCP platform)
    - Setting up Q & A meeting with
    - Setting up eligibility file discussion
    - Completing on-boarding packet
    - Training users on Primary

- Within 3-6 weeks of contract signing:
  - Completing the IT milestones/steps, which include:
    - VPN connectivity
    - ADT feed/messages—receive ADT feed from both IDN hospitals (SNHMC and St. Joseph Hospital)
    - Obtain patient historical file—12 to 24 months of patient enrollment and encounter data prior to going live
    - Notification return type – determine with hospitals which return type they prefer for notification (print or electronic)

The implementation will consist of the following IT milestones/steps after securing a contract.

- Initiation call
- Review of project plan
- Building training environment
- Meeting with IDN 3 member entities to confirm design
- Adding logos
- Building reports
- Provisioning users
- Training staff/users
- Validating workflows
- Transitioning to support

The following IDN organizations have been identified as needing some level of access to the SCP with their need to support the attributed patient population as they update and share various levels of information:

- American Medical Response (AMR)
- Home Health & Hospice
- Ascentria Care Alliance
- Keystone Hall
- Bridges
- Lamprey Health Care
- Dartmouth Hitchcock Nashua
- Life Coping
- The Emmaus Institute
- Merrimack River Medical Services
- Foundation Medical Center (FMP)
- NAMI, NH
- The Front Door Agency
- Nashua Public Health Department / City of Nashua
- Gateways Community Services
- Southern New Hampshire Medical Center (SNHMC)
- Granite State Independent Living
- Southern New Hampshire Services
- Greater Nashua Mental Health Center (GNMHC)
- St. Joseph Hospital
- Harbor Homes
- St. Joseph Primary Care Practice Network
- Healthy at Home

- YMCA of Greater Nashua

- HEARTS Peer Support Center of Greater NashuaThe Youth Council
- Hillsborough County Corrections and Nursing Home
- New Hampshire Hospital
    - pending future discussions

will be used by IDN 3 for both the Shared Care Plan (SCP) and Event Notification Service (ENS). The cost for IDN 3's Medicaid population is .12 per member per month (PMPM). The initial cost is based on the 2016 IDN attribution (24,068), with quarterly payments based upon actual patient attribution numbers received from DHHS, averaged over 4 months.

Each of the seven (7) EMR-based IDN organizations will receive a one-time allocation [redacted] to support IT staff supporting the outbound HL7 integration interface, while the remaining fourteen (14) non-EMR based IDN member entities will receive a one-time allocation [redacted].

The IDN Information Sharing and Standardized Workflow Protocols Work Team will collaborate with the Patient Privacy and Consent Work Team to determine what data will be included in the SCP and who will have access to the different types of information to be housed in it. The Information Sharing Work Team will also determine the method (email or fax) of event notification or if the provider/entity will receive a message asking them to log into the portal to view the SCP. The work team will also determine the levels of role-based access to patient data.

Below is further detail related to the data type and reason for access for each IDN Member Entity.

Member Entity	Type of Shared Data Allowed to View	Reason
Ascentria Care Alliance	Non-medical	Referral
Bridges	Non-medical	Referral
Dartmouth Hitchcock Nashua	Medical/SUD-related	Treatment/Referral
Division of Public Health and Community Services	Non-medical	Referral
Foundation Medical Center	Medical/SUD-related	Treatment/Referral
Gateways Community Services	Non-medical	Referral
Granite State Independent Living	Non-medical	Referral
Greater Nashua Mental Health Center (GNMHC)	Medical/SUD-related	Treatment/Referral
Harbor Homes	Non-medical	Referral
H.E.A.R.T.S. Peer Support Center of Greater Nashua	Non-medical	Referral
Healthy at Home	Non-medical	Referral
Hillsborough County Nursing Home	Non-medical	Referral
Hillsborough County Corrections	Non-medical	Referral
Home Health & Hospice	Non-medical	Referral
Keystone Hall	Non-medical	Referral
Lamprey Health Care	Medical/SUD-related	Treatment/Referral
Life Coping	Non-medical	Referral
Merrimack River Medical Services	Medical/SUD-related	Treatment/Referral
Nashua School District	Non-medical	Referral
Southern New Hampshire Medical Center (SNHMC)	Medical/SUD-related	Treatment/Referral

St. Joseph Hospital	Medical/SUD-related	Treatment/Referral
St. Joseph Primary Care Practice Network	Medical/SUD-related	Treatment/Referral
The Emmaus Institute	Non-medical	Referral
The Front Door Agency	Non-medical	Referral
The Youth Council	Non-medical	Referral

Minimum: Transmit Event Notifications

will be used by the IDN for transmitting event notifications from hospital emergency departments. This will allow for St. Joseph Hospital and Southern NH Medical Center to receive and send event notifications related to admissions, discharges and transfers of IDN attributed patients and help support the goal of the IDN to use technology to identify at risk patients, as outlined in attachment_B1.9.

IDN 3 will begin setting up data feeds/extracts with the emergency departments at SNHMC and SJH to connect with GNMHC in order to begin project C1 (Critical Time Intervention) in late November/early December. Once the EDs are set up with ENS, the physician practices at FMP and St. Joseph will be configured to receive them.

Minimum: Direct Secure Messaging

The ability to transmit patient information between providers is a minimum HIT capability/standard for the IDN. We will contract with for all 29 Member Entities to ensure that the ability is available for this important capability.

Upon securing a contract with each IDN 3 member entity will:

- Assign a director level employee to go through identity proofing process performed by Equifax.
- Identify and assign application administrators to provision users for each individual organization
- Determine security for users/roles and document download locations

Each administrator from respective member entities will set up:

- Document types
- Application users based on level of security

Administrators will be trained by staff. IDN lead may assist in getting member entities registered and set up with

A staff member from Life Coping was assigned to research capabilities and pricing options. We expect to have a report on the findings at the October IDN 2 Data/IT Committee meeting. The committee will also discuss which entities need an application to send secure messages and therefore need to contract with

Minimum: Data Aggregation

IDN Member Entities will have the ability to report against the required DHHS/CMS metrics and the Administrative Lead will have the ability to analyze data to generate non-required organizational or IDN-level reporting based upon project-related strategy evaluation outcomes through contracting with

It was determined that only select IDN organizations would be providing patient health information to support the DHHS/CMS metrics, which would require a data feed for allowing to extract data from their EMR. These organizations are listed below. New Hampshire Hospital's level of participation is unknown at the time of this report.

- Dartmouth Hitchcock Nashua
- Foundation Medical Partners (FMP)
- Greater Nashua Mental Health Center (GNMHC)
- Harbor Homes
- Lamprey Health Care
- Southern New Hampshire Medical Center (SNHMC)
- St. Joseph Hospital and St. Joseph Primary Care Practice Network
- New Hampshire Hospital *pending future discussions

Additionally, the following four entities will also provide patient health information as determined by the IDN, but do not have an EMR, so therefore will be required to manually enter data into web-based data portal.

- Division of Public Health and Community Services
- Keystone Hall
- NH Hospital
- Merrimack River Medical Services

To support the one-time set fee for a data extraction interface with each of the seven IDN Member Entities with EMRs will receive a one-time IT allocation [redacted].

The implementation for data aggregation will consist of the following IT milestones/steps after securing a contract with These milestones are also listed above under the minimum requirement of data extraction and validation.

- Scoping session with representatives from IDN 3 member entities and ENS vendor,
- Building, testing and validating ADT feeds and data extracts
- Building and uploading historical data as necessary
- Identifying data import needs; i.e. from outside vendors/applications
- Building a data entry portal
- Provisioning users
- Training staff/users
- Building reports
- Transitioning to support

IDN 3 will begin the first wave of setting up data feeds/extracts for data aggregation with the emergency departments at SNHMC and SJH and GNMHC with the goal of completing them by early January. The second wave of data feed set up will begin once the first wave has been completed and tested. This second wave will include FMP, St. Joseph Physician Practices, Harbor Homes and Lamprey Health. The IDN 3 Data/IT Committee will discuss the necessity of creating and retrieving flat files (Excel, CSV) from member entities which currently have no EMR (Division of Public Health & Community Services, Keystone

Hall, NH Hospital and Merrimack River Medical Services) in late December, 2017.

Desired: Query/Response CCDA Exchange

Contracting with IT vendor (or other similar vendor) will give IDN Member Entities the ability to share, query, and retrieve data on IDN attributed patients they share treatment plans with. Seven IDN Member Entities with EMRs below will receive a one-time IT allocation to support their CCDA exchange. They are listed below. * New Hampshire Hospital's level of participation is unknown at the time of this report.

- Dartmouth Hitchcock Nashua
- Foundation Medical Partners
- Southern NH Medical Center
- Greater Nashua Mental Health Center
- Harbor Homes
- Lamprey Health
- St. Joseph Hospital and Physician Practices
- New Hampshire Hospital *pending future discussions

IDN 3 will assign individuals to investigate the possibility of using in mid-December.

Desired: Integrated Direct Secure Messaging (DSM)

(or other similar vendor's) application will allow IDN Member Entities to opportunity use the protocol Direct Secure Messaging (DSM) to transmit patient information between providers, enabling integration in EMR systems. Each of the seven Member Entities with EMRs will receive a one-time IT allocation [redacted] for the EMR integration of CCDA.

The IDN 3 Data/IT committee will identify member entities that need integrated secure messaging and assign an individual to investigate in late October. Findings will be reported at the end of November, 2017.

Desired: Closed Loop Referrals/Discrete Data Collection

Contracting with (or other similar vendor) will provide for an application to allow IDN Member Entities to send referrals electronically in a closed loop system. The IDN will fund the one-time fee for the licenses, implementation and hosting for the application, as well as the annual subscription for the remainder of the demonstration period. However, the IDN will begin by using to ensure the ability to conduct closed loop referrals, as outlined in attachment_B1.9c.

The IDN will continue to investigate the need/desire for the use of (or other similar vendor) to allow discrete data collection as part of the shared care plan. IDN 3 is expecting to secure a contract and begin implementation in mid to late December, 2017.

The first wave of the closed loop referrals and potential for the use of discrete data collection will include the emergency departments at SNHMC and SJH and GNMHC with the goal of completing them by May 2018. The second wave of data feed set up will begin once the first wave has been completed and tested. This second wave will include FMP, St. Joseph Physician Practices, Harbor Homes and Lamprey Health. The IDN 3 Data/IT Committee will discuss the necessity of creating and retrieving flat files (Excel, CSV) from member entities which currently have no EMR (Division of Public Health & Community Services, Keystone Hall, NH Hospital and Merrimack River Medical Services) in mid- 2018.

Optional Requirements

At this time, the IDN has not allocated any funds for the following optional technologies Secure Texting, Discrete Data Capture, E-Consents, Population Health Tool, Capacity Management Tools, Patient Engagement Tools, however, these capabilities may be available as we further investigate the opportunities available through our IT vendors. We expect that with the remaining funds that we have available in our budget, we may have the ability to secure applications to support some of these capabilities.

IDN 3 will identify member entities that require secure texting, E-Consents, Population Health Tools, Capacity Management Tools and Patient Engagement Tools at IDN Data/IT Committee meetings beginning in late-December, 2017/early January. Some entities with EHRs may have tools in place that would satisfy some of these optional requirements. Further investigation is required and will begin once the priority IT vendors' systems (and have been implemented.

Training

The vendors selected for the Shared Care Plan, Event Notification Service, and Data Aggregation technology will each provide training not only to the organizations who have EMRs, but will offer the opportunity to allow other IDN Member Entities to participate in learning about how the technology will help operationalize the goals outlined for each of the IDN's project strategies.

Further information related to the HIT implementation and timeline are provided in attachment_A2.3b (HIT Implementation Plan)

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	IDN Data/IT Governance Committee Project Planning	160d	02/02/17	09/13/17
DONE	Vendor Demos	160d	02/02/17	09/13/17
DONE		64d	02/02/17	05/02/17
DONE	IDN 3	1d	02/02/17	02/02/17
DONE	Statewide	1d	05/02/17	05/02/17
DONE		20d	04/06/17	05/03/17
DONE	IDN 3	1d	04/06/17	04/06/17
DONE	Statewide	1d	05/03/17	05/03/17
DONE		1d	06/22/17	06/22/17
DONE	IDN 3	1d	06/22/17	06/22/17
DONE		1d	03/02/17	03/02/17
DONE	IDN 3	1d	03/02/17	03/02/17
DONE		1d	07/13/17	07/13/17
DONE	IDN 3	1d	07/13/17	07/13/17
DONE		1d	06/22/17	06/22/17
DONE	Statewide	1d	06/22/17	06/22/17
DONE		1d	06/29/17	06/29/17
DONE	Statewide	1d	06/29/17	06/29/17
	-	7d	09/05/17	09/13/17
	IDN 3, 4 and 6	1d	09/05/17	09/05/17
	IDN 3	1d	09/13/17	09/13/17
DONE	IDN Participation in Statewide HIT Taskforce: Current State Assessment	111d	10/19/16	03/22/17
DONE	Taskforce Convened	1d	10/19/16	10/19/16
DONE	Assessment Conducted	1d	11/22/16	11/22/16
DONE	Assessment Report Published	46d	01/18/17	03/22/17
DONE	IDN Participation in Statewide HIT Taskforce: Achieve Consensus on Min, Desired, Optional HIT HIE Infrastructure Projects for IDNs to Pursue	88d	03/28/17	07/27/17
DONE	Consensus Meetings Held	1d	03/28/17	03/28/17
DONE	Consensus Report Published	1d	04/05/17	04/05/17
DONE	IDN HIT Minimum, Desired and Optional Current State Analysis	47d	05/11/17	07/14/17
DONE	IDN Member HIT staff interviews to set baseline	47d	05/11/17	07/14/17
DONE	Current State Analysis Complete	1d	07/14/17	07/14/17
DONE	IDN Plans Developed	11d	07/13/17	07/27/17
DONE	HIT Budget developed	11d	07/13/17	07/27/17
DONE	Budget approved by IT/Data Committee	1d	07/13/17	07/13/17
DONE	Budget approved by Finance Committee	1d	07/20/17	07/20/17
DONE	Budget approved by Executive Committee	1d	07/27/17	07/27/17
	Individual IDN Milestone: Develop Future State IDN-Specific Implementation Plans and Timelines	252d	06/14/17	05/31/18
DONE	IDN HIE Integration Plan includes all providers: hospital, CMHC, community mental health providers, primary care, SUD and DRF participants.	28d	06/14/17	07/21/17
DONE	IDN HIE Integration Plan includes level of anticipated integration with NH Hospital and with the County nursing home, corrections facility, and developmental disability agency.	28d	06/14/17	07/21/17
DONE	Implementation Plan describes how key population health management capabilities will be supported	229d	07/17/17	05/31/18
	Individual and community risk assessments	229d	07/17/17	05/31/18
	Through and	229d	07/17/17	05/31/18
	Care coordination and care management	229d	07/17/17	05/31/18
	Through and	229d	07/17/17	05/31/18

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Health care transitions support	229d	07/17/17	05/31/18
	Through and	229d	07/17/17	05/31/18
	Quality management	229d	07/17/17	05/31/18
	Through and	229d	07/17/17	05/31/18
	Implementation Plan describes the clinical and financial analytic systems required outputs and inputs using the State-approved, interoperable standard	229d	07/17/17	05/31/18
	Described in plan through use of as vendor	229d	07/17/17	05/31/18
DONE	IDN Submits Draft Plan	15d	07/31/17	08/18/17
DONE	State Reviews Draft	15d	07/31/17	08/18/17
DONE	State Communicates Comments on Draft	1d	08/18/17	08/18/17
	IDN Submits Final Plan	1d	09/15/17	09/15/17
	State Approves/Denies Plan	1d	09/15/17	09/15/17
	Support IDN Member Entities in closing key infrastructure gaps among providers (physical health, behavioral health) and community-based service organizations and demonstrating the use of interoperability best practices	731d	08/09/17	05/27/20
	Address IDN Member Entities' HIT needs to engage in IDN strategies for 1115 Waiver Demonstration	731d	08/09/17	05/27/20
	Data Extraction/Validation and Aggregation--	731d	08/09/17	05/27/20
	Contract and Project Implementation Timeline	293d	08/09/17	09/21/18
DONE	Review contract and plan with			
DONE	Secure Subcontractor Approval from DHHS	1d	08/09/17	08/09/17
DONE	Have SHHS Legal Review Contract	7d	08/10/17	08/18/17
	Execute contract	286d	08/18/17	09/21/18
	Identify Goals and Objectives and get IDN Buy-in	730d	08/10/17	05/27/20
	Whiteboard Process to Outline Goals and Objectives for Data Collection and Aggregation	37d	08/10/17	09/29/17
	IDN 3 Kick Off Meeting	11d	10/01/17	10/13/17
	Meet with IT staff from IDN 3 member entities that are providing data via feeds or extracts. These are Foundation Medical Partners (FMP), Greater Nashua Mental Health Center (GNMHC), Harbor Homes, Lamprey Health, Southern New Hampshire Medical Center (SNHMC), St. Joseph Hospital (SJH) and St. Joseph Physician Practices.	11d	10/01/17	10/13/17
	Statewide IDN Scoping Session	5.5d	10/13/17	10/20/17
	Meet with representatives from all IDNs and to work through data flow and integration	4h	10/13/17	10/13/17
	Define roles and responsibilities	5d	10/13/17	10/20/17
	Connectivity to Data Sources	683.5d	10/13/17	05/27/20
	ADT Feeds	122d	10/13/17	04/03/18
	Build ADT feeds for SNHMC, SJH and GNMHC	61d	10/13/17	01/08/18
	Test	30d	10/13/17	11/24/17
	Validate	30d	11/24/17	01/05/18
	Go live on first wave of ADT feeds	1d	01/05/18	01/08/18
	Build ADT feeds for FMP, St. Joseph Physician Practices, Harbor Homes and Lamprey Health	61d	01/08/18	04/03/18
	Test	30d	01/08/18	02/19/18
	Validate	30d	02/19/18	04/02/18
	Go live on second wave of ADT feeds	1d	04/02/18	04/03/18
	Develop data extracts (in lieu of data feeds) from IDN 3 members (TBD if necessary)	1d	12/28/17	12/28/17

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Discuss necessity of flat file extracts (Excel/CSV) for entities with no EMR; Division of Public Health & Community Services, Keystone Hall, NH Hospital and Merrimack River Medical Services	1d	12/28/17	12/28/17
	Build extracts	30d	TBD	TBD
	Mappings for import into	45d	TBD	TBD
	Test	30d	TBD	TBD
	Validate	30d	TBD	TBD
	Develop extracts from for performance measures/metrics and data exchange	150d	10/13/17	05/11/18
	Determine what information needs to be exported	15d	10/13/17	11/03/17
	Build extracts per vendor/state specifications	45d	11/03/17	01/05/18
	Map extracts	30d	01/05/18	02/16/18
	Test extracts	30d	02/16/18	03/30/18
	Validate extracts	30d	03/30/18	05/11/18
	Secure Historical Data	115d	10/13/17	03/23/18
	Identify historical data needs	15d	10/13/17	11/03/17
	Build historical files	45d	11/03/17	01/05/18
	Map historical files	30d	01/05/18	02/16/18
	Upload historical data	10d	02/16/18	03/02/18
	Validate historical data	15d	03/02/18	03/23/18
	Secure imports from other applications			
	Determine what information needs to be imported	15d	TBD	
	Determine method and frequency of imports	5d	TBD	
	Prioritize data sources	1d	TBD	
	Map imports to data warehouse based on priority	45d	TBD	
	Test imports	30d	TBD	
	Validate imports	30d	TBD	
	Data entry portal	90d	10/13/17	02/16/18
	Determine entities using manual data entry portal	15d	10/13/17	11/03/17
	Configure portals for each site	90d	10/13/17	02/16/18
	Determine users responsible for manual entry	10d	10/20/17	11/03/17
	User Provisioning	35d	10/20/17	12/08/17
	Identify list of initial users and entity administrators	10d	10/20/17	11/03/17
	Identify role-based groups for security	10d	11/03/17	11/17/17
	Set up initial users based on roles	15d	11/17/17	12/08/17
	Training	302d	11/03/17	12/31/18
	Train IT administrators on user provisioning, reporting and data entry (train the trainer)	29d	11/03/17	12/13/17
	Train users on using portal	286d	11/27/17	12/31/18
	Wave One	23d	11/27/17	12/27/17
	Wave Two	15d	12/11/18	12/31/18
	Wave Three	24d	01/02/18	02/02/18
	Report Design	318.5d	10/13/17	01/02/19
	Design IDN 3 specific dashboard	30d	10/13/17	11/24/17
	Design member entity level reports	30d	11/24/17	01/05/18
	Project Go Live	1d	01/01/19	01/01/19
	Go live support	1d	01/01/19	01/01/19
	Post Go Live	1d	01/02/19	01/02/19
	Transition to support	1d	01/02/19	01/02/19
	Ongoing reporting	365d	01/03/19	05/27/20

Status	Task Name	Duration	Start Date	End Date
	will provide ongoing reporting of outcome measures per state requirements	365d	01/03/19	05/27/20
	Internet Connectivity	26.031d	12/14/17	01/19/18
	Identify IDN Member Entities who need Internet connectivity allocations through educational email to assess need/interest	10d	12/14/17	12/27/17
	Assign staff from identified member entities to research vendors/pricing for identified IDN member entities	0.25h	12/14/17	12/14/17
	Report on findings	0.25h	12/28/17	12/28/17
	Secure a contract with Internet Service Provider	15d	12/28/17	01/18/18
	Set up Internet access for identified member entities	1d	01/18/18	01/19/18
	Secure Data Storage	871d	08/31/17	12/31/20
	Solicit Request for Funds from IDN Member Entities for allocations to support consultants to provide verify compliance with NIST secure PHI data storage standards	45d	01/02/18	03/05/18
DONE	Assign staff to research	40.063d	08/31/17	10/26/17
DONE	Assign an IT staff member to research requirements and consultants	1h	08/31/17	08/31/17
	Report on findings	0.25h	10/26/17	10/26/17
	Identify which member entities store/will store PHI or other personal data	0.5h	10/26/17	10/26/17
	Secure a contract with a NIST security consultant	40d	10/26/17	12/21/17
	Security evaluations for SNHMC, FMP, SJH, St. Joseph Practices and GNMHC.	60d	12/21/17	03/15/18
	Security evaluations for Harbor Homes and Lamprey Health	30d	03/15/18	04/26/18
	Annual security evaluations for all identified member entities		TDB	12/31/20
	Event Notification Service (ENS) and Transmit Event Notification--	74d	11/01/17	02/12/18
	Secure contract with	30d	11/01/17	12/12/17
	Complete hospital contracts and engage IT for ADT connectivity (and ED tracking board integration), for a minimum "soft go live" where the ADT is being shared, but notifications are not turned on.	30d	11/01/17	12/12/17
	Transmit Event Notification for Hospitals only -	74d	11/01/17	02/12/18
	VPN Connectivity	74d	11/01/17	02/12/18
	ADT Feed / Messages	44d	11/01/17	01/01/18
	Set up event notification service for SNHMC and SJH	10d	11/01/17	11/14/17
	Configure the physician practices at FMP and St. Joseph to receive event notifications.	5d	11/15/17	11/21/17
	Test	14d	11/22/17	12/11/17
	Mappings	30d	11/01/17	12/12/17
	Prod	14d	12/13/17	01/01/18
	EMR Integration (Optional)			
	Return Message	10d	TBD	
	Build/ Configuration	45d	TBD	
	Validation	14d	TBD	
	Print Notification	14d	12/12/17	12/29/17
	Test Print Notification	14d	12/12/17	12/29/17
	Historical File	59d	11/01/17	01/22/18
	Build Historial File	14d	11/01/17	11/20/17
	Historical File Processing	30d	12/12/17	01/22/18
	IT Implementation Go Live	1d	02/12/18	02/12/18
	Active Directory / SSO (Optional)			
	Investigate Issue	30d	TBD	
	Identify Solution	14d	TBD	

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Implement Solution	30d	TBD	
	Clinical Kick Off Meeting	1d	11/13/17	11/13/17
	User Provisioning	44d	11/01/17	01/01/18
	Identify list of initial users and entity administrators	30d	11/01/17	12/12/17
	Identify role-based groups for security	14d	11/01/17	11/20/17
	Set up initial users	14d	12/13/17	01/01/18
	Training	62d	11/17/17	02/12/18
	ED providers on Report	30d	11/17/17	12/28/17
	CM and SW on Portal	30d	01/01/18	02/09/18
	Clinical/Project Go Live	1d	02/12/18	02/12/18
	Shared Care Plan	162d	08/10/17	03/23/18
	Contract Executed	1d	11/15/17	11/15/17
	Project Kickoff Call	1h	11/17/17	11/17/17
	Develop plan for manually entering data into shared care plan for Keystone Hall, Harbor Homes and Lamprey Health	1d	11/17/17	11/20/17
	Develop plan to capture evidence of CSA screenings and referrals	10d	11/17/17	12/01/17
	IT Implementation	75d	11/17/17	03/02/18
	SFTP Setup	14.125d	11/17/17	12/07/17
	Set up data feeds with the emergency departments at SNHMC and SJH to connect with GNMHC in order to begin project C1	3d	11/17/17	11/22/17
	Set up data feeds for physician practices; FMP and St. Joseph Practices	3d	12/04/17	12/07/17
	Eligibility File	30d	11/17/17	12/29/17
	Eligibility Design	30d	11/17/17	12/29/17
	Upload to SFTP	20d	12/29/17	01/26/18
	Test (Validate)	5d	12/29/17	01/05/18
	Process to Production	10d	01/05/18	01/19/18
	Automatic Pickup from SFTP Setup	5d	01/19/18	01/26/18
	Clinical Implementation	0.25d	12/04/17	12/04/17
	Onboarding Packet	2h	12/04/17	12/04/17
	Provisioning	75d	11/17/17	03/02/18
	Identify role-based groups for security	14d	11/17/17	12/07/17
	Develop list of initial users	30d	11/17/17	12/29/17
	Provision users	30d	11/17/17	12/29/17
	Cohorts Set up	30d	01/19/18	03/02/18
	Notification Destination Set Up	30d	01/19/18	03/02/18
	Reports Set up	30d	01/19/18	03/02/18
	Training	30d	01/02/18	02/12/18
	Account Managers/IT	30d	01/02/18	02/12/18
	Clinical Staff	30d	01/02/18	02/12/18
	Direct Secure Messaging	162d	08/10/17	03/23/18
DONE	Assign staff to research	55.031d	08/10/17	10/26/17
DONE	Assign staff member to research capabilities and pricing options	1d	08/10/17	08/10/17
	Report on findings	0.25h	10/26/17	10/26/17
	Secure contract with	103d	11/01/17	03/23/18
	Determine which member entities have a need for DSM	1d	10/26/17	10/26/17
	Each identified member entity to sign up individually	33d	12/13/17	01/26/18
	A director level employee from each member entity must go through identity proofing process	33d	12/13/17	01/26/18

Status	Task Name	Duration	Start Date	End Date
	Identity proofing process through Equifax	30d	12/13/17	01/23/18
	Determine application administrators from each member entity to provision users	1d	01/24/18	01/24/18
	Assign administrators in application	1d	01/24/18	01/24/18
	Administrator training	2d	01/02/18	01/03/18
	Determine security for users/roles and document download locations	2d	01/25/18	01/26/18
	Set up document types	2d	01/25/18	01/26/18
	Set up users based on level of security	2d	01/25/18	01/26/18
	Identified entities go live	23d	01/29/18	02/28/18
	Query-Based Exchange	30.031d	12/14/17	01/25/18
	Assign staff to investigate the possibility of using CareEquality/CommonWell	1d	12/14/17	12/14/17
	Report on findings	0.25h	01/25/18	01/25/18
	Contract with an integrated secure messaging vendor		TBD	
	Implement query-based exchange		TBD	
	Integrated Secure Messaging	25.031d	10/26/17	11/30/17
	Identify IDN member entities that need integrated secure messaging	1d	10/26/17	10/26/17
	Assign staff to research integrated secure messaging	1d	10/26/17	10/26/17
	Report on findings	0.25h	11/30/17	11/30/17
	Contract with an integrated secure messaging vendor		TBD	
	Implement secure texting with identified member entities	30d	TBD	
	Discrete Electronic Data Capture--	116.01d	12/12/17	05/23/18
	Pre-Implementation	1.063d	12/12/17	12/13/17
	Contract and Clarity Project Received	1d	12/12/17	12/12/17
	Update Clarity	0.063d	12/12/17	12/12/17
	Push Budget/Financial Plan out to a future Quarter	5m	12/12/17	12/12/17
	Place Hold on Health Check Projects	0.063d	12/12/17	12/12/17
	Project Manager and Kick-Off Assignment	0.063d	12/12/17	12/12/17
	Request Project Manager and Sascha Schwab	0.063d	12/12/17	12/12/17
	Propose week where Kick-Off Call will occur, Assign Project Manager, Solutions Consultant, Integration Architect (if needed) and Block	0.5h	12/12/17	12/12/17
	Project Manager notified of project assignment via Clarity email notification	0	12/12/17	12/12/17
	Review and Update Clarity Budgets and Forecasting	0.063d	12/12/17	12/12/17
	University	0.063d	12/12/17	12/12/17
	Contact Sales to get client contact info	15m	12/12/17	12/12/17
	Contact Client Project Manager to Discuss Client Enrollment in University	5.125d	12/12/17	12/19/17
	Enroll Client in University	0.5h	12/12/17	12/12/17
	Review Contract	5.125d	12/12/17	12/19/17
	Sales to Services Turnover	6.125d	12/12/17	12/20/17
	Schedule Sales to Services Turnover Call	0.01d	12/12/17	12/12/17
	Send Agenda and StS Document prior to meeting in separate email	5m	12/12/17	12/12/17
	Attend and Conduct Sales to Services Turnover Call	0.01d	12/19/17	12/19/17
	Send Sales to Services Turnover post-Meeting Notes to Attendees	5m	12/19/17	12/19/17
	Upload Sales to Services Turnover Notes to Clarity Collaboration tab	5m	12/19/17	12/19/17
	Send Welcome Email to Client Project Manager	1.125d	12/19/17	12/20/17
	Contact Client for quick Introduction via phone	1.125d	12/19/17	12/20/17

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Review Welcome Email	1.125d	12/19/17	12/20/17
	Project Kick Off Call Prep	111.01d	12/19/17	05/23/18
	Contact Client Project Manager to Schedule Project Kick Off Call	15m	12/19/17	12/19/17
	Populate Project Kick Off Agenda and PowerPoint Presentation	0.01d	12/19/17	12/19/17
	Send Project Kick Off Call Meeting Invite w/ Agenda to Call Invitees	5m	12/19/17	12/19/17
	Update Clarity	0.01d	12/19/17	12/19/17
	Budget/Financial Plan	5m	12/19/17	12/19/17
	Project Stage	65.188d	12/19/17	03/20/18
	Services Project Data	1.125d	12/19/17	12/20/17
	Services Status Report	5m	12/19/17	12/19/17
	Project Event Log (Ed Serv Class Dates)	5m	12/19/17	12/19/17
	Project Kick Off	0.125d	12/20/17	12/20/17
	Project Kick Off Call	0.125d	12/20/17	12/20/17
	Conduct Project Kick Off Call	1h	12/20/17	12/20/17
	Attend Project Kick Off Call	4.188d	12/20/17	12/26/17
	Send Project Kick Off Call post-Meeting Notes to Attendees	4.188d	12/20/17	12/26/17
	Upload Project Kick Off Notes to Clarity Collaboration tab	4.188d	12/20/17	12/26/17
	Send Call Invite, Agenda and Questionnaires for Clinical Initiation Call	0.25d	12/20/17	12/20/17
	Clinical Initiation Call Prep	0.25d	12/20/17	12/20/17
	Complete Client Questionnaire	2h	12/20/17	12/20/17
	Complete Security Questionnaire and Administrat	30m	12/20/17	12/20/17
	Clinical Initiation Call	0.125d	12/26/17	12/26/17
	Conduct Clinical Initiation Call	1h	12/26/17	12/26/17
	Attend Clinical Initiation Call	1h	12/26/17	12/26/17
	Send Clinical Initiation Call post-Meeting Notes to Attendees	15m	12/26/17	12/26/17
	Upload Clinical Initiation Call Notes to Clarity Collaboration tab	5m	12/26/17	12/26/17
	Send Call Invite for Weekly Clinical Call Meeting Series	3.188d	12/21/17	12/26/17
	Finalize Implementation Dates within Clarity	3.188d	12/21/17	12/26/17
	Set up data feeds/extracts with the emergency departments at SNHMC and SJH to connect with GNMHC in order to begin project C1	30d	12/26/17	02/06/18
	Set up data feeds for physician practices; FMP and St. Joseph Practices	30d	02/06/18	03/20/18
	Set up data feeds to and from data aggregator	30d	12/26/17	02/06/18
	Project Plan	3.188d	12/21/17	12/26/17
	Update Project Plan and Send to Client Project Manager	1.5h	12/26/17	12/26/17
	Upload Project Plan to Clarity Collaboration tab	5m	12/26/17	12/26/17
	IDN 3 meet with Integration Managers/IT staff of 6 entities providing patient data	1d	12/21/17	12/21/17
	Determine integration method and frequency (ADT feed, extract)	1d	12/21/17	12/21/17
	Event Acceptance	6.063d	12/26/17	01/03/18
	Call Prep	0.031d	12/26/17	12/26/17
	Contact Client Project Manager to Schedule Event Sign Off Call	15m	12/26/17	12/26/17
	Populate Event Sign Off Agenda and Sign Off Form	15m	12/26/17	12/26/17
	Send Event Acceptance Sign Off Meeting Invite w/ Agenda and Sign Off Form to Client	0.063d	01/03/18	01/03/18

Status	Task Name	Duration	Start Date	End Date
	Event Acceptance Call	0.063d	01/03/18	01/03/18
	Conduct Event Acceptance Call	30m	01/03/18	01/03/18
	Attend Event Acceptance Call	30m	01/03/18	01/03/18
	Event Acceptance Sign Off	0.031d	01/03/18	01/03/18
	Send Event Acceptance Sign Off Form to Client (if not already sent)	5m	01/03/18	01/03/18
	Sign Event Acceptance and Send to	0.01d	01/03/18	01/03/18
	Upload Event Acceptance to Clarity Collaboration tab	0.01d	01/03/18	01/03/18
	Update Clarity	0.01d	01/03/18	01/03/18
	Budget/Financial Plan	5m	01/03/18	01/03/18
	Project Stage	0.01d	01/03/18	01/03/18
	Services Project Data	5m	01/03/18	01/03/18
	Services Status Report	0.125d	01/04/18	01/04/18
	Build	0.125d	01/04/18	01/04/18
	Process and Application Design and Build - Session Prep	0.125d	01/04/18	01/04/18
	Complete MCG activation paperwork and follow submission instructions	15m	01/04/18	01/04/18
	Create Shell for Production Org and Send SFDC Case to Database Analyst	15m	01/04/18	01/04/18
	Build Training Org	0.125d	01/04/18	01/04/18
	Load Training Patients	1h	01/04/18	01/04/18
	Load Training Users in Train	30m	01/04/18	01/04/18
	Send Agenda for Onsite Process and Application Design and Build Session	3d	01/10/18	01/12/18
	Onsite Process and Application Design and Build Session	3d	01/10/18	01/12/18
	Conduct Onsite Design and Build Session	2d	01/10/18	01/11/18
	Attend Onsite Design and Build Session	2d	01/10/18	01/11/18
	Day 1: Demo, Current State, Future State Design and Build	31.92d	01/11/18	02/23/18
	Day 2: Future State Design and Build, Handlers and Logos, Securelink	8h	01/11/18	01/11/18
	Day 3: Future State Design and Build	8h	01/12/18	01/12/18
	Deliver Next Steps and Homework Info to Client	1h	01/12/18	01/12/18
	Additional Clinical Calls	30.92d	01/12/18	02/23/18
	Implementation Consultant and Project Manager Survey	30.021d	01/12/18	02/23/18
	Create Survey in SurveyMonkey	30.021d	01/12/18	02/23/18
	Send Out Implementation Consultant and Project Manager Survey	5m	02/23/18	02/23/18
	Complete Implementation Consultant and Project Manager Survey	10m	02/23/18	02/23/18
	Logos	20d	01/12/18	02/08/18
	Build Logos	4w	01/12/18	02/08/18
	Validate Logos in Train Environment	2h	02/08/18	02/08/18
	Handlers	12d	02/15/18	03/02/18
	Build Handler	6d	02/23/18	03/02/18
	Deploy and QA Handler (Training environment)	30m	03/02/18	03/02/18
	Reports	5d	02/26/18	03/02/18
	Build Reports	1w	02/26/18	03/02/18
	Client Site Prep	0.031d	02/23/18	02/23/18
	Provide Connectivity Link to on each User Workstation / Intranet Homepage	15m	02/23/18	02/23/18
	Pre-Load File	1.125d	01/08/18	01/09/18
	Receive Pre-Load File	5m	01/08/18	01/08/18
	Load Pre-Load File into Training Environment	6.01d	02/23/18	03/05/18

Status	Task Name	Duration	Start Date	End Date
	Populate Event Sign Off Agenda and Sign Off Form	2.063d	02/23/18	02/27/18
	Conduct Event Acceptance Call	4.01d	02/27/18	03/05/18
	Send Event Acceptance Sign Off Form to Client (if not already sent)	0.01d	03/05/18	03/05/18
	Upload Event Acceptance to Clarity Collaboration tab	0.004d	03/05/18	03/05/18
	Budget/Financial Plan	0.004d	03/05/18	03/05/18
	Project Stage	2m	03/05/18	03/05/18
	Services Project Data	2m	03/05/18	03/05/18
	Services Status Report	22.063d	03/05/18	04/04/18
	Validation & QA	0.13d	03/05/18	03/05/18
	Site Prep Validation	0.13d	03/05/18	03/05/18
	Site Prep Validation Call	0.13d	03/05/18	03/05/18
	Schedule Site Prep Validation Call	15m	03/05/18	03/05/18
	Conduct Site Prep Validation Call	22.063d	03/05/18	04/04/18
	Attend Site Prep Validation Call	0.042d	03/05/18	03/05/18
	Send Site Prep Validation Call Notes to Attendees	22.063d	03/05/18	04/04/18
	Workflow Validation and Tips and Tricks Training Call	0.625d	03/05/18	03/05/18
	Conduct Workflow Validation, Tips and Tricks	2h	03/05/18	03/05/18
	Attend Workflow Validation, Tips and Tricks	2h	03/05/18	03/05/18
	Workflow Documentation	0.625d	03/05/18	03/05/18
	Provide " Workflow" template to client	22.063d	03/05/18	04/04/18
	Complete Workflow Documentation	5h	03/05/18	03/05/18
	Obtain Client Finalized Workflow	15m	03/05/18	03/05/18
	eLearning	21.063d	03/06/18	04/04/18
	Log a Service Desk Request for Client to be contacted for eLearning	15m	03/06/18	03/06/18
	Register end users in eLearning Programs	28d	03/05/18	04/12/18
	IDN member entities provide list of users	1d	03/05/18	03/06/18
	IDN staff members attend training	1d	03/19/18	03/19/18
	Confirm End User Completion of eLearning	5.01d	04/05/18	04/12/18
	Event Acceptance	5.01d	04/05/18	04/12/18
	Call Prep	0.031d	04/05/18	04/05/18
	Contact Client Project Manager to Schedule Event Sign Off Call	15m	04/05/18	04/05/18
	Populate Event Sign Off Agenda and Sign Off Form	0.042d	03/05/18	03/05/18
	Validate Client Plan for Signature Load	10m	03/05/18	03/05/18
	Plan Date for Workflow Validation Call	5m	03/05/18	03/05/18
	Verify Training Room Availability	5m	03/05/18	03/05/18
	Finalize Training and Activation Dates	20m	03/05/18	03/05/18
	Send Event Acceptance Sign Off Meeting Invite w/ Agenda and Sign Off Form to Call	5m	04/05/18	04/05/18
	Event Acceptance Call	2.01d	04/10/18	04/12/18
	Update Clarity	0.004d	04/12/18	04/12/18
	Budget/Financial Plan	2m	04/12/18	04/12/18
	Project Stage	2m	04/12/18	04/12/18
	Services Project Data	2m	04/12/18	04/12/18
	Services Status Report	5.25d	05/03/18	05/10/18
	Readiness (Activation Readiness)	5.125d	05/03/18	05/10/18
	Preparation Verification	0.125d	05/03/18	05/03/18
	Patient / Worklist Set Up for Training Scenarios	1h	05/03/18	05/03/18
	Activation Preparation Call	5.125d	05/03/18	05/10/18
	Call Prep	0.031d	05/03/18	05/03/18

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Contact Client Project Manager to Schedule Activation Preparation Call	15m	05/03/18	05/03/18
	Populate Activation Preparation Call Agenda	15m	05/03/18	05/03/18
	Send Activation Preparation Call Invite w/ Agenda to Call Invitees	1.031d	05/09/18	05/10/18
	Activation Preparation Call	1.031d	05/09/18	05/10/18
	Conduct Activation Preparation Call	30m	05/09/18	05/09/18
	Attend Activation Preparation Call	0.063d	05/09/18	05/09/18
	Confirm General Readiness tasks per Agenda and notify client you will be sending them Sign-In Sheets and Training	0.25d	05/10/18	05/10/18
	Send Activation Preparation Call post-Meeting Notes to Attendees	15m	05/10/18	05/10/18
	Upload Activation Preparation Notes to Clarity Collaboration tab	15m	05/10/18	05/10/18
	Move Application Configurations to Production	1h	05/10/18	05/10/18
	Client Activation Preparation	0.25d	05/10/18	05/10/18
	Build Users in Production	9.01d	05/10/18	05/23/18
	Load Client Signatures into Production	0.031d	05/10/18	05/10/18
	Print Agendas for Training	15m	05/10/18	05/10/18
	Print Classroom Sign-In Sheets	2d	05/10/18	05/12/18
	Handlers	0.25d	05/10/18	05/10/18
	Send reminder to Jeff Morgan to move Handlers to prod (via email)	5m	05/10/18	05/10/18
	Move Handlers to Production	2h	05/10/18	05/10/18
	Logos	0.125d	05/12/18	05/12/18
	Deploy Logos in Production (occurs on Monday nights)	2d	05/10/18	05/11/18
	Test Environment Preparation	0.375d	05/10/18	05/10/18
	Load Training Patients in Test	3h	05/10/18	05/10/18
	Assign Test Patients to Users	1h	05/10/18	05/10/18
	Test 'Upload Patient File Template' in Training (if client using patient loader)	15m	05/10/18	05/10/18
	Training and Activation/Go Live Templates	2d	05/10/18	05/11/18
	Send Training Schedule Template	5m	05/10/18	05/10/18
	Complete Training Schedule Template	2d	05/10/18	05/12/18
	Send Activation / Go Live Schedule Template	5m	05/10/18	05/10/18
	Complete Activation / Go Live Schedule Template	1h	05/12/18	05/12/18
	Activation Preparation	0.031d	05/10/18	05/10/18
	Send Pre-Activation Notification	15m	05/10/18	05/10/18
	Verify all Users in Training and Production	6.01d	05/10/18	05/18/18
	Order / Ship Pens for Client	15m	05/10/18	05/10/18
	Event Acceptance	5.01d	05/11/18	05/18/18
	Call Prep	0.031d	05/11/18	05/11/18
	Populate Event Sign Off Agenda and Sign Off Form	3.063d	05/11/18	05/16/18
	Attend Event Acceptance Call	2.01d	05/16/18	05/18/18
	Update Clarity	0.004d	05/18/18	05/18/18
	Budget/Financial Plan	2m	05/18/18	05/18/18
	Project Stage	2m	05/18/18	05/18/18
	Services Project Data	2m	05/18/18	05/18/18
	Services Status Report	4.01d	05/17/18	05/23/18
	Activation	2d	05/17/18	05/18/18
	Enable Ad Hoc Reporting	2d	05/17/18	05/18/18
	End User Training	2d	05/17/18	05/18/18

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Conduct End User Training	1d	05/18/18	05/18/18
	Attend End User Training	2.01d	05/21/18	05/23/18
	End User Activation Go Live Support	2.01d	05/21/18	05/23/18
	Conduct End User Activation Go Live Support	2.01d	05/21/18	05/23/18
	Daily Tasks During Activation	0.125d	05/21/18	05/21/18
	Meet with Client Management to Review Issues Daily and Follow-Up on any Issues with Client Management and End Users	1h	05/21/18	05/21/18
	Update Project Manager with any Workflow Issues	1h	05/21/18	05/21/18
	Run Reports Daily for User Productivity	1h	05/21/18	05/21/18
	Conduct End User Tracking and Competency	0.01d	05/23/18	05/23/18
	Post "Activation Visit" Documentation	0.01d	05/23/18	05/23/18
	End User Tracking and Competency Sheet Sent to Client	5m	05/23/18	05/23/18
	Send Follow-Up Documentation / Issue Resolution	5m	05/23/18	05/23/18
	Post Final Project Documentation to Clarity Collaboration tab	0.004d	05/23/18	05/23/18
	Final Training and Activation Schedule	1.031d	05/23/18	05/24/18
	Classroom Sign-In Sheets	1.031d	05/23/18	05/24/18
	Agendas (all, if not previously posted)	1.031d	05/23/18	05/24/18
	Tip Sheets	2m	05/23/18	05/23/18
	Complete and Send Go Live Announcement	15m	05/24/18	05/24/18
	Manage and Resolve Issues in Production (1 WEEK DURATION ON THIS FOR 30 MIN A DAY)	21.41d	05/24/18	06/22/18
	Purge Data in Test (if Production ADT feed is pointed to Test database)	0.031d	05/24/18	05/24/18
	Event Acceptance	6.01d	05/24/18	06/01/18
	Budget/Financial Plan	2m	06/01/18	06/01/18
	Project Stage	0.004d	06/01/18	06/01/18
	Services Project Data	2m	06/01/18	06/01/18
	Services Status Report	15.41d	06/01/18	06/22/18
	Post-Activation	15.41d	06/01/18	06/22/18
	Follow Up Calls	15.41d	06/01/18	06/22/18
	Schedule Follow Up Call Series	15m	06/01/18	06/01/18
	Follow Up Call #1 - Standard Report Review	0.125d	06/08/18	06/08/18
	Conduct Follow Up Call	21d	06/08/18	07/06/18
	Send Transition to Support Invite w/ Agenda to Meeting Invitees	28.125d	07/06/18	08/15/18
	Closed Loop E-Referrals--	125.031d	08/10/17	02/01/18
	e-referral capability	125.031d	08/10/17	02/01/18
	Assign staff to research e-referral capability	30d	08/10/17	09/20/17
	Report on findings	0.25h	09/28/17	09/28/17
	Secure contract with for e-referrals	30d	09/28/17	11/09/17
	Configure FMP and St. Joseph Physician practices' EMRs to send and accept referrals	30d	11/09/17	12/21/17
	Configure Harbor Homes, Lamprey Health Care EMRs to send and accept referrals	30d	12/21/17	02/01/18
	Develop plan to send and accept referrals to/from Division of Public Health & Community Services, Keystone Hall, NH Hospital and Merrimack River Medical Services	30d	09/28/17	11/09/17
	Application users	31d	11/09/17	12/22/17
	Identify users	3d	11/09/17	11/14/17
	Provision users	1d	12/21/17	12/22/17
	Train users			
	Secure Text	80.031d	12/28/17	04/19/18

A2 Health Information Technology Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Identify member entities that need secure texting	1d	12/28/17	12/28/17
	Assign staff to research secure texting	1d	12/28/17	12/28/17
	Report on findings	0.25h	01/25/18	01/25/18
	Contract with a secure text vendor	30d	01/25/18	03/08/18
	Implement secure texting with identified member entities	30d	03/08/18	04/19/18
	Population Health Tool--	20.031d	01/25/18	02/22/18
	Identify member entities that require a population health tool	1d	01/25/18	01/25/18
	Assign staff to research as a population health tool	1d	01/25/18	01/25/18
	Report on findings	0.25h	02/22/18	02/22/18
	Contract with a			
	Implement population health tool for identified member entities			
	Application users			
	Identify users			
	Provision users		TBD	
	Train users		TBD	
	Patient Engagement Technology	80.031d	12/28/17	04/19/18
	Identify member entities that require patient engagement technology	1d	12/28/17	12/28/17
	Assign staff to research patient engagement application vendors	1d	12/28/17	12/28/17
	Report on findings	0.25h	01/25/18	01/25/18
	Contract with a patient engagement application vendor	30d	01/25/18	03/08/18
	Implement patient engagement application with identified member entities	30d	03/08/18	04/19/18
	Application users and application administrators	4d	03/08/18	03/14/18
	Identify users	3d	03/08/18	03/13/18
	Provision users	1d	03/13/18	03/14/18
	Train users	3d	03/14/18	03/19/18
	Capacity Management Tools--	20.031d	01/25/18	02/22/18
	Identify member entities that require a capacity management tool	1d	01/25/18	01/25/18
	Assign staff to research as a capacity management tool	1d	01/25/18	01/25/18
	Report on findings	0.25h	02/22/18	02/22/18
	Contract with a			
	Implement capacity tool for identified member entities			
	Application users			
	Identify users			
	Provision users		TBD	
	Train users		TBD	

A2-4. IDN HIT: Evaluation Project Targets

Below are the IDN 3 HIT evaluation targets to address the capabilities and standards set by the Statewide HIT Task Force to meet the goals of IDN.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Data Extraction	All of the 8 IDN Member provider entities with Electronic Health Records (EHRs) will develop report templates (as applicable) to allow for data extraction and validation of Protected Health Information for IDN attributed patients through the use of as the data aggregator and data warehouse by July 31, 2018.			
Internet Connectivity	Up to 23 of the IDN Member provider entities who store or capture Protected Health Information for IDN attributed patients will have a secure Internet connection with support from the IDN by December 31, 2018.			
Secured Data Storage	Up to 23 of the IDN Member provider entities who store or capture Protected Health Information for IDN attributed patients will have completed annual reviews of their data storage systems to ensure compliance with NIST secure PHI data storage standards through IDN funding allocations for consultant contracts by December 31, 2018.			
Direct Secure Messaging (DSM)	Up to 29 of the IDN Member provider entities will have the ability to use the protocol Direct Secure Messaging (DSM) to transmit attributed patient information between providers to support robust interoperability through the use of as the HIT vendor by December 31, 2018.			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Shared Care Plan (SCP)	Up to 12 of the IDN Member provider entities will have the ability to access and/or contribute to an electronic Shared Care Plan (SCP) for an individual attributed IDN patient to facilitate communication and share data to encourage a team approach to care through the use of as the HIT vendor by June 30, 2019.			
Event Notification Service (ENS)	Up to 12 of the IDN Member provider entities will have the ability to receive alert notifications when patients are discharged from a hospital or emergency department, as well as patient medical services encounters with authorized recipients with an existing relationship with the patient through the use of by December 31, 2018.			
Transmit Event Notification Service	Southern NH Medical Center, St. Joseph Hospital and NH Hospital will have the ability to produce Admission, Discharge or Transfers (ADTs) to alert downstream clinical, behavioral and community providers of these activities with the attributed target sub- population system through the use of by July 31, 2018.			
Discrete Electronic Data Capture	Up to 8 of the IDN Member provider entities will have the ability to capture discrete data and/or use Certified Electronic Health Record Technology (CEHRT) as needed, through the use of or a similar vendor by June 30, 2019.			
Integrated Direct Secure Messaging	Up to 8 of the IDN Member provider entities will have the ability to use Direct Secure Messaging (DSM) to transmit patient information between providers through the integration of EHRs or cloud-based technologies via the use of or a similar vendor by June 30, 2019.			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Query-Based Exchange	Up to 8 of the IDN Member provider entities will have the ability to use Inter-Vendor capabilities to share, query and retrieve data through the use of or a similar vendor by June 30, 2019.			
Closed Loop E-Referrals	Up to 12 of the IDN Member provider entities will have the ability to send referrals electronically in a closed loop system through the use of or a similar vendor by June 30, 2019.			
Data Analysis/Validation	The IDN Admin Lead will have the ability to analyze/validate data to generate non-required organizational or IDN level reporting through the use of as its data aggregator/data warehouse by December 31, 2018.			
Population Health Tools	The IDN Admin Lead will have the ability to identify patients who are high utilizers of provider services through the use of or a similar vendor by June 30, 2019.			
Capacity Management Tools	The IDN Admin Lead will have the ability to review and analyze provider utilization (and subsequently availability) through the use of or a similar vendor by June 30, 2019.			
Patient Engagement Technology	The IDN IT/Data Governance Committee will research and make a determination about the feasibility of securing patient engagement technology for IDN provider organizations by December 31, 2018.			
Secure Text	The IDN IT/Data Governance Committee will research and make a determination about the feasibility of procuring secure texting capabilities for IDN provider organizations by December 31, 2018.			

A2-5. IDN HIT: Workforce Staffing

Members of the IDN Data/IT committee have interviewed and surveyed member entities to identify gaps in the HIT workforce capacity needed to accomplish the IDN project goals and strategies. It was determined that the seven organizations who will be required to provide patient health data for the IDN have dedicated information technology staff on site to manage their Electronic Medical Records (EMRs). However, we had heard that building the data templates, participating in meetings to discuss the data needs, and supporting the data analysis would require some additional support for the IT workforce.

Therefore, the IDN determined that providing allocations to support organizations as they build their capacity with the minimum, desired and optional capabilities and standards would help enable for the time of these experts to participate in work with the IT vendors, IDN training and support for the IDN IT/Data Governance and Clinical Governance Committees and their affiliated work teams.

Additionally, the IDN 3 Administrative Lead team determined it would be necessary to hire a full-time Data Manager (with funds from the Administrative Lead budget), as well as a Quality Improvement Manager (from the A1 Behavioral Health Workforce Capacity budget) to support the determination of data collection and analysis needs. These positions are reflected below.

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
DSRIP Data Manager	1	.15			
DSRIP Quality Improvement Manager	1	0			

A2: Health Information Technology (HIT)
2017 - 2020 Budget

Standard	Category and Item	Item Notes	Total Available 2017 - 2018	Total Available 2019 - 2020	August 2017 - June 2018 (11 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020	Total Requested 2017- 2020	Total Available 2017 - 2020
	Totals		$1,414,883	$1,214,694	$1,054,342.70	$586,852.90	$456,278.68	$227,845.80	$2,325,320.08	$2,639,577.00
Minimum	**Data Extraction/Validation to develop reports to meet DHHS and IDN metrics**	Ability to validate data for State outcome measures and send it to one single collector at the overall IDN level only			$256,667.00	$151,666.90	$140,092.68	$70,000.14	$618,426.72	
Minimum	**Internet Connectivity to store or capture data and ensure it is secure**	Securely connected to the internet (Provide a recommended but not required speed)			$33,000	$30,000.00	$30,000	$15,000	$108,000.00	
Minimum	**Secure Data Storage**	Ability and knowledge to secure PHI through technology and training			$265,832.27	$139,999.44	$139,999.44	$69,999.72	$615,830.87	
Minimum	**Shared Care Plan (SCP) and Event Notification Service (ENS)**	Ability to access and/or contribute an electronic shared care plan for an individual patient and ability to receive notifications as a minimum for all organizations.			$31,769.76	$35,350.56	$35,350.56	$17,328.96	$119,799.84	
Minimum	**Transmit Event Notification**	Hospital Emergency Departments only (Admission, Discharge, Transfer ADTs)			$29,268	$30,578.00	$30,578.00	$15,288.00	$105,712.00	
Minimum	**Direct Secure Messaging**	Ability to use protocol DSM to transmit patient information between providers. Can use webmail client as a minimum.			$7,975	$8,700.00	$8,700.00	$4,350.00	$29,725.00	
Minimum	**Data Aggregation**	A minimum HIT capability and standard, this application allows the IDN to report against the required DHHS/CMS metrics and to analyze data to generate non-required organizational or IDN level reporting based upon identified project metrics set by the IDN.			$91,116.67	$153,000.00	$34,000.00	$17,000.00	$295,116.67	
Desired	**Query/Response CCDA Exchange**	Ability to use Inter-Vendor capabilities to share data, query, and retrieve--May have capability through (or another similar vendor)			$30,000	$0.00	$0.00	$0.00	$30,000.00	
Desired	**Integrated Direct Secure Messaging (DSM)**	Ability to use the protocol DSM to transmit patient information between providers. Integration in EHR system as a desired--May have capability through (or another similar vendor)			$60,000.00	$0.00	$0.00	$0.00	$60,000.00	
Optional	**Closed Loop Referrals/Discrete Data Collection**	Ability to send referrals electronically in a closed loop system			$248,714	$37,558.00	$37,558.00	$18,878.98	$342,708.98	
Optional	**Secure Texting**	Ability to use secure texting for patient to agency, agency to agency, or other use cases			$0	$0.00	$0.00	$0.00	$0.00	
Optional	**E-Consents**	Potentially through (or another similar vendor)			$0	$0.00			$0.00	
Optional	**Population Health Tool**	Ability to identify high utilizers within populations at organizational or IDN level--Potentially available through (or another similar vendor)			$0	$0.00	$0.00	$0.00	$0.00	
Optional	**Capacity Management Tools**	Ability to see provider utilization and availability for tracking provider capacity and appointment availability			$0.00	$0.00	$0.00	$0.00	$0.00	
Optional	**Patient Engagement Tools**	Ability to better engage patients which includes telemedicine, secure texting, and others.			$0.00	$0.00	$0.00	$0.00	$0.00	

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

Below is a list of key organizations and providers participating in the IDN HIT project.

Organization Name	Organization Type
Foundation Medical Partners	Primary and Specialty Care Practices
St. Joseph Physician Practices	Primary and Specialty Care Practices
Dartmouth Hitchcock Nashua	Primary and Specialty Care Practices
Harbor Homes	FQHC
Lamprey Health	FQHC
Southern NH Medical Center	Acute Care Hospital
St. Joseph Hospital	Acute Care Hospital
Greater Nashua Mental Health Center	Community Mental Health Center
Ascentria Care Alliance	Home and Community-Based Provider
City of Nashua Division of Public Health	Public Health Organization
Gateways Community Services	Community-based Organization providing social and support services
Merrimack River Medical Services	Substance Use Treatment Provider
Keystone Hall	Substance Use Treatment Provider
H.E.A.R.T.S.	Community-based Organization providing social and support services
Healthy at Home	Home and Community-Based Provider
Hillsborough County Nursing Home	County Nursing Facility
Hillsborough County Corrections Facility	County Corrections Facility
Home Health and Hospice Care	Home and Community-Based Provider
Granite State Independent Living	Community-based Organization providing social and support services
American Medical Response (AMR)	Other Organization Type
NAMI NH	Community-based Organization providing social and support services
The Emmaus Institute	Community-based Organization providing social and support services
The Front Door Agency	Community-based Organization providing social and support services
The Youth Council	Substance Use Treatment Provider
YMCA of Greater Nashua	Community-based Organization providing social and support services

A2-8. IDN HIT. Data Agreement

Below is documentation of progress on the Data Sharing Agreement, as required in STC 22. Since the IDN has not formally secured IT vendor contracts, we determined that we would bring in the IT staff from each of the key providers who will be responsible for compiling and sharing patient health data as we finalized those vendor contracts. Then, as the contracts are finalized (hopefully by the end of September 2017, upon approval of implementation plans and fund distribution from DHHS), we will secure data agreements.

Organization Name	Data Sharing Agreement Signed Y/N
Foundation Medical Partners	N (in progress, once IT vendor contracts are signed)
St. Joseph Physician Practices	N (in progress, once IT vendor contracts are signed)
Dartmouth Hitchcock Nashua	N (in progress, once IT vendor contracts are signed)
Harbor Homes	N (in progress, once IT vendor contracts are signed)
Lamprey Health	N (in progress, once IT vendor contracts are signed)
Southern NH Medical Center	N (in progress, once IT vendor contracts are signed)
St. Joseph Hospital	N (in progress, once IT vendor contracts are signed)
Greater Nashua Mental Health Center	N (in progress, once IT vendor contracts are signed)
Ascentria Care Alliance	N (in progress, once IT vendor contracts are signed)
City of Nashua Division of Public Health	N (in progress, once IT vendor contracts are signed)
Gateways Community Services	N (in progress, once IT vendor contracts are signed)
Merrimack River Medical Services	N (in progress, once IT vendor contracts are signed)
Keystone Hall	N (in progress, once IT vendor contracts are signed)
H.E.A.R.T.S. Peer Support Center	N (in progress, once IT vendor contracts are signed)
Healthy at Home	N (in progress, once IT vendor contracts are signed)
Hillsborough County Nursing Home	N (in progress, once IT vendor contracts are signed)
Hillsborough County Corrections Facility	N (in progress, once IT vendor contracts are signed)
Home Health and Hospice Care	N (in progress, once IT vendor contracts are signed)
Granite State Independent Living	N (in progress, once IT vendor contracts are signed)
American Medical Response (AMR)	N (in progress, once IT vendor contracts are signed)
NAMI NH	N (in progress, once IT vendor contracts are signed)
The Emmaus Institute	N (in progress, once IT vendor contracts are signed)

Organization Name	Data Sharing Agreement Signed Y/N
The Front Door Agency	N (in progress, once IT vendor contracts are signed)
The Youth Council	N (in progress, once IT vendor contracts are signed)
YMCA of Greater Nashua	N (in progress, once IT vendor contracts are signed)

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

IDN 3 formed an Integrated Practice Designation (IPD) Work Team in April 2017 to begin the process of determining the gaps for each of the required practices in the IDN. The initial goal was to identify the contacts in each practice to ask them to work with the IDN Administrative Lead to conduct a baseline integration Site Self-Assessment (SSA) for each practice. Then, as the HIT and clinical strategies (including training and coaching) were implemented, additional assessments would be conducted every six months.

The IPD Work Team included representation from:

- Southern NH Health (Foundation Medical Partner's Chief Medical Officer)
- Dartmouth Hitchcock Nashua (physician)
- The Emmaus Institute (Executive Director)
- Greater Nashua Mental Health Center (Chief of Services)
- Harbor Homes (Clinical Director)
- St. Joseph Hospital Physician Practices (President of Physician Practices)
- Lamprey Health (Clinical Director)

The Work Team met with representatives from the who were contracted with the IDN to support the administration of a baseline Practice Integration Site Self-Assessment (SSA), which was conducted in June 2017. There were 48 practices who were required to complete the baseline assessment tool (see attachment_B1.1b), as outlined in the IDN's project plan, including:

- Dartmouth Hitchcock (8 practices)
- Foundation Medical Partners (22 practices)
- Greater Nashua Mental Health Center
- Lamprey Health Care
- Harbor Health, Inc.
- Keystone Hall
- Merrimack River Medical Services
- St. Joseph Hospital Physician Practices (13 practices)

The Work Team determined additional practices would receive the baseline SSA, as each of the practices had indicated interest in engaging in efforts to become more integrated. These included:

- Gateways Community Services
- The Emmaus Institute
- The Youth Council

It was also determined that the Southern NH Medical Center Acute Behavioral Health Unit was not applicable to completing the assessment, due to its specific nature of being an Intensive Outpatient/Partial Hospitalization Program, so while they received the assessment invitation, they were not required to complete it.

SSA Roll-Out

The SSA protocol included a letter emailed to the practice managers at each practice site through either the organization's Chief Medical Officer (CMO), lead physician, or Clinical lead. Each practice was asked to have individual team members complete the assessment themselves separately and then come

together as a group to share their responses. The practice would then come to consensus for where they thought their practice was for each question in the assessment. The assessment tool is attached (attachment_B1.1c).

The SSA was administered on the Qualtrics online platform, with the assessment open for one month (from May 15, 2017 through June 16, 2017). One automated follow-up email was provided to the practices at the half-way point and phone calls were made for those practices who had not yet completed their assessments by Monday June 12, 2017 to remind them of the deadline of June 16th. A great completion rate of 39 out of the required 48 practices was achieved, with the 3 other provider organizations also completing the baseline SSA.

provided a results interpretation session via webinar on July 13, 2017, which was open to all members of the Integrated Practice Designation Work Team as well as the Clinical Governance Committee. The session was recorded, with a baseline report provided.

Next Steps

Next steps for the IDN related to assessing current state of practice against SAMHSA's Framework for Integrated Levels of Care include:

- Securing a Letter of Agreement (as part of attachment_B1.6) from each Practice Manager to participate in the B1 Integrated Health strategies in moving as far as possible along the SAMHSA Levels of Integrated Care. Many have been secured, but some are still in progress.
- The Integrated Practice Designation Work Team meeting to:
    - Review the results of the individual practice assessments in the order of wave (Fall/Winter 2017, Spring 2018 or Summer 2018) to determine the gaps to achieving *Coordinated Care Practice and Integrated Care Practice* designation, as perceived by their practice and as identified by SAMHSA/NH DHHS.
    - Determine the process for meeting with the practices to define steps and resources needed to achieve the designation(s) judged to be feasible by the provider and the IDN during the period of the demonstration.
- Hiring an IDN Practice Integration Project Manager to work with each wave of practices. The manager will support the practices as they identify the steps and timeline to achieving movement from their baseline level their goal level (as determined by the practice and the IDN).
- Working with to complete the baseline SSA with the remaining 8 IDN practices who have not yet completed it.
- Working with to complete subsequent SSAs with all IDN practices every 6 months to assess and monitor progress:
    - December 2017
    - June 2018
    - December 2018
    - June 2019
    - December 2019
    - June 2020
    - December 2020

attachment_B1.1b

IDN 3 Completed Baseline Site Self-Assessments by Waves
July 2017

Practice ID	Practice Name	Completed Baseline SSA June 2017	Medicaid Attribution (from 2016 MMIS and 2016 St. Joseph Hospital Medicaid Records)	Timeline Wave 1: August 1, 2017	Timeline Wave 2: April 2, 2018	Timeline Wave 1: July 9, 2018
3-102	Dartmouth-Hitchcock Nashua Family Medicine		361	8/1/2017 Coordinated Care Wave One		
3-101	Dartmouth-Hitchcock Nashua Internal Medicine		0	8/1/2017 Coordinated Care Wave One		
3-106	Dartmouth-Hitchcock Hudson		124		4/02/18 Coordinated Care Wave Two	
3-108	Dartmouth-Hitchcock Merrimack		164		4/02/18 Coordinated Care Wave Two	
3-107	Dartmouth-Hitchcock Milford		375		4/02/18 Coordinated Care Wave Two	
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology		110		4/02/18 Coordinated Care Wave Two	
3-103	Dartmouth-Hitchcock Nashua Pediatrics		2638			7/9/18 Coordinated Care Wave Three
3-105	Norris Cotton Cancer Center		0			7/9/18 Coordinated Care Wave Three
			3772	361	623	2638
3-138	Foundation Medical Partners, Foundation Pediatrics		1085	8/1/2017 Integrated Care Pilot		
3-131	Foundation Medical Partners, Medicine- Pediatrics of Nashua		598	8/1/2017 Integrated Care Pilot		
3-152	Pediatrics & Adolescent Medicine		392	8/1/2017 Integrated Care Pilot		
3-140	Foundation Medical Partners, Partners in Pediatrics		538		4/02/18 Coordinated Care Wave Two	
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics		164		4/02/18 Coordinated Care Wave Two	
3-129	Foundation Medical Partners, Primary Care of Milford		388	8/1/2017 Coordinated Care Wave One		
3-125	Foundation Medical Partners, Family Practice of Merrimack		367	8/1/2017 Coordinated Care Wave One		
3-128	Foundation Medical Partners, Primary Care of Hudson		338	8/1/2017 Coordinated Care Wave One		
3-126	Foundation Medical Partners, Family Practice of South Nashua		316	8/1/2017 Coordinated Care Wave One		
3-124	Foundation Medical Partners, Amherst Family Practice		255	8/1/2017 Coordinated Care Wave One		
3-133	Foundation Medical Partners, Nashua Primary Care		186	8/1/2017 Coordinated Care Wave One		
3-137	Foundation Medical Partners, Foundation Internal Medicine		77	8/1/2017 Coordinated Care Wave One		
3-141	Foundation Medical Partners, Foundation OB/GYN		220		4/02/18 Coordinated Care Wave Two	
3-135	Foundation Medical Partners, Nashua Center for Healthy Adults		151		4/02/18 Coordinated Care Wave Two	
3-143	Foundation Medical Partners, Women's Care of Nashua		143		4/02/18 Coordinated Care Wave Two	
3-134	Foundation Medical Partners, Downtown Medical Associates		129		4/02/18 Coordinated Care Wave Two	
3-127	Foundation Medical Partners, Pepperell Family Practice		121		4/02/18 Coordinated Care Wave Two	
3-142	Foundation Medical Partners, NE GYN & Surgical Services		100			7/9/18 Coordinated Care Wave Three
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham		80			7/9/18 Coordinated Care Wave Three
3-132	Foundation Medical Partners, Nashua West Adult Medicine		78			7/9/18 Coordinated Care Wave Three
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua		34			7/9/18 Coordinated Care Wave Three
3-144	Foundation Medical Partners, Foundation Community Care		1			7/9/18 Coordinated Care Wave Three

attachment_B1.1b

IDN 3 Completed Baseline Site Self-Assessments by Waves
July 2017

			5761	4002	1466	293
3-150	Gateways Community Services	N/A	0	N/A		
3-145	Greater Nashua Mental Health Center		1726	8/1/2017 Integrated Care Pilot as part of Lamprey/GNMHC co-located effort		
3-109	Lamprey Health Care		356			
3-146	Harbor Health/Harbor Care Health and Wellness Center		1014	8/1/2017 Coordinated Care Pilot as part of PSL		
3-151	Keystone Hall		107			
	Healthy at Home					
3-148	Merrimack River Medical Services		701	8/1/2017 Coordinated Care Wave One		
3-110	Southern New Hampshire Medical Center Acute Behavioral Health Unit	N/A	N/A	N/A		
3-119	St. Joseph Hospital Pediatrics Nashua		2390	8/1/2017 Coordinated Care Wave One		
3-120	St. Joseph Hospital Pediatrics Milford		9	8/1/2017 Coordinated Care Wave One		
3-118	St. Joseph Hospital Pediatrics Sky Meadow		698	8/1/2017 Coordinated Care Wave One		
3-121	St. Joseph Hospital OB/GYN Merrimack		304		4/02/18 Coordinated Care Wave Two	
3-111	St. Joseph Hospital Family Medicine, Nashua		231		4/02/18 Coordinated Care Wave Two	
3-116	St. Joseph Hospital Internal Medicine		221		4/02/18 Coordinated Care Wave Two	
3-115	St. Joseph Hospital Family Medicine & Specialty Services Milford		187		4/02/18 Coordinated Care Wave Two	
3-113	St. Joseph Hospital Family Medicine & Specialty Services Hudson		172		4/02/18 Coordinated Care Wave Two	
3-117	St. Joseph Hospital Adult Medicine		163			7/9/18 Coordinated Care Wave Three
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack		143			7/9/18 Coordinated Care Wave Three
3-112	St. Joseph Hospital Family Medicine Nashua South		104			7/9/18 Coordinated Care Wave Three
3-123	St. Joseph Hospital Midwifery		20			7/9/18 Coordinated Care Wave Three
3-122	St. Joseph Hospital OB/GYN Hudson		0			7/9/18 Coordinated Care Wave Three
			4642	3097	1115	430
3-147	The Emmaus Institute Counseling	N/A	2	N/A		
3-149	The Youth Council	N/A	0	N/A		

CITIZENS HEALTH INITIATIVE

Dear NH Integrated Delivery Network Participant,

As part of the Integrated Delivery Network (IDN), participating health care and behavioral health practices are asked to complete the Site Self-Assessment Survey (SSA). The purpose of the assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. The administration and evaluation of the SSA falls under the guidelines of a research project for NH Citizens Health Initiative at the University of New Hampshire (Initiative).

The purpose of this research is to identify the level of behavioral health integration existing in participating practices at the inception of the IDN and to track progress over time. As a participant in this research you will be asked to provide basic contact information for the person completing the person and site completing the SSA and answer questions about the level of integrated ion your practice. You will receive your practice SSA scores at the conclusion of the SSA survey.

Data collected will be used by the Initiative staff to track the level of behavioral health integration across practices and will be shared with your IDN. Information you provide will be used for IDN and Initiative organizational purposes, for program evaluation of the IDN; aggregated, de-identified data may be used in reporting to funders, participants, and other stakeholders; dissemination to the field; or publication of evaluation results. We seek to maintain the confidentiality of all data and records associated with your participation in this research.

There are, however, rare instances when I am required to share personally-identifiable information (e.g., according to policy, contract, regulation). For example, in response to a complaint about the research, officials at the University of New Hampshire, designees of the sponsor(s), and/or regulatory and oversight government agencies may access research data.

Participation in this research is voluntary and you may cease to participate at any time. If you do choose to participate in the SSA survey you may still refuse to answer any research questions asked of you. This survey will take approximately 30 minutes to complete. There is no cost to participate in this study and no compensation is provided. Your participation will provide valuable information to program administrators and may help to improve the program and benefit yourself and future participants. Participating in this study is not expected to present any greater risk of your loss of personal privacy than you would encounter in everyday life when sending and/or receiving information over the Internet or participating in mailed surveys.

If you have any questions about this research project, please contact Jeanne Ryer, the Principal Investigator on this project at Jeanne.Ryer@UNH.edu.

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

If you have questions about your rights as a research subject you can contact Dr. Julie Simpson in UNH Research Integrity Services, 603-862-2003 or Julie.simpson@unh.edu to discuss them.

Thank you for taking part in this important assessment of behavioral health integration.

SURVEY CONSENT: Please select your choice below.

Clicking on the "Agree" button below indicates that:

- You have read the above information
- You voluntarily agree to participate
- You are at least 18 years of age

If you do not wish to participate in the research study, please decline participation by clicking on the "Disagree" button.

☐ Agree ☐ Disagree

Organization Information _____

IDN Region _____ IDN Practice Identifier _____

*Provided to you by IDN Administrative Leads

Site Name _____

Street Address _____ Street Address _____

City/Town_____ State_____ Zip_____

Email _____

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

Organization Type

O Health Care System

O Health Care Practice, including FQHCs, etc.

O Behavioral Health Practice, including CMHCs, etc.

O Other Health Care Provider (Please Specify) _____

O Provider Organization (e.g., PHO/IPA)

O Other (Please Specify) _____

Practice Type:

O Independent Practice

O Hospital-Owned Practice

O Community Health Center/FQHC

O Rural Health Clinic

O Community Mental Health Center

O Behavioral Health Practice

O Other _____

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

Integrated Delivery Network Behavioral Health Integration Site Self-Assessment

Name of Site Assessed _____

Did you discuss these ratings with other members of your team? ☐ Yes ☐ No

The following questions will help you and your IDN region assess the current level of behavioral health integration in your practice site. This Site Self-Assessment instrument will be used to track your site's progress over time.

Instructions for Completing the Site Self-Assessment (SSA) Survey

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's current extent of integration for patient and family-centered primary care, behavioral and mental health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA.

For this update of the SSA, please respond in terms of your site's current status on each dimension. Obtain input from your team to complete this form. For example, ask each team member to score it, then discuss the scores in a team meeting and reach consensus. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.

Using the 1-10 scale in each row, select ONE numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess. You may indicate any comments or feedback you would like to give regarding that item in the feedback box at the end of the SSA.

NOTE: There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

This form is adapted from and used with permission by Maine Health Access Foundation's Site Self Assessment

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	Levels			
1. Level of integration: primary care and mental/behavioral health care	none; consumers go to separate sites for services **1**	…are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2 3 4**	. are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5 6 7**	. . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8 9 10**
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	… are not done (in this site) **1**	…are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	... do not exist **1**	. . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	.Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**
5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2 3 4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5 6 7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8 9 10**
6. Communication with patients about integrated care	. . . does not occur **1**	. . . occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style **2 3 4**	. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/ family cultures and learning styles is frequent **5 6 7**	. . .is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in *how* to communicate with patients about integrated care **8 9 10**
7. Follow-up of assessments, tests, treatment, referrals and other services	. . . is done at the initiative of the patient/family members **1**	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up **2 3 4**	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments **5 6 7**	. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments **8 9 10**

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

8. Social support (for patients to implement recommended treatment)	. . . is not addressed **1**	. is discussed in general terms, not based on an assessment of patient's individual needs or resources **2 3** **2 3 4**	. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs **5 6 7**	. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources **8 9 10**
9. Linking to Community Resources	. . . does not occur **1**	. . . is limited to a list or pamphlet of contact information for relevant resources **2 3 4**	. . . occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral **5 6** **5 6 7**	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients **8 9 10**

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	**Levels**			
1. Organizational leadership for integrated care	. . . does not exist or shows little interest **1**	. . . is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care **2 3 4**	. . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) **5 6 7**	. . . strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models **8 9 10**
2. Patient care team for implementing integrated care	. . . does not exist **1**	. . . exists but has little cohesiveness among team members; not central to care delivery **2 3 4**	. . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills **5 6 7**	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled **8 9 10**

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

3. Providers' engagement with integrated care ("buy-in")	. . . is minimal **1**	. . . engaged some of the time, but some providers not enthusiastic about integrated care **2 3 4**	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components **5 6 7**	. . . all or nearly all providers are enthusiastically implementing all components of your site's integrated care **8 9 10**
4. Continuity of care between primary care and behavioral/mental health	. . . does not exist **1**	. . . is not always assured; patients with multiple needs are responsible for their own coordination and follow-up **2 3 4**	. . . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only **5 6 7**	. . . systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained **8 9 10**
5. Coordination of referrals and specialists	…does not exist **1**	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team **2 3 4**	. . occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care **5 6 7**	. . . is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement **8 9 10**
6. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2 3 4**	. . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5 6 7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8 9 10**

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

CITIZENS HEALTH INITIATIVE

7. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2 3 4**	. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate **5 6 7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8 9 10**
8. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic **2 3 4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5 6 7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8 9 10**
9. Funding sources/resources	. . . no shared resource streams **1**	. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/ agencies **2 3 4**	. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training **5 6 7**	. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly **8 9 10**

Copyright © 2016 University of New Hampshire. All rights reserved.
Institute for Health Policy & Practice

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

Implementation Plan

The IDN has been meeting since late summer 2016 with its Clinical Governance Committee to determine the needs and assets for the Greater Nashua region. Much of the information received through conversations among the IDN Member Entities was that there were gaps in communication and information sharing among providers, with a lack of understanding of what resources exist in the region to support the IDN's attributed population and its behavioral health conditions. The opportunity that exists to work together as part of the DSRIP demonstration, offers a unique prospect to the region. It allows the IDN Member Entities to collaborate to transform the health care delivery system for mental illness and substance use disorder for patients and individuals at risk for these diseases through leveraging the existing resources/assets. These assets include:

Hundreds of front-line providers (physicians, mental health clinicians, substance use treatment providers) as well as numerous social service support organizations who can support the continuum of care:

DSRIP funding will enable the IDN to build the capacity of this workforce through:

- Recruitment, hiring, training and retaining those who will be working directly with patients to change the system will help reduce gaps in care as well as enable smooth transitions between care settings.
- Integrating physical and mental health with substance use treatment, while addressing the "whole person" through conducting universal screening and assessments.
- Incorporating social service organizations who can provide resources to address the social determinants of health.

Initial efforts to integrate and coordinate care for patients in the region among some of the providers (through FQHCs, embedded care coordinators in practices, and some use of Community Health Workers):

DSRIP funding will enable the IDN to build upon what has been started, through:

- Contracting with outside IT vendors to build platforms for electronic Shared Care Plans, Event Notification Services, Direct Secure Messaging, and data aggregation to allow for understanding the needs of our attributed population, coordinating referrals through closed loops, and ensuring that information about the patient's health is shared/available in a timely and easily accessible format.
- Conducting baseline Site Self-Assessments (SSAs) for each practice, for both the practice as well as the IDN, to understand where they perceive their level of integration to currently be, as well as set goals for where they can be with respect to integration.
- Supporting providers (through IDN Admin Lead Staff and Work Teams, as well as through outside training opportunities) to build multi-disciplinary core teams encompassing physicians, psychiatric providers (psychiatrist/psychiatric APRN), behavioral health coordinator/specialists, and care manager/coordinators, who will be trained to understand:
    - their role in care coordination and information sharing
    - how physical health intersects with behavioral health and
    - how case management for patients with significant behavioral health or chronic conditions can improve health outcomes.

Milestones

A. Identify Comprehensive Core Standardized Assessment and screening tools applicable to adults, adolescents and children

The IDN conducted work sessions with Member Entities in February 2017 using a focus group format, then engaged in some in-person interviews. We determined through these conversations that many providers and social service agencies providing community-based supports were completing some form of screening and/or assessment, as well as compiling patient information that would be helpful to the IDN and potential care transition team members moving forward.

Some of information that we learned was that the domains identified in the Comprehensive Core Standardized Assessment (CCSA) were captured through stand-alone screening or assessment tools, while other domains were captured on patient intake forms or through case notes as the patient continues interacting with the provider. We compiled as many of the tools and forms as we could, both through requests of the organizations and through secondary searches of websites.

The *CSA and Universal Screenings Work Team* determined that we had compiled enough information to be able to assess whether or not there was evidence that each domain was covered for each IDN practice.

The Work Team plans to engage with the *Provider Integrated Practice Designation*, *Information Sharing and Standardized Workflow Protocols*, as well as the *Provider Workforce Training* Work Teams to engage with the practices going through each of the three waves of B1 (Wave 1: Fall 2017; Wave 2: Spring 2018; Wave 3: Summer 2018) outlined in attachment_B1.1b (*List of Completed Baseline SSAs by Practice)*. This will include:

- Providing training to increase their understanding about the importance of annual universal screening
- Providing training for universal screening tools, including PHQ 2 & 9, SBIRT, Developmental Screening for Pediatrics (ASQ:3 and/or ASQ SE)
- Incorporating assessment process as the basis for the individualized care plan used by the care team to guide the treatment and management of the target population
- Developing workflows and protocols for referrals based upon positive screening results (see Milestone D below)

This rich dialogue and sharing of strategies so far has allowed our IDN members to start to strategize about innovative ways that might work to transition, refer and treat the target population, which we know will contribute to the continued development and implementation of strategies within all of our projects across the region.

B. Develop Shared Care Plan for treatment and follow-up of both behavioral and physical health to appropriate medical, behavioral health, community and social services

Development of the Shared Care Plan (SCP) is underway. The IDN has determined it will contract with upon DHHS approval of the implementation plans, who will support the development of the platform for SCP. The *HIT Infrastructure to Support Integration* and the *Information Sharing and Standardized Workflow Protocols Work Teams* will collaborate with the Clinical Governance Committee and in next steps, which include:

- Within 1-2 weeks of contract signing:
  - IDN sharing with which providers will be on the SCP network, with providing an email intro to each provider
  - Completing the Provider milestones/steps:
    - Viewing video demo of (SCP platform)
    - Setting up Q & A meeting with
    - Setting up eligibility file discussion
    - Completing on-boarding packet
    - Training users on Primary
- Within 3-6 weeks of contract signing:
  - Completing the IT milestones/steps, which include:
    - VPN connectivity
    - ADT feed/messages—receive ADT feed from both IDN hospitals (SNHMC and St. Joseph Hospital)
    - Obtain patient historical file—12 to 24 months of patient enrollment and encounter data prior to going live
    - Notification return type – determine with hospitals which return type they prefer for notification (print or electronic)
  - Completing the Clinical milestones/steps, which include:
    - Determining the clinical workflow between providers
    - Determining the provision of users for the SCP and level of access
    - Training providers
    - Training users

SCP Template Development

The IDN expects to collaborate with other IDNs around the state as we determine the template for the SCP. The SCP platform allows for a dashboard function that provides real-time charts and graphs on recent ED visit activity, notifications, facility groups and other statistics that will be useful in care coordination, as well as intake, treatment, management and referral workflows.

We have initially determined the following information will be standard in the SCP:

- CCDA info:
  - Patient demographics
  - Health Insurance provider
  - Problem/condition
  - Allergies/drug sensitivities
  - Medications
  - Immunizations
  - Vital signs
  - Results
  - Encounters
  - Procedures
  - Social history

- Care team members
- Assessment and plan of treatment
- Goals
- Health Concerns

Other information that we are contemplating inclusion in the SCP includes:

- Housing security
- Food security
- Domestic violence
- Transportation
- Care coordination instructions
- Pain management/contract

We plan to work throughout the fall 2017 to finalize the standard information that will be included in the SCP for our region, with the target of December 31, 2017 for completion.

The SCP platform allows for patients to view their detailed demographic and clinical data through the web-portal, which will provide an excellent collaborative tool for all case managers/care coordinators, behavioral health clinicians, and other front-line providers to use in their treatment plans with patients. All of the community-driven projects will utilize this technology, once it is up and running.

C. Identify protocols for patient assessment, treatment and management

Identification of protocols for patient assessment, treatment and management will be developed in conjunction with the Information Sharing/Standardized Workflow Work Team addressed once the IDN work teams (Provider Integrated Practice Designation, Information Sharing/Standardized Workflow, and Patient Privacy and Consent) have come together to finalize their goals and strategies with the first wave of B1 practices.

The DSRIP Practice Integration Manager (once hired) and the DSRIP Quality Improvement Manager (once hired) will be instrumental in securing these agreements with the participating providers and organizations. It is expected that these agreements will be secured no later than September 30, 2017.

D. Identify/develop referral protocols, including to those to/from PCPs, BH providers, social service support providers, hospitals and EDs

Identification and/or development of referral protocols to and from providers, hospitals and EDs has begun through the work of the *Patient Privacy and Consent Work Team.* Since there will be vulnerable patients who have been or may be diagnosed with Substance Use Disorders (SUDs), it has been important for this work team to think through the patient flow across providers with the IDN for the projects and their strategies.

This work will continue in August and September 2017, with the goal of developing an IDN Patient Consent packet, which will contain background information about the goals of the IDN and its member providers, the patient's rights, applicable privacy, consent and disclosure forms, and contact information for the IDN's Compliance Officer. The work group will bring together IDN provider entities, including their

Compliance Officer and a clinician (preferably someone serving on one of the IDN Governance Committees or who is familiar with the IDN's goals) to determine the protocol and workflow for this IDN Patient Consent packet, allowing for discussion and concerns. This meeting will be held in August or September 2017, depending upon availability of invitees.

The *Information Sharing and Standardized Workflow Protocols Work Team and Provider Integrated Practice Designation Work Team* will have already been working on universal screening workflows and protocols, so the next logical step would be to focus on what happens with positive screens and the need for patient referrals.

E. Develop core team meeting/communication plan and relevant workflows for communication among core care team and other patient providers, including case conferences

Development of core team meeting/communication plan and relevant protocols for communication across the providers will be the focus of the training being planned by the *Provider Workforce Training Work Team,* as well as the work of the *Information Sharing and Standardized Workflow Protocols and Provider Integrated Practice Designation Work Teams*.

As outlined in attachment_B1.8e (Case Conference Schedule), the IDN plans to pilot two cross-IDN multi-disciplinary core teams in 2018 around our community-driven projects, starting with C1: Critical Time Intervention (CTI). Training for the CTI team will occur in November and December 2017 with , with the expectation that the team begins accepting patients soon after the training ends. The IDN plans to begin piloting the core team case management structure in January 2018 and after the training of Integrated Dual Diagnosis Treatment (IDDT) team members in December, plans to add a second core team around that program, likely by February 2018.

Through piloting the core team case management structure around the CTI and IDDT programs, we expect to engage providers from across the IDN, as well as social service support organizations, who will all work together to address the needs of complex patients in those programs. Starting small with two teams will also allow the IDN to develop its HIT infrastructure, which will support the Event Notification Service (ENS) and Shared Care Plan (SCP) and begin utilizing its Direct Secure Messaging (DSM) vendor to communicate securely.

The work of the *Privacy and Consent Work Team* will finalize its work to ensure a standardized protocol for patients to garner consent for these case management meetings and training will be occurring to support the pilot case management process, as well as the use of the communication and information sharing workflows and protocols.

The DSRIP Project Manager and Quality Manager (expected to be hired by November 2017) will be also be instrumental in supporting this work in collaboration with the DSRIP Data Manager and Program Director.

F. Develop written roles and responsibilities for core team members and other members, as needed

Development of written roles and responsibilities for core team will be the focus of the training being planned by the *Provider Workforce Training Work Team,* as well as the work of the *Information Sharing and Standardized Workflow Protocols and Provider Integrated Practice Designation Work Teams*.

As each wave of practices works with the DSRIP Project Manager and Quality Manager to set goals and strategies and completes their training, the core team structure, as well as the sharing of what we've learned about roles and responsibilities of team members will broaden to practices where there are concentrations of patients with complex needs. It is also expected that the 5 practices moving toward Integrated Care Designation will be forming their own core teams, which will allow for a broader base of learning about the value of supporting not only complex patients, but also providers across the IDN.

The DSRIP Practice Integration Manager (once hired) and the DSRIP Quality Improvement Manager (once hired) will be instrumental in supporting this work.

G. Identify training plan for each member of the core team and extended team as needed

The IDN has numerous training plans already outlined with contracts pending upon approval of the implementation plans by DHHS. We have worked with our IDN Member Entities to identify the roles in each practice (attachment_B1.8b) to support our thinking for how the waves of training will occur across the region.

The training will include team-based training specific to the Critical Time Intervention (CTI) and Integrated Dual Diagnosis Treatment (IDDT) projects, as outlined below:

1. Critical Time Intervention (CTI) through to train the CTI staff housed under Greater Nashua Mental Health Center.
   - Staff trained include the CTI Supervisor/Coordinator and 2.5 FTEs CTI Specialists (Case Managers) for Project C1.
   - It is expected that at least one individual from the IDN Administrative Lead team and one from the Clinical Governance Committee will also attend the trainings.

These trainings will be provided to the CTI Team, an extended team for B1, to provide intensive case management for IDN attributed patients with Serious Mental Illness (SMI) transitioning from NH Hospital or one of the IDN's Emergency Departments (Southern NH Medical Center or St. Joseph Hospital).

- CTI Staff training: 2 days in November 2017 and again in late Spring 2018 CTI staff hired after the October training.
- CTI Supervisor training: 2 days in December 2017 and again in late Spring 2018.
- Once a month Community of Practice meetings (2 hours via phone/webinar) for 12 months to talk through practical applications of the CTI model
- Quarterly Community of Practice meetings (3 hours in person) over 12 months to work together and share best practices and learning across the 5 IDNs implementing the CTI model
- CTI Train-the-Trainer trainer: 2 days in August 2018

2. Integrated Dual Diagnosis Treatment (IDDT) through , to train the IDDT multi-disciplinary staff housed under Greater Nashua Mental Health Center for Project E4.
   - Staff trained include the Team Leader/Clinical Director, as well as the Psychiatrist, Nurse, two Case Managers, SUD Therapist and Mental Health Therapist, as well as the sub-contracted Peer Support Specialist (through H.E.A.R.T.S. Peer Support Center).
   - Other team members who will participate in the training include the Supportive Employment Specialist, Criminal Justice Specialist, Housing Specialist and Family Specialist.
   - It is expected that at least one individual from the IDN Administrative Lead team and one from the Clinical Governance Committee will also attend the trainings.

These trainings will be provided to the IDDT Team, an extended team for B1, to provide 'stages of change' treatment for IDN attributed patients with co-occurring Serious Mental Illness (SMI) and Substance Use Disorder (SUD).

- IDDT Staff training: 2.5 days in December 2017, covering an overview of the model and the Engagement and Persuasion stages of treatment
- IDDT Staff training: 2 days in February/March 2018, covering Action and Relapse Prevention stages of treatment
- Once a month meetings (1 -2 hours via phone/webinar) for 12 months to talk through practical, clinical applications of the IDDT model content covered in the training

Additional training will be provided to core team members identified in attachment_B1.8b, as well as in attachments b1.8ci-cvi. Funding was set aside in the A1: Behavioral Health Workforce Capacity Building Budget to support training for the various roles in the core team (physicians, behavioral health providers and assigned care managers/Community Health Workers), but also to build the core competencies of behavioral health providers. These include:

- Universal Screening
- Co-Occurring Disorders
- Care Planning and Care Coordination Models
- Cultural Competency and Adaptation
- Understanding Addiction
- Behavioral Health Core Competencies
    - Interpersonal Communication
    - Collaboration and Teamwork
    - Screening and Assessment
    - Care Planning and Care Coordination
    - Intervention
    - Cultural Competence and Adaptation
    - Systems-Oriented Practice
    - Practice-Based Learning and Quality Improvement
    - Informatics

Non-direct care staff will also engage in training throughout December 2018 and 2019, including the following areas:

- Mental Health First Aid
- Addressing Challenges with Coding
- Cultural Competency

H. Identify training curricula for each member of the core team and extended team, as needed

Examples of training curriculum are available for the following trainings (outlined broadly in attachment_C1.9c and attachment_E4.9b):

1. Critical Time Intervention (CTI) through

2. Integrated Dual Diagnosis Treatment (IDDT) through

We are working with potential training vendors, IDN partners in the Greater Nashua region, as well as in our neighboring IDN regions to determine the appropriate training curriculum for the other trainings. We expect to complete that process no later than January 15, 2018.

I. Develop agreements with participating providers and organizations, including:

- *Referral protocols*
- *Formal arrangements (contract or MOU) with community-based social support service providers*
- *Coverage schedules*
- *Consultant report turnaround time, as appropriate*

Agreements with participating providers and organizations in the IDN related to referral protocols, formal arrangements with community-based social support service providers, coverage schedules and consultant report turnaround time (as appropriate) will be addressed once the IDN work teams (Provider Integrated Practice Designation, Information Sharing/Standardized Workflow, and Patient Privacy and Consent) have come together to finalize their goals and strategies with the first wave of B1 practices.

The DSRIP Project Manager and Quality Improvement Manager (once hired in late 2017) will be instrumental in securing these agreements with the participating providers and organizations. It is expected that these agreements will be secured no later than December 31, 2017.

J. Develop evaluation plan, including metrics that will be used as ongoing impact indicators to provide the IDN with a sense of whether or not they are on the path to improve broader outcome measures that drive payment.

The work teams, in collaboration with the Clinical Governance Committee and the IDN Administrative Lead Team will be finalizing its evaluation plan associated with the B1 project goals and objectives. It is expected that tools and indicators will be developed to help us assess our progress. We plan to complete this process no later than December 31, 2017.

However, we have set some initial goals for our IDN, mostly associated with securing buy-in from the practices in the IDN (through securing the Letter of Agreement) and achieving progress in hiring the needed workforce to accomplish the B1 goals. Our initial targets are outlined in attachment_B1.3:

K. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

Tracking and monitoring of individuals served by the strategies implemented across the IDN will initially be achieved through the use of case management/coordination planning and progress notes through individual patient care plans. Once up and running, the Shared Care Plan platform hosted by will provide for timely information sharing among providers, with the IDN examining other HIT vendors to support additional tools to support case management workflows and triggers.

Adherence to impact measures will be monitored and tracked timely use of the Shared Care Plan, Event Notification Service and data aggregation provided by

Fidelity to evidence-supported project elements will be accomplished by monitoring outcome indicators for each of the strategies, using the prescribed protocols for patient intake assessment, treatment, management, and referral, and tracking improved patient health outcomes achieved.

Expected Challenges and Solutions

We expect to work very quickly over the next several months to address some of the challenges to ensuring success for care transition teams. These include:

- Investing funding and time into the behavioral health workforce, including recruiting and hiring, as well as training and retaining individuals who understand the value of integrated care and are working in a workplace that supports this coordinated approach
- Developing and implementing intake procedures, treatment planning, and referral protocols that systematically solicit patient consent to confidentially share information among providers through educating the patient as well as the providers and social service support organizations serving the patient
- Integrating electronic health records (or at least shared care plans) across service providers who touch the attributed patients in our IDN
- Investing in enhanced technology and shared record-keeping to ensure systematic information sharing and communication for care coordination across the multi-disciplinary teams being formed in practices across the IDN as part of the B1 Integrated Health project
- Participating in monthly case management meetings for those patients with significant behavioral health or chronic conditions that include all of their providers and social service support team members.

Status	Task Name	Duration	Start Date	End Date
DONE	Develop Implementation Plan	988d	03/21/17	12/31/20
DONE	Develop Implementation Timeline	893d	08/01/17	12/31/20
	Coordinated Care Practice designation	370d	08/01/17	12/31/18
	Wave 1	174d	08/01/17	03/30/18
	Dartmouth Hitchcock Nashua	174d	08/01/17	03/30/18
	Family Medicine	174d	08/01/17	03/30/18
	Internal Medicine	174d	08/01/17	03/30/18
	Foundation Medical Partners	174d	08/01/17	03/30/18
	Foundation Medical Partners, Primary Care of Milford	174d	08/01/17	03/30/18
	Foundation Medical Partners, Family Practice of Merrimack	174d	08/01/17	03/30/18
	Foundation Medical Partners, Primary Care of Hudson	174d	08/01/17	03/30/18
	Foundation Medical Partners, Family Practice of South Nashua	174d	08/01/17	03/30/18
	Foundation Medical Partners, Amherst Family Practice	174d	08/01/17	03/30/18
	Foundation Medical Partners, Nashua Primary Care	174d	08/01/17	03/30/18
	Foundation Medical Partners, Foundation Internal Medicine	174d	08/01/17	03/30/18
	Merrimack River Medical Services (Health Care Resource Centers)	174d	08/01/17	03/30/18
	St. Joseph Hospital Primary Care Practice Network and Greater Nashua Mental Health Center	174d	08/01/17	03/30/18
	St. Joseph Hospital Pediatrics Nashua	174d	08/01/17	03/30/18
	St. Joseph Hospital Pediatrics Milford	174d	08/01/17	03/30/18
	St. Joseph Hospital Pediatrics Sky Meadow	174d	08/01/17	03/30/18
	Wave 2	196d	04/02/18	12/31/18
	Dartmouth Hitchcock Nashua	196d	04/02/18	12/31/18
	Hudson	196d	04/02/18	12/31/18
	Merrimack	196d	04/02/18	12/31/18
	Milford	196d	04/02/18	12/31/18
	Obstetrics and Gynecology	196d	04/02/18	12/31/18
	Foundation Medical Partners	196d	04/02/18	12/31/18
	Foundation Medical Partners, Foundation OB/GYN	196d	04/02/18	12/31/18
	Foundation Medical Partners, Nashua Center for Healthy Adults	196d	04/02/18	12/31/18
	Foundation Medical Partners, Women's Care of Nashua	196d	04/02/18	12/31/18
	Foundation Medical Partners, Downtown Medical Associates	196d	04/02/18	12/31/18
	Foundation Medical Partners, Pepperell Family Practice	196d	04/02/18	12/31/18
	St. Joseph Hospital Primary Care Practice Network and Greater Nashua Mental Health Center	196d	04/02/18	12/31/18
	St. Joseph Hospital OB/GYN Merrimack	196d	04/02/18	12/31/18
	St. Joseph Hospital Family Medicine Nashua	196d	04/02/18	12/31/18
	St. Joseph Hospital Internal Medicine	196d	04/02/18	12/31/18
	St. Joseph Hospital Family Medicine & Specialty Services Milford	196d	04/02/18	12/31/18
	St. Joseph Hospital Family Medicine & Specialty Services Hudson	196d	04/02/18	12/31/18
	Wave 3	126d	07/09/18	12/31/18
	Dartmouth Hitchcock Nashua	126d	07/09/18	12/31/18
	Pediatrics	126d	07/09/18	12/31/18
	Norris Cotton Cancer Center	126d	07/09/18	12/31/18
	Foundation Medical Partners	126d	07/09/18	12/31/18
	Foundation Medical Partners, NE GYN & Surgical Services	126d	07/09/18	12/31/18
	Foundation Medical Partners, Southern New Hampshire Health System at Pelham	126d	07/09/18	12/31/18
	Foundation Medical Partners, Nashua West Adult Medicine	126d	07/09/18	12/31/18
	Foundation Medical Partners, Internal Medicine Associates of Nashua	126d	07/09/18	12/31/18
	Foundation Medical Partners, Foundation Community Care	126d	07/09/18	12/31/18
	St. Joseph Hospital Primary Care Practice Network and Greater Nashua Mental Health Center	126d	07/09/18	12/31/18
	St. Joseph Hospital Adult Medicine	126d	07/09/18	12/31/18
	St. Joseph Hospital Family Medicine & Specialty Services Merrimack	126d	07/09/18	12/31/18
	St. Joseph Hospital Family Medicine Nashua South	126d	07/09/18	12/31/18
	St. Joseph Hospital Midwifery	126d	07/09/18	12/31/18

Status	Task Name	Duration	Start Date	End Date
	St. Joseph Hospital OB/GYN Hudson	126d	07/09/18	12/31/18
	Integrated Care Practice designation	893d	08/01/17	12/31/20
	Foundation Medical Partners (FMP) Pediatrics Pilot	893d	08/01/17	12/31/20
	FMP: Foundation Pediatrics	893d	08/01/17	12/31/20
	FMP: Medicine-Pediatrics of Nashua	893d	08/01/17	12/31/20
	FMP: Pediatrics & Adolescent Medicine	893d	08/01/17	12/31/20
	GNMHC and Lamprey Health Co-Located Pilot	893d	08/01/17	12/31/20
	Greater Nashua Mental Health Center	893d	08/01/17	12/31/20
	Lamprey Health	893d	08/01/17	12/31/20
DONE	Complete Project Budget	17d	07/07/17	07/31/17
DONE	Review with Clinical Committee to get their approval and recommendations to Finance and Executive Committees	17d	07/07/17	07/31/17
DONE	Review with Finance Committee to get their approval and recommendations to Executive Committee for final approval	16d	07/10/17	07/31/17
DONE	Review with Executive Committee and engage in discussion/feedback for final draft plan for submission	16d	07/10/17	07/31/17
DONE	Executive Committee signs off on plan	16d	07/10/17	07/31/17
DONE	Outline Workforce Staffing Plan	74d	03/21/17	06/30/17
DONE	Identify staffing needs for practices to achieve Coordinated Care Practice and move toward Integrated Care Practice designation	74d	03/21/17	06/30/17
DONE	Assess existing workforce as well as workforce needs for multi-disciplinary core team members across IDN practices	74d	03/21/17	06/30/17
DONE	Identify recruitment strategies for workforce needs	74d	03/21/17	06/30/17
DONE	Identify retention strategies for current and new workforce	74d	03/21/17	06/30/17
DONE	Identify Key Organizational/Provider Participants	152d	06/01/17	12/29/17
	Secure signed Letters of Agreement from IDN Practice Managers	152d	06/01/17	12/29/17
DONE	Secure Organizational Leadership Sign-Off	1d	07/27/17	07/27/17
	Executive Committee approves implementation plans	1d	07/27/17	07/27/17
	Demonstrate Progress Along SAMHSA Framework for Integrated Levels of Care	1022d	02/01/17	12/31/20
	Identify/Develop Comprehensive Core Standardized Assessment and screening tools applicable to adults, adolescents and children	498d	02/01/17	12/28/18
DONE	Gap analysis of assessment and screening tools used by partners	18d	02/01/17	02/24/17
DONE	Work sessions with partners	18d	02/01/17	02/24/17
DONE	Interviews with partners	18d	02/01/17	02/24/17
DONE	Identification of workflows where existing assessments and screenings are utilized	18d	02/01/17	02/24/17
DONE	Form IDN 3 CSA Work Team	186d	04/14/17	12/29/17
DONE	Gateways Community Services	186d	04/14/17	12/29/17
DONE	The Youth Council	186d	04/14/17	12/29/17
DONE	Dartmouth Hitchcock Nashua	186d	04/14/17	12/29/17
DONE	H.E.A.R.T.S. Peer Support Center	186d	04/14/17	12/29/17
DONE	NAMI NH	186d	04/14/17	12/29/17
DONE	Southern NH Health	186d	04/14/17	12/29/17
DONE	Greater Nashua Mental Health Center	186d	04/14/17	12/29/17
	Engage with IDN practices in waves to train and support incorporating universal screening into shared care planning workflows and protocols	369d	08/01/17	12/28/18
	Wave 1	195d	08/01/17	04/30/18
	Provide training to a minimum of 8 physical health providers across IDN practices to increase understanding of universal screening and use of screening tools	174d	08/01/17	03/30/18
	Provide training to a minimum of 10 behavioral health providers across IDN practices to increase understanding of universal screening and use of screening tools	174d	08/01/17	03/30/18
	Provide training to a minimum of 4 care managers or Community Health Workers (CHWs) across IDN practices to increase understanding of universal screening and use of screening tools	174d	08/01/17	03/30/18
	Incorporate screening and assessment process into individualized care plan used by care team to guide treatment and management of the target population	195d	08/01/17	04/30/18

Status	Task Name	Duration	Start Date	End Date
	Develop workflows and protocols for referrals based upon positive screening results	195d	08/01/17	04/30/18
	Wave 2	175d	12/08/17	08/09/18
	Provide training to a minimum of 8 health providers across practices to increase understanding of universal screening and use of screening tools	146d	12/18/17	07/09/18
	Provide training to a minimum of 5 behavioral health providers across IDN practices to increase understanding of universal screening and use of screening tools	146d	12/18/17	07/09/18
	Provide training to a minimum of 4 care managers or Community Health Workers (CHWs) across IDN practices to increase understanding of universal screening and use of screening tools	146d	12/18/17	07/09/18
	Incorporate screening and assessment process into individualized care plan used by care team to guide treatment and management of the target population	170d	12/15/17	08/09/18
	Develop workflows and protocols for referrals based upon positive screening results	175d	12/08/17	08/09/18
	Wave 3	251d	01/12/18	12/28/18
	Provide training to a minimum of 11 physical health provider practices to increase understanding of universal screening and use of screening tools	229d	01/12/18	11/28/18
	Provide training to a minimum of 5 behavioral health providers across IDN practices to increase understanding of universal screening and use of screening tools	229d	01/12/18	11/28/18
	Provide training to a minimum of 2 care managers or Community Health Workers (CHWs) across IDN practices to increase understanding of universal screening and use of screening tools	229d	01/12/18	11/28/18
	Incorporate screening and assessment process into individualized care plan used by care team to guide treatment and management of the target population	246d	01/19/18	12/28/18
	Develop workflows and protocols for referrals based upon positive screening results	251d	01/12/18	12/28/18
	Identify/Develop Shared Care Plan (SCP) development and implementation	236d	03/20/17	02/12/18
DONE	Identification of SCP platform IT vendor	75d	03/20/17	06/30/17
DONE	Identification of clinical workflow between providers	66d	08/01/17	10/31/17
	Identification of users of SCP and level of access	66d	08/01/17	10/31/17
	Development of SCP template with	54d	09/05/17	11/17/17
	IDN Clinical and IT/Data Committee members work with and to develop template model	29d	09/05/17	10/13/17
	IDN Clinical Committee approves SCP template	25d	10/16/17	11/17/17
	Train providers and users in use of SCP template	31d	01/01/18	02/12/18
	Development of process for incorporating SCP into selected partners workflow	42d	12/01/17	01/29/18
	Identification of process for compiling patient screening and assessment results into patient goals in SCP	42d	12/01/17	01/29/18
	Identify/Develop protocols for patient assessment, treatment, management	230d	03/20/17	02/02/18
	IDN Clinical Committee works with providers and other care team members to create protocols, which include the use of HIT platforms to assess, treat and manage patients	230d	03/20/17	02/02/18
	Event Notification Service (ENS) development and implementation	205d	03/20/17	12/29/17
DONE	Identification of ENS platform IT vendor (	75d	03/20/17	06/30/17
	Identification of subscribers for clinical workflow between providers (senders and receivers)	66d	08/01/17	10/31/17
	Identify care plan elements	66d	08/01/17	10/31/17
	Development of ENS care plan template with	54d	09/05/17	11/17/17
	IDN Clinical and IT/Data Committee members work with and to develop template model	29d	09/05/17	10/13/17
	IDN Clinical Committee approves ENS care plan template	25d	10/16/17	11/17/17
	Train providers and users in use of ENS care plan template	31d	11/17/17	12/29/17
	Direct Secure Messaging (DSM) development and implementation	227d	03/20/17	01/30/18
DONE	Identification of DSM platform IT vendor (	75d	03/20/17	06/30/17

B1 Integrated Health Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Identification of clinical workflow between providers (senders and receivers)	66d	08/01/17	10/31/17
	Train providers and users in use of DSM	21d	01/02/18	01/30/18
	Shared Care Plan development and implementation	226d	03/20/17	01/29/18
DONE	Identification of SCP platform IT vendor (	75d	03/20/17	06/30/17
	Development of SCP template	54d	09/05/17	11/17/17
	Identification of clinical workflow for PHI	42d	12/01/17	01/29/18
	Identification of process for compiling patient screening and assessment results into patient goals in SCP	42d	12/01/17	01/29/18
	Discrete Electronic Data Capture and Query Based Exchange implementation	109d	08/01/17	12/29/17
	Identification of HIT technology (or similar vendor)	109d	08/01/17	12/29/17
	Data Aggregator/Warehouse development and implementation	230d	03/20/17	02/02/18
DONE	Identification of Data Aggregator/Warehouse platform IT vendor ( )	119d	03/20/17	08/31/17
	IDN meeting with key HIT providers who will provide PHI	36d	09/01/17	10/20/17
	Development of reporting template with for IDN Member Entities	87d	07/03/17	10/31/17
	Train providers and users in use of reporting template	112d	08/31/17	02/02/18
	Identify/Develop patient referral protocols including to those to/from PCPs, BH providers, social service support providers, hospitals and EDs	979d	04/03/17	12/31/20
DONE	Educate IDN and Admin Lead team about patient privacy, consent and especially 42 CFR Part 2	195d	04/03/17	12/29/17
DONE	Sign contract with for TA and Privacy Boot Camp sessions	35d	04/03/17	05/19/17
DONE	Form IDN 3 Privacy Work Team	175d	05/01/17	12/29/17
DONE	Lamprey Health	175d	05/01/17	12/29/17
DONE	Greater Nashua Mental Health Center	175d	05/01/17	12/29/17
DONE	Harbor Homes	175d	05/01/17	12/29/17
DONE	Keystone Hall	175d	05/01/17	12/29/17
DONE	Southern NH Health	175d	05/01/17	12/29/17
DONE	H.E.A.R.T.S. Peer Support Center	175d	05/01/17	12/29/17
DONE	Merrimack River Medical Services	175d	05/01/17	12/29/17
DONE	St. Joseph Hospital	175d	05/01/17	12/29/17
DONE	Attend Boot Camp Sessions	40d	05/23/17	07/17/17
DONE	May 23, 2017 Webinar	40d	05/23/17	07/17/17
DONE	June 6, 2017 In person	40d	05/23/17	07/17/17
DONE	June 29, 2017 In person	40d	05/23/17	07/17/17
DONE	July 17, 2017 In person	40d	05/23/17	07/17/17
DONE	Participating partners workflows and protocols created/implemented	56d	05/01/17	07/17/17
DONE	Work through patient provider flow cases in Privacy Boot Camp sessions	56d	05/01/17	07/17/17
	Develop patient packet addressing privacy and consent for IDN	76d	07/17/17	10/30/17
	Bring together key provider partners as well as their compliance officers to finalize packet	76d	07/17/17	10/30/17
	Use of (or similar vendor) as e-referral HIT platform	216d	09/01/17	06/29/18
	Sign contract with (or similar vendor)	46d	09/01/17	11/03/17
	Develop workflows for referrals between providers for attributed population	46d	09/01/17	11/03/17
	Training for care coordinators/case managers	130d	01/01/18	06/29/18
	Develop protocols for using e-referral platform or inputting referral information into Shared Care Plan	870d	09/01/17	12/31/20
	Support care coordinators/case managers to ensure patient follow-through to referral, working toward closed loop e-referral	870d	09/01/17	12/31/20
	Identify/Develop multi-disciplinary care teams across IDN practices	260d	04/03/17	03/30/18
	IDN Member Entities respond to IDN A1 and B1 RFP to identify gaps and needs for team members	45d	04/03/17	06/02/17
	Team members are identified in implementation plans, including proposed budgets for approval by IDN Governance Committees	45d	04/03/17	06/02/17
	Written roles and responsibilities for core team members are identified/developed	175d	05/01/17	12/29/17

Status	Task Name	Duration	Start Date	End Date
	Care Manager/Community Health Worker roles defined	175d	05/01/17	12/29/17
	Behavioral Health Specialist/Coordinator roles defined	175d	05/01/17	12/29/17
	Training plan for each member of core team and extended team identified/developed, as needed	65d	07/03/17	09/29/17
	Physical health team member training plan developed	65d	07/03/17	09/29/17
	Behavioral health team member training developed	65d	07/03/17	09/29/17
	Front desk/billing staff team member training developed	65d	07/03/17	09/29/17
	Training curricula for each member of the core team and extended team identified/developed, as needed	89d	07/03/17	11/02/17
	Physical health team member training provider (and curricula) identified/developed	89d	07/03/17	11/02/17
	Behavioral health team member training provider (and curricula) identified/developed	89d	07/03/17	11/02/17
	Front desk/billing staff team member training provider (and curricula) identified/developed	89d	07/03/17	11/02/17
	Agreements with participating providers and organizations received	260d	04/03/17	03/30/18
	Referral protocols	260d	04/03/17	03/30/18
	Formal arrangements (Contract or MOU) with community-based social service providers	260d	04/03/17	03/30/18
	Coverage schedules	260d	04/03/17	03/30/18
	Consultant report turnaround time, as appropriate	260d	04/03/17	03/30/18
	Evaluation plan developed, including metrics to be used as ongoing impact indicators to provide a sense of whether or not the IDN is on the path to improve broader outcome measures that drive payment	914d	07/03/17	12/31/20
	Adoption of Coordinated Care Practice designation strategies	391d	07/03/17	12/31/18
	Use of Comprehensive Core Standardized Assessment process/universal screening	391d	07/03/17	12/31/18
	Use of Shared Care Plan	391d	07/03/17	12/31/18
	Use of documented workflow for information sharing	391d	07/03/17	12/31/18
	Use of IDN monthly case conferences for complex patients	391d	07/03/17	12/31/18
	Protocols for assessment, treatment, and management created	391d	07/03/17	12/31/18
	Use and tracking of documented workflows, including protocols for information sharing	391d	07/03/17	12/31/18
	Protocols developed and tracked for safe care transitions from institutional settings to primary care, behavioral health and social support service providers	391d	07/03/17	12/31/18
	Protocols developed and tracked for intake procedures that systematically track patient consent among providers	391d	07/03/17	12/31/18
	Adoption of Integrated Care Practice designation strategies	914d	07/03/17	12/31/20
	Medication-assisted treatment (MAT) in both primary care and specialty care settings	914d	07/03/17	12/31/20
	Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., through use of the IMPACT or other evidence-supported model)	914d	07/03/17	12/31/20
	"Use of Technology" implemented	914d	07/03/17	12/31/20
	Use of Event Notification Service, Shared Care Plan and other HIT platforms to ensure information sharing	914d	07/03/17	12/31/20
	Documented workflows, joint service protocols and communication channels with community based social support service providers implemented	914d	07/03/17	12/31/20
	Mechanisms (e.g., registries) developed/implemented to track and monitor individuals served by the program, adherence, impact measures, and fidelity to integration framework	805d	12/01/17	12/31/20
	Will utilize the HIT tools, including the Event Notification Service (ENS), Shared Care Plan (SCP), and data aggregator to create processes for tracking attributed patients with interventions	805d	12/01/17	12/31/20
	Operationalization of Program	518d	07/05/17	06/28/19
	Implementation of workforce plan	389d	07/05/17	12/31/18
	IDN 3 Website created	48d	07/05/17	09/08/17
	Contract with signed	42d	07/05/17	08/31/17
	Work sessions held with SNHH Marketing Team and	42d	07/05/17	08/31/17
	Community Engagement Committee reviews site	6d	09/01/17	09/08/17
	IDN 3 Career Fair conducted to broadly recruit workforce	370d	08/01/17	12/31/18

Status	Task Name	Duration	Start Date	End Date
	Contract with signed	29d	08/01/17	09/08/17
	Secure contract with Crowne Plaza hotel for venue	15d	08/21/17	09/08/17
	Obtain job descriptions from IDN Member Entities to populate Career Board on IDN website	31d	08/14/17	09/25/17
	Secure tables for IDN Member Entities and educational entities	31d	08/14/17	09/25/17
	Conduct media campaign with radio spots, professional association posts, sponsored ads on social media	12d	09/11/17	09/26/17
	Secure RSVPs for Career Fair through landing page on IDN website	12d	09/11/17	09/26/17
	Obtain resumes through Career Board application per job or through RSVPs	12d	09/11/17	09/26/17
	Career Fair held	1d	09/26/17	09/26/17
	Workforce positions filled	347d	09/01/17	12/31/18
	Deployment of training plan	499d	08/01/17	06/28/19
	Multi-disciplinary Core Team Trainings (includes physical health providers, behavioral health providers and care managers/CHWs)	370d	08/01/17	12/31/18
	Wave One	262d	08/01/17	08/01/18
	Co-Occurring Disorders	174d	08/01/17	03/30/18
	Universal Screening	174d	08/01/17	03/30/18
	Care Planning and Care Coordination	174d	08/01/17	03/30/18
	Cultural Competence and Adaptation	174d	08/01/17	03/30/18
	Understanding Addiction	1d	08/01/18	08/01/18
	Wave Two	140d	12/18/17	06/29/18
	Co-Occurring Disorders	65d	04/02/18	06/29/18
	Universal Screening	140d	12/18/17	06/29/18
	Care Planning and Care Coordination	65d	04/02/18	06/29/18
	Cultural Competence and Adaptation	65d	04/02/18	06/29/18
	Understanding Addiction	65d	04/02/18	06/29/18
	Wave Three	252d	01/12/18	12/31/18
	Co-Occurring Disorders	126d	07/09/18	12/31/18
	Universal Screening	252d	01/12/18	12/31/18
	Care Planning and Care Coordination	126d	07/09/18	12/31/18
	Cultural Competence and Adaptation	126d	07/09/18	12/31/18
	Understanding Addiction	126d	07/09/18	12/31/18
	Front desk/billing staff team member training implemented	370d	08/01/17	12/31/18
	Wave One	174d	08/01/17	03/30/18
	Mental Health First Aid	174d	08/01/17	03/30/18
	Addressing Challenges with Coding	174d	08/01/17	03/30/18
	Cultural Competency	174d	08/01/17	03/30/18
	Wave Two	145d	12/18/17	07/06/18
	Mental Health First Aid	145d	12/18/17	07/06/18
	Addressing Challenges with Coding	145d	12/18/17	07/06/18
	Cultural Competency	145d	12/18/17	07/06/18
	Wave Three	252d	01/12/18	12/31/18
	Mental Health First Aid	252d	01/12/18	12/31/18
	Addressing Challenges with Coding	252d	01/12/18	12/31/18
	Cultural Competency	252d	01/12/18	12/31/18
	Behavioral Integration Core Competencies	499d	08/01/17	06/28/19
	Interpersonal Communication	499d	08/01/17	06/28/19
	Collaboration and Teamwork	499d	08/01/17	06/28/19
	Screening and Assessment	499d	08/01/17	06/28/19
	Care Planning and Care Coordination	499d	08/01/17	06/28/19
	Intervention	499d	08/01/17	06/28/19
	Cultural Competence and Adaptation	499d	08/01/17	06/28/19
	Systems-Oriented Practice	499d	08/01/17	06/28/19
	Practice-Based Learning & Quality Improvement	499d	08/01/17	06/28/19
	Informatics	499d	08/01/17	06/28/19
	Use of annual Comprehensive Core Standardized Assessment	282d	12/01/17	12/31/18
	Use of Shared Care Plan	1d	12/01/17	12/01/17

Status	Task Name	Duration	Start Date	End Date
	Operationalization of core team meeting/communication plan, including case conferences	282d	12/01/17	12/31/18
	Use of EHR, electronic coordinated care management system, or other documented work flow to ensure timely communication of clinical and other information critical to diagnosis, treatment and management of care	1d	12/01/17	12/01/17
	Initiation of Data Reporting	206d	07/01/17	04/13/18
	Report on the number of Medicaid beneficiaries who received Comprehensive Core Standardized Assessment (during reporting period and cumulative) vs. projected	206d	07/01/17	04/13/18
	Report on the number of Medicaid beneficiaries scoring positive on scoring tools	206d	07/01/17	04/13/18
	Report on the number of Medicaid beneficiaries scoring positive on scoring tools and referred for additional intervention	206d	07/01/17	04/13/18
	Report on the number of new staff positions recruited and trained (during reporting period and cumulative) vs. projected	131d	07/01/17	12/29/17
	Report on the impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	131d	07/01/17	12/29/17
	Ongoing Data Reporting	130d	01/01/18	06/29/18
	Report on the number of Medicaid beneficiaries received Comprehensive Core Standardized Assessment (during reporting period and cumulative) vs. projected	130d	01/01/18	06/29/18
	Report on the number of Medicaid beneficiaries scoring positive on scoring tools	130d	01/01/18	06/29/18
	Report on the number of Medicaid beneficiaries scoring positive on scoring tools and referred for additional intervention	130d	01/01/18	06/29/18
	Report on the number of new staff recruited and trained (during reporting period and cumulative) vs. projected	130d	01/01/18	06/29/18
	Report on the new staff vacancy and turnover rate for period and cumulative vs. projected	130d	01/01/18	06/29/18
	Report on the impact measures as defined in evaluation plan	130d	01/01/18	06/29/18
	Ongoing Data Reporting	131d	07/02/18	12/31/18
	Report on the number of Medicaid beneficiaries received Comprehensive Core Standardized Assessment (during reporting period and cumulative) vs. projected	131d	07/02/18	12/31/18
	Report on the number of Medicaid beneficiaries scoring positive on scoring tools	131d	07/02/18	12/31/18
	Report on the number of Medicaid beneficiaries scoring positive on scoring tools and referred for additional intervention	131d	07/02/18	12/31/18
	Report on the number of new staff recruited and trained (during reporting period and cumulative) vs. projected	131d	07/02/18	12/31/18
	Report on the new staff vacancy and turnover rate for period and cumulative vs. projected	131d	07/02/18	12/31/18
	Report on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-support program elements	131d	07/02/18	12/31/18

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

Below are initial Integrated Health measurable process evaluation targets that the IDN plans to implement the strategies to achieve.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased knowledge of universal screening/assessment process (Comprehensive Core Standardized Assessment), across 10 domains to guide the treatment and management of the target sub-population.	Up to 30 physical health providers across the IDN provider practices will participate in universal screening training by December 31, 2018.			
	Up to 20 behavioral health providers across the IDN provider practices will participate in universal screening training by December 31, 2018.			
	Up to 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in universal screening training by December 31, 2018.			
Increased knowledge of co-occurring disorders, including physical health conditions such as diabetes hyperglycemia, dyslipidemia, hypertension, with behavioral health conditions to guide the treatment and management of the target sub-population.	Up to 30 physical health providers across the IDN provider practices will participate in training on co-occurring disorders by December 31, 2018.			
	Up to 20 behavioral health providers across the IDN provider practices will participate in training on co-occurring disorders training by December 31, 2018.			
	Up to 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in training on co-occurring disorders by December 31, 2018.			
Increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub-population.	Up to 30 physical health providers across the IDN provider practices will participate in care planning and care coordination models training by December 31, 2018.			

	Up to 20 behavioral health providers will participate in training on care planning and care coordination models by December 31, 2018.			
	Up to 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in training on care planning/care coordination by December 31, 2018.			
Increased knowledge of cultural competency and adaptation to guide the treatment and management of the target sub-population.	Up to 30 physical health providers across the IDN provider practices will participate in cultural competency and adaptation training by December 31, 2018.			
	Up to 20 behavioral health providers across the IDN provider practices will participate in cultural competency and adaptation training by December 31, 2018.			
	Up to 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in training on cultural competency and adaptation by December 31, 2018.			
Increased knowledge of addiction to guide the treatment and management of the target sub-population.	Up to 30 physical health providers across the IDN provider practices will participate in understanding addiction training by December 31, 2018.			
	Up to 20 behavioral health providers across the IDN provider practices will participate in understanding addiction training by December 31, 2018.			
	Up to 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in understanding addiction training by December 31, 2018.			

Improved communication between and among providers in the treatment, management and referral of the target sub-population.	Up to 10 care coordinators/case managers/Community Health Workers will implement integrated care coordination models across IDN practices through the use of a Shared Care Plan platform by June 30, 2018.			.
Expanded capacity to address behavioral health needs in appropriate settings.	Up to 10 participants from physical health, mental health, and/or substance use treatment and/or case management workforce will complete the behavioral health integration core competencies training series by June 30, 2019.			
Development of multi-disciplinary core teams.	Up to 3 multi- disciplinary core teams will be created across the IDN provider practices by December 31, 2018.			
Achievement of Coordinated Care Practice Designation.	All participating IDN provider practices will achieve a minimum of Level 2 on SAMHSA's Levels of Integrated Care by December 31, 2018.			
IDN provider practices demonstrate progress toward Integrated Care Practice Designation.	A minimum of 30 IDN provider practices will complete a site self-assessment bi-annually, in June and December.			
IDN provider practices reach Integrated Care Practice Designation.	Up to 5 IDN provider practices will reach Level 5 of SAMHSA's levels of Integrated Care by December 31, 2020.			

B1-4. IDN Integrated Healthcare: Workforce Staffing

Below are workforce targets and timeline milestones specifically related to the B1 project.

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
Physician's Assistant (Certified)	.2	6			
Psychiatrist/Psychiatric Advanced Practice Registered Nurse (APRN)	1.1	11			
Consulting Pharmacist	.10	20			
Consulting Psychiatrist	.2	3			
Psychiatric APRN	.8	6.4			
Psychiatric Certified Nurse	1	0			
Psychiatric Advanced Registered Nurse Practitioner (ARNP)	.5	Unsure			
RN (Bachelor's Level)	1.2	70.6			
Licensed Pastoral Psychotherapist	.75	2			
Mental Health Counselor (Master's Level LMHC)	6	85			
Case Manager (Bachelor's Level)	1	56			
Clinical Care Coordinator (Master's)	1	6			
Clinical Care Coordinator (RN Associate's)	.5	70.6			
Clinical Operations	.20	9			
Behavioral Health Specialist (Master's Level)	3.6	63			
Behavioral Health Care Coordinator (Bachelor's Level)	3	5			
Behavioral Health Case Manager (Bachelor's; LADC preferred)	3	12			
Recovery/Transitional Care Case Manager	1	.5			
Case Manager (RN Bachelor's Level)	.5	90.6			
Family Education and Peer Specialist	1	14			
Peer Support Specialist	.5	30			
Community Health Worker	8	40			
Training Coordinator	.5	7			
Receptionist	1	27			
Billing and Information Staff	1	290.5			

B1-5a. IDN Integrated Healthcare: Budget

There was some overlap between the B1 Integrated Healthcare budget and the A1 Behavioral Health Workforce Capacity budgets, especially as it related to supporting building of the multi-disciplinary core teams and training for the practices toward integrated care.

For the B1 budget, there was a budget to support the sub-contract with , which is conducting the practice integration Site Self-Assessment (SSA) at the baseline level (June 2017) and then every 6 months throughout the remainder of the demonstration.

The remainder of the budget reflects support for providers to bring their practices to the minimum level of Coordinated Care Practice designation by the end of 2018, with a couple of providers proposing to move practices toward Integrated Care Practice designation. See below for the identification of which practices will move to Coordinated Care and/or Integrated Care Practice designation:

- Coordinated Care Practice designation:
  - Partnership for Sustainable Living (Harbor Homes, Healthy at Home and Keystone Hall)
  - St. Joseph Hospital Physician Practices (collaborating with Greater Nashua Mental Health Center for behavioral health and psychiatric support)
  - Dartmouth Hitchcock Nashua
  - Merrimack River Medical Services

- Integrated Care Practice designation:
  - Lamprey Health and Greater Nashua Mental Health Center partnering to create two co-located facilities
  - Foundation Medical Partners creating a co-located set of practices

Category of Funding	Entity Funded	Amount of Funding 2017 - 2020
Practice Integration Site Self-Assessment (SSA)	[redacted]	$26,400
Integrated Care Practice Designation Team—Co-Located Practice	[redacted]	$1,415,465.97
Integrated Care Practice Designation Team—Co-Located Practice	[redacted]	$621,611.35
Coordinated Care Practice Designation Team	[redacted]	$1,734,907
Coordinated Care Practice Designation Team	[redacted]	$1,102,282.36
Coordinated Care Practice Designation Team	[redacted]	$451,980

Category of Funding	Entity Funded	Amount of Funding 2017 - 2020
Coordinated Care Practice Designation Team	[redacted]	$225,000
Total		**$5,577,646.68**

B1: Integrated Health
2017 - 2020 Budget

Category and Item	Item Notes	Comments	2017-2018 Budget Available	2019-2020 Budget Available	August 2017 - June 2018 (11 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	Total Requested 2017 - 2020	Total Available 2017 - 2020
Totals			**$1,709,859**	**$4,377,461**	$1,604,173	$1,574,189	$1,561,164	$779,957	**$5,519,483.00**	**$6,087,320.00**
Practice Integration Site Self-Assessment (SSA)	[redacted]	[redacted]			**$6,600**	**$6,600.00**	**$6,600.00**	**$3,300.00**	**$23,100.00**	
Integrated Care Designation Practice Teams	[redacted]				**$654,973.22**	**$500,266.36**	**$487,766.36**	**$243,258.18**	**$1,886,264.12**	
	[redacted]	[redacted]	5.98 FTEs		$476,316.85	$322,834.26	$310,334.26	$154,542.13	$1,264,027.50	
	[redacted]	[redacted]	4.8 FTEs		$178,656.37	$177,432.10	$177,432.10	$88,716.05	$622,236.62	
Coordinated Care Designation Practice Teams	[redacted]				**$942,599.67**	**$1,067,322.72**	**$1,066,797.72**	**$533,398.77**	**$3,610,118.88**	
	[redacted]	[redacted]	6.5 FTEs		$478,639.50	$502,822.00	$502,297.00	$251.148.50	$1,483,758.50	
	[redacted]	[redacted]	2.2 FTEs		$255,408.56	$340,000.72	$340,000.72	$170,000.36	$1,105,410.36	
	[redacted]	[redacted]	2 FTEs		$139,801.61	$149,500.00	$149,500.00	$74,749.91	$513,551.52	
	[redacted]	[redacted]	1.5 FTEs		$68,750.00	$75,000.00	$75,000.00	$37,500.00	$256,250.00	

attachment_B1.6

IDN Integrated Healthcare: Key Organizational and Provider Participants

Received?	Practice ID	Practice Name
		Dartmouth Hitchcock Practices
Yes	3-101	Dartmouth-Hitchcock Nashua Internal Medicine
Yes	3-102	Dartmouth-Hitchcock Nashua Family Medicine
Yes	3-103	Dartmouth-Hitchcock Nashua Pediatrics
Yes	3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology
No	3-105	Norris Cotton Cancer Center
Yes	3-106	Dartmouth-Hitchcock Hudson
Yes	3-107	Dartmouth-Hitchcock Milford
Yes	3-108	Dartmouth-Hitchcock Merrimack
Yes	3-109	Lamprey Health Care
		St. Joseph Hospital Practices
Yes	3-111	St. Joseph Hospital Family Medicine, Nashua
Yes	3-112	St. Joseph Hospital Family Medicine Nashua South
Yes	3-113	St. Joseph Hospital Family Medicine & Specialty Services Hudson
Yes	3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack
Yes	3-115	St. Joseph Hospital Family Medicine & Specialty Services Milford
Yes	3-116	St. Joseph Hospital Internal Medicine
Yes	3-117	St. Joseph Hospital Adult Medicine
Yes	3-118	St. Joseph Hospital Pediatrics Sky Meadow
Yes	3-119	St. Joseph Hospital Pediatrics Nashua
Yes	3-120	St. Joseph Hospital Pediatrics Milford
No	3-121	St. Joseph Hospital OB/GYN Merrimack
No	3-122	St. Joseph Hospital OB/GYN Hudson
No	3-123	St. Joseph Hospital Midwifery
		Foundation Medical Partners Practices
Yes	3-124	Foundation Medical Partners, Amherst Family Practice
Yes	3-125	Foundation Medical Partners, Family Practice of Merrimack
Yes	3-126	Foundation Medical Partners, Family Practice of South Nashua
No	3-127	Foundation Medical Partners, Pepperell Family Practice
Yes	3-128	Foundation Medical Partners, Primary Care of Hudson
Yes	3-129	Foundation Medical Partners, Primary Care of Milford
Yes	3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham
No	3-131	Foundation Medical Partners, Medicine-Pediatrics of Nashua

No	3-132	Foundation Medical Partners, Nashua West Adult Medicine
Yes	3-133	Foundation Medical Partners, Nashua Primary Care
Yes	3-134	Foundation Medical Partners, Downtown Medical Associates
Yes	3-135	Foundation Medical Partners, Nashua Center for Healthy Adults
Yes	3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua
Yes	3-137	Foundation Medical Partners, Foundation Internal Medicine
Yes	3-138	Foundation Medical Partners, Foundation Pediatrics
No	3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics
Yes	3-140	Foundation Medical Partners, Partners in Pediatrics
Yes	3-141	Foundation Medical Partners, Foundation OB/GYN
Yes	3-142	Foundation Medical Partners, NE GYN & Surgical Services
Yes	3-143	Foundation Medical Partners, Women's Care of Nashua
Yes	3-144	Foundation Medical Partners, Foundation Community Care
No	3-152	Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine
Yes	3-145	Greater Nashua Mental Health Center
Yes	3-146	Harbor Health/Harbor Care Health and Wellness Center
Yes	3-147	The Emmaus Institute Counseling Services
Yes	3-148	Merrimack River Medical Services
Yes	3-149	The Youth Council
Yes	3-150	Gateways Community Services
Yes	3-151	Keystone Hall
Yes	3-153	Healthy at Home

Letter of Commitment to Participate Signatory	Title	Date Signed
		07/25/17
		07/25/17
		07/25/17
		07/26/17
		09/18/17
		09/18/17
		09/18/17
		07/25/17
		07/24/17
		07/21/17
		07/24/17
		08/15/17
		07/21/17
		07/24/17
		07/21/17
		07/21/17
		09/18/17
		09/18/17
		07/20/17
		08/21/17
		08/14/17
		08/15/17
		07/26/17
		08/23/17

		08/23/17
		07/25/17
		07/25/17
		07/25/17
		07/25/17
		08/23/17
		08/14/17
		07/25/17
		08/14/17
		07/25/17
		07/25/17
		07/26/17
		07/25/17
		07/26/17
		07/25/17
		07/26/17
		07/25/17
		07/25/17
		07/28/17

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

The IDN Executive Steering Committee met on July 27, 2017 and officially approved the B1 Integrated Health plan. The members are outlined below, indicating their approval (as noted as a "Y" as sign-off received).

Name	Title	Organization	Sign Off Received (Y/N)
Craig Amoth	Chief Executive Officer	Greater Nashua Mental Health Center	Y
Mike Apfelberg	President IDN Community Engagement Committee Chair	United Way of Greater Nashua	Y**
Bobbie Bagley	Director	City of Nashua Division of Public Health	N*
Paul Bergeron	Commissioner	Hillsborough County	N*
Kathy Cowette	Director of Planning	St. Joseph Hospital	Y
Carol Furlong	Vice President of Operations	Partnership for Successful Living	Y
Ken Lewis	Executive Director	HEARTS Peer Support Center	Y
Marilou Patalinjug Tyner	Chief Medical Officer IDN Chief Medical Officer	Greater Nashua Mental Health Center	Y**
Jonathan Thyng	Physician	Dartmouth Hitchcock Nashua	Y
Greg White	Chief Executive Officer IDN Finance Committee Chair	Lamprey Health	Y
Cynthia Whitaker	Chief of Services IDN Clinical Committee Chair	Greater Nashua Mental Health Center	Y**
Susan Stearns	Deputy Director	NAMI NH	Y#
Lisa Madden	Assistant Vice President of Behavioral Health IDN 3 Executive Director	Southern NH Health	Y
Stephanie Wolf-Rosenblum	Vice President, Development and External Affairs IDN Senior Administrative Sponsor	Southern NH Health	Y#

Name	Title	Organization	Sign Off Received (Y/N)
Paul Trainor	Senior Vice President of Finance IDN Finance Director	Southern NH Health	Y#
Kathryn Skouteris	Vice President of Legal and Regulatory Affairs/General Counsel IDN Compliance Officer	Southern NH Health	Y#
Michele Craig	DSRIP Program Director	Southern NH Medical Center	Y#

*Not in attendance at meeting on July 27, 2017 when vote was taken to approve B1 Plan.
**Non-voting Member
#Ex-Officio Member

B1-8a CSA

attachment_B1.8ai

Practice ID	Practice Name	Demographic Information - Domain Assessed? (Y/N)	Physical Health Review - Domain Assessed? (Y/N)	Substance Use Review - Domain Assessed? (Y/N)	Housing Assessment - Domain Assessed? (Y/N)	Family &Support Services - Domain Assessed? (Y/N)	Educational Attainment - Domain Assessed? (Y/N)	Access to Legal Services - Domain Assessed? (Y/N)	Suicide Risk Assessment - Domain Assessed? (Y/N)	Functional Status - Domain Assessed? (Y/N)	PHQ 2 and 9 - Domain Assessed? (Y/N)	SBIRT - Domain Assessed? (Y/N)
	Dartmouth Hitchcock Practices											
3-101	Dartmouth-Hitchcock Nashua Internal Medicine	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-102	Dartmouth-Hitchcock Nashua Family Medicine	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-103	Dartmouth-Hitchcock Nashua Pediatrics	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-105	Norris Cotton Cancer Center	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-106	Dartmouth-Hitchcock Hudson	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-107	Dartmouth-Hitchcock Milford	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-108	Dartmouth-Hitchcock Merrimack	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-109	Lamprey Health Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	St. Joseph Hospital Practices											
3-111	St. Joseph Hospital Family Medicine, Nashua	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-112	St. Joseph Hospital Family Medicine Nashua South	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-113	St. Joseph Hospital Family Medicine & Specialty Services Hudson	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-115	St. Joseph Hospital Family Medicine & Specialty Services Milford	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-116	St. Joseph Hospital Internal Medicine	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-117	St. Joseph Hospital Adult Medicine	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-118	St. Joseph Hospital Pediatrics Sky Meadow	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-119	St. Joseph Hospital Pediatrics Nashua	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-120	St. Joseph Hospital Pediatrics Milford	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-121	St. Joseph Hospital OB/GYN Merrimack	Y	Y	Y	Y	N	N	N	Y	Y	Y	N

Practice ID	Practice Name	Demographic Information - Domain Assessed? (Y/N)	Physical Health Review - Domain Assessed? (Y/N)	Substance Use Review - Domain Assessed? (Y/N)	Housing Assessment - Domain Assessed? (Y/N)	Family &Support Services - Domain Assessed? (Y/N)	Educational Attainment - Domain Assessed? (Y/N)	Access to Legal Services - Domain Assessed? (Y/N)	Suicide Risk Assessment - Domain Assessed? (Y/N)	Functional Status - Domain Assessed? (Y/N)	PHQ 2 and 9 - Domain Assessed? (Y/N)	SBIRT - Domain Assessed? (Y/N)
3-122	St. Joseph Hospital OB/GYN Hudson	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
3-123	St. Joseph Hospital Midwifery	Y	Y	Y	Y	N	N	N	Y	Y	Y	N
	Foundation Medical Partners Practices											
3-124	Foundation Medical Partners, Amherst Family Practice	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-125	Foundation Medical Partners, Family Practice of Merrimack	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-126	Foundation Medical Partners, Family Practice of South Nashua	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-127	Foundation Medical Partners, Pepperell Family Practice	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-128	Foundation Medical Partners, Primary Care of Hudson	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-129	Foundation Medical Partners, Primary Care of Milford	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-131	Foundation Medical Partners, Medicine-Pediatrics of Nashua	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-132	Foundation Medical Partners, Nashua West Adult Medicine	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-133	Foundation Medical Partners, Nashua Primary Care	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-134	Foundation Medical Partners, Downtown Medical Associates	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-135	Foundation Medical Partners, Nashua Center for Healthy Adults	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-137	Foundation Medical Partners, Foundation Internal Medicine	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-138	Foundation Medical Partners, Foundation Pediatrics	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-140	Foundation Medical Partners, Partners in Pediatrics	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-141	Foundation Medical Partners, Foundation OB/GYN	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N

Practice ID	Practice Name	Demographic Information - Domain Assessed? (Y/N)	Physical Health Review - Domain Assessed? (Y/N)	Substance Use Review - Domain Assessed? (Y/N)	Housing Assessment - Domain Assessed? (Y/N)	Family &Support Services - Domain Assessed? (Y/N)	Educational Attainment - Domain Assessed? (Y/N)	Access to Legal Services - Domain Assessed? (Y/N)	Suicide Risk Assessment - Domain Assessed? (Y/N)	Functional Status - Domain Assessed? (Y/N)	PHQ 2 and 9 - Domain Assessed? (Y/N)	SBIRT - Domain Assessed? (Y/N)
3-142	Foundation Medical Partners, NE GYN & Surgical Services	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-143	Foundation Medical Partners, Women's Care of Nashua	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-144	Foundation Medical Partners, Foundation Community Care	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-152	Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N
3-145	Greater Nashua Mental Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
3-146	Harbor Health/Harbor Care Health and Wellness Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3-147	The Emmaus Institute Counseling Services	Y	Y	Y	Y	Y	Y	N	Y	N	N	N
3-148	Merrimack River Medical Services	Y	Y	Y	Y	N	N	Y	N	Y	Y	Y
3-149	The Youth Council	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
3-150	Gateways Community Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
3-153	Keystone Hall	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N

B1-8a Pedi

attachment_B1.8aii

Practice ID	Practice Name	Validated Developmental Screening (Y/N)	Developmental Screening (Y/N)
	Dartmouth Hitchcock Practices		
3-102	Dartmouth-Hitchcock Nashua Family Medicine	N	Y
3-103	Dartmouth-Hitchcock Nashua Pediatrics	N	Y
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology	N	Y
3-106	Dartmouth-Hitchcock Hudson	N	Y
3-107	Dartmouth-Hitchcock Milford	N	Y
3-108	Dartmouth-Hitchcock Merrimack	N	Y
3-109	Lamprey Health Care	N	Y
	St. Joseph Hospital Practices		
3-111	St. Joseph Hospital Family Medicine, Nashua	Y	Y
3-112	St. Joseph Hospital Family Medicine Nashua South	Y	Y
3-113	St. Joseph Hospital Family Medicine & Specialty Services Hudson	Y	Y
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack	Y	Y
3-115	St. Joseph Hospital Family Medicine & Specialty Services Milford	Y	Y
3-118	St. Joseph Hospital Pediatrics Sky Meadow	Y	Y
3-119	St. Joseph Hospital Pediatrics Nashua	Y	Y
3-120	St. Joseph Hospital Pediatrics Milford	Y	Y
	Foundation Medical Partners Practices		
3-124	Foundation Medical Partners, Amherst Family Practice	N	Y
3-125	Foundation Medical Partners, Family Practice of Merrimack	N	Y
3-126	Foundation Medical Partners, Family Practice of South Nashua	N	Y
3-127	Foundation Medical Partners, Pepperell Family Practice	N	Y
3-128	Foundation Medical Partners, Primary Care of Hudson	N	Y

attachment_B1.8aii

Practice ID	Practice Name	Validated Developmental Screening (Y/N)	Developmental Screening (Y/N)
3-129	Foundation Medical Partners, Primary Care of Milford	N	Y
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham	N	Y
3-131	Foundation Medical Partners, Medicine-Pediatrics of Nashua	N	Y
3-133	Foundation Medical Partners, Nashua Primary Care	N	Y
3-134	Foundation Medical Partners, Downtown Medical Associates	N	Y
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua	N	Y
3-137	Foundation Medical Partners, Foundation Internal Medicine	N	Y
3-138	Foundation Medical Partners, Foundation Pediatrics	N	Y
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics	N	Y
3-140	Foundation Medical Partners, Partners in Pediatrics	N	Y
3-152	Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine	N	Y

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
	Dartmouth Hitchcock Practices		
3-101	Dartmouth-Hitchcock Nashua Internal Medicine		
		No Information Available	
3-102	Dartmouth-Hitchcock Nashua Family Medicine		
		Provider, MD	5
		Provider, PA-C	3
3-103	Dartmouth-Hitchcock Nashua Pediatrics		
		Provider, MD	6
		Provider, DO	1
		Provider, PA-C	1
		Provider, APRN	2
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology		
		Provider, MD	3
		Provider, MSN, APRN	1
		MD	1
		Provider, MS, CNM	1
3-105	Norris Cotton Cancer Center		
		No information available	
3-106	Dartmouth-Hitchcock Hudson		
		Provider, MPAS, PA-C	1
		Provider, MS, PA-C	1
		Provider, MD	1
3-107	Dartmouth-Hitchcock Milford		
		Provider, MD	4
		Provider, DO	1
		Provider, PA-C	3
3-108	Dartmouth-Hitchcock Merrimack		
		Provider, MD	2
		Provider, DO	1
		Provider, PA-C	2
3-109	**Lamprey Health Care**		
		Providers	15
		More detail being sought for other core team members	
	St. Joseph Hospital Practices		
3-111	St. Joseph Hospital Family Medicine, Nashua		
		Certified Medical Assistant	2.4
		Licensed Practical Nurse	3.9
		Managed Care Specialist	0.9
		Med Rec / Recept Supervisor	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Physician	4.8
		Nurse Practitioner	1.0 vacant
		Office Manager	1
		Patient Service Representative	5.0 (1.0 vacant)
		Registered Nurse	0.9
		Urgent Care Coordinator	0.2 (1.0 vacant)
3-112	St. Joseph Hospital Family Medicine Nashua South		
		Certified Medical Assistant	0.9
		Front Office Support	0.4
		Licensed Practical Nurse	2.8
		Physician	3
		Nurse Practitioner	1
		Office Manager	1
		Patient Service Representative	2.6
		Registered Nurse	0
3-113	St. Joseph Hospital Family Medicine & Specialty Services Hudson		
		Certified Medical Assistant	0.9
		Front Office Support	1
		Licensed Practical Nurse	2.4 (0.5 vacant)
		Physician	2
		Nurse Practitioner	1
		Office Manager	1
		Patient Service Representative	3.6
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack		
		Certified Medical Assistant	3
		Licensed Practical Nurse	1
		Physician	3
		Nurse Practitioner	1
		Office Manager	1
		Patient Service Representative	4
3-115	St. Joseph Hospital Family Medicine & Specialty Services Milford		
		Certified Medical Assistant	1
		Licensed Practical Nurse	3.0 (1.0 vacant)
		Physician	3
		Office Manager	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Patient Service Representative	5.9
		Registered Nurse	0
3-116	St. Joseph Hospital Internal Medicine		
		Certified Medical Assistant	5.0 (2.0 vacant)
		Licensed Practical Nurse	1.0 (2.6 vacant)
		Managed Care Specialist	1
		Physician	5.0 (1.0 vacant)
		Med Rec/Recept Supervisor	1
		Nurse Practitioner	4.9 (1.0 vacant)
		Nurse Coordinator	1
		Office Manager	1
		Physician Assistant	0.9
		Patient Service Representative	9.8
		Registered Nurse	1.0 (2.0 vacant)
3-117	St. Joseph Hospital Adult Medicine		
		Certified Medical Assistant	6.9
		Front Office Staff	0.5
		Licensed Practical Nurse	0.9
		Physician	3.3
		Nurse Practitioner	0.6
		Office Manager	1
		Physician Assistant	0.8
		Patient Service Representative	4.8 (1.0 vacant)
		Referral Coordinator	0.8
		Registered Nurse	1.9
		Supervisor Operations	1
3-118	St. Joseph Hospital Pediatrics Sky Meadow		
		Physician	2.8
		Nurse Practitioner	1
		Office Coordinator	0.9
		Patient Service Representative	2.6
		Registered Nurse	3.7
3-119	St. Joseph Hospital Pediatrics Nashua		
		Lactation Consultant	0.4
		Licensed Practical Nurse	6.8
		Physician	7.6
		Nurse Practitioner	1.8
		Office Manager	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Patient Service Representative	6.4 (1.0 vacant)
		Registered Nurse	3.9 (2.0 vacant)
3-120	St. Joseph Hospital Pediatrics Milford		
		Included in Pediatrics Nashua Practices	
3-121	St. Joseph Hospital OB/GYN Merrimack		
		Certified Medical Assistant	4
		Certified Nurse Midwife	2.6
		Front Office Support	1
		Licensed Practical Nurse	4.2
		Physician	6.0 (1.0 vacant)
		Nurse Practitioner	0
		Nurse Coordinator	1
		Office Manager	1
		Patient Service Representative	7.0 (2.0 vacant)
		Registered Nurse	1
3-122	St. Joseph Hospital OB/GYN Hudson		
		Included as part of OB/GYN Merrimack	
3-123	St. Joseph Hospital Midwifery		
		Included as part of OB/GYN Merrimack	
	Foundation Medical Partners Practices		
3-124	Foundation Medical Partners, Amherst Family Practice		
		Medical Assistant	3
		Medical Receptionist	3
		RN Embedded Care Coord	1
		LPN	3
		RN	1
		Site Manager	1
		Office Coordinator	1
		Clinician	1
		Provider, APRN	4
		PA	1
		Provider, DO	2
3-125	Foundation Medical Partners, Family Practice of Merrimack		
		RN Embedded Care Coord	1
		Medical Assistant	2
		RN	1
		LPN	1
		Medical Receptionist	2
		Office Coordinator	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Provider, DO	2
		Provider, MD	1
3-126	Foundation Medical Partners, Family Practice of South Nashua		
		Medical Receptionist	3
		RN	6
		Medical Assistant	1
		LPN	1
		Site Manager	1
		Office Coordinator	1
		RN Embedded Care Coord	1
		Provider, MD	2
		APRN	2
		PA	1
		Psychologist	1
3-127	Foundation Medical Partners, Pepperell Family Practice		
		RN	3
		LPN	3
		Medical Receptionist	3
		Medical Assistant	4
		RN Embedded Care Coord	1
		Office Coordinator	1
		Site Manager	1
		Provider, MD	6
		Provider, APRN	2
3-128	Foundation Medical Partners, Primary Care of Hudson		
		RN	4
		Medical Receptionist	5
		Site Manager	1
		LPN	3
		Medical Assistant	1
		Office Coordinator	1
		RN Embedded Care Coord	1
		Social Worker	1
		Provider, APRN	3
		Provider, MD	3
3-129	Foundation Medical Partners, Primary Care of Milford		
		Medical Receptionist	4
		Lead Medical Receptionist	1
		Medical Assistant/Receptionist	1
		Practice Manager	1
		Medical Assistant	3

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		RN	1
		RN Embedded Care Coord	1
		Provider, MD	5
		Provider, APRN	2
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham		
		Lead Medical Receptionist	1
		Medical Receptionist	1
		Medical Assistant	1
		Site Manager	1
		RN	2
		Provider, APRN	2
		Provider, MD	1
3-131	Foundation Medical Partners, Medicine-Pediatrics of Nashua		
		Medical Receptionist	5
		RN	5
		Medical Assistant	2
		RN Embedded Care Coord	1
		Practice Manager	1
		Provider, MD	4
3-132	Foundation Medical Partners, Nashua West Adult Medicine		
		RN Embedded Care Coord	1
		LPN	1
		Medical Assistant	1
		Medical Receptionist	4
		Office Coordinator	1
		RN	2
		Practice Manager	1
		Provider, APRN	1
		Provider, MD	3
3-133	Foundation Medical Partners, Nashua Primary Care		
		RN	6
		Medical Receptionist	4
		Medical Assistant	1
		RN Embedded Care Coord	1
		LPN	1
		Lead Medical Receptionist	1
		Provider, MD	2
		Provider, APRN	2
3-134	Foundation Medical Partners, Downtown Medical Associates		
		RN Embedded Care Coord	1
		Medical Receptionist	2

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Medical Records Clerk	1
		Medical Assistant	2
		LPN	1
		RN	1
		Office Coordinator	1
		Provider, APRN	2
		Provider, MD	2
		Provider, DO	1
3-135	Foundation Medical Partners, Nashua Center for Healthy Adults		
		Medical Assistant	3
		RN	1
		RN Embedded Care Coord	1
		Medical Receptionist	1
		Provider, MD	2
		Provider, APRN	1
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua		
		Lead Medical Receptionist	1
		RN	1
		Medical Assistant	1
		Medical Receptionist	3
		RN Embedded Care Coord	1
		LPN	1
		Provider, MD	1
3-137	Foundation Medical Partners, Foundation Internal Medicine		
		Medical Receptionist	2
		Practice Manager	1
		RN Embedded Care Coord	1
		RN	1
		LPN	1
		Clinician	1
		Clinical Psychologist	1
		Provider, MD	1
		Provider, DO	1
		Provider, APRN	1
3-138	Foundation Medical Partners, Foundation Pediatrics		
		RN	4
		Practice Manager	1
		Medical Receptionist	5
		RN Embedded Care Coord	1
		LPN	2
		Medical Assistant/Receptionist	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Lead Rcptnst/Interpreter	1
		Provider, MD	5
		Provider, APRN	1
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics		
		RN	1
		Lead Medical Receptionist	1
		Provider, MD	1
3-140	Foundation Medical Partners, Partners in Pediatrics		
		RN	6
		RN Embedded Care Coord	1
		Medical Receptionist	2
		Provider, MD	2
3-141	Foundation Medical Partners, Foundation OB/GYN		
		Medical Assistant	5
		RN	3
		Lead Medical Receptionist	1
		Medical Receptionist	3
		RN Embedded Care Coord	1
		Office Coordinator	1
		Scheduling Coordinator	1
		Practice Manager	1
		Provider, APRN	3
		Provider, MD	5
3-142	Foundation Medical Partners, NE GYN & Surgical Services		
		Medical Assistant	1
		Medical Receptionist	2
		RN	1
		Provider, APRN	2
		Provider, MD	1
3-143	Foundation Medical Partners, Women's Care of Nashua		
		Lead Medical Receptionist	1
		Resource Nurse	1
		LPN	2
		Practice Manager	2
		Medical Assistant	2
		RN	1
		Medical Receptionist	3
		Scheduling Coordinator	2
		Provider, APRN	2
		Provider, MD	2

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
3-144	Foundation Medical Partners, Foundation Community Care		
		Behavioral Health Coordinator	1
		Medical Receptionist	1
		Provider, MD	1
		Provider, PA	1
3-152	Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine		
		LPN	2
		Medical Receptionist	1
		RN	1
		Provider, APRN	1
3-145	Greater Nashua Mental Health Center		
		Team Coordinator	3
		President & CEO	1
		Supported Employment Specialist	6
		Therapist	40
		Advanced Practice Registered Nurse	3
		Child Impact Program Facilitator	4
		Acute Care Services Clinician	2
		Building Services Coordinator	1
		Case Manager	46
		Licensed Practical Nurse	2
		Medical Records Manager	1
		Admission/Collections Clerk	2
		Psychiatric Rehabilitation Professional	10
		Visitation Center Supervisor	8
		Intake Clinician	2
		Receptionist/Switchboard Operator	2
		Medical Records Associate	3
		Elders Program Manager	1
		Staff Accountant	1
		Administrative Assistant	5
		Drug Court Coordinator	1
		Secretary	3
		Intake Call Center Staff	2
		Health Mentor Specialist	3

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Mental Health Court Liaison	1
		Interpreter	2
		Nursing and Wellness Coordinator	1
		Telehealth Specialist	1
		Supported Employment Coordinator	1
		Director of Outpatient Services	1
		Coord for Functional Support and Case Mgmt Services	1
		Director of Acute Care Services	1
		CSS Training Coordinator	1
		Lead Accounts Receivable Specialist	1
		ACT Team Leader	1
		Community Outreach & Education Coordinator	1
		Supervisor of Child Impact Program	1
		Crisis Respite Provider	1
		Director of Child & Adolescent Services/APRN	1
		Coordinator of the Child ACT Team	1
		Assoc Director of Community Based Supports	1
		Medical Support Staff Manager	1
		Medical Director	1
		Supervised Visitation Center Coordinator	1
		ACT FSS	1
		Deaf Services Coordinator	1
		Admission Collection Clerk - Generalist	1
		Director of Quality & Corporate Compliance	1
		Medical Assistant	1
		ACT Registered Nurse	1
		Network Administrator	1
		Transcriptionist	1
		Director of Community Support Services	1
		Client Benefits Technician	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		ACT Team Leader	1
		Chief of Services	1
3-146	Harbor Health/Harbor Care Health and Wellness Center		
		Administration Count	11
		Asst Proj Dirt Count	1
		Assistant Program Manager Count	7
		CertPharmTech Count	1
		Clinic Staff Count	3
		Computer lab Count	1
		Content Manager Count	1
		Case Manager Count	16
		Data Analyst Count	1
		Dental Staff Count	8
		Development Associate Count	3
		Director Count	4
		Employment Assistance Count	2
		Facilities Count	20
		Finance Count	8
		Functional Support Staff Count	5
		HR Count	5
		IT Count	6
		LCMHC Count	1
		LICSW Count	2
		LNA Count	7
		LPN Count	2
		MAT Therapist Count	2
		MD Count	3
		Medical Staff Count	14
		Navigator Count	1
		Nurse Practitioner Count	6
		Operations Count	2
		Outreach Worker Count	3
		Overnight Staff Count	1
		Patient Educator Count	1
		Program Manager Count	20
		Pharmacist Count	2
		Project Mgr Count	2
		PRS CEO Count	2
		PSYC Count	1
		Residential Coordinator Count	3

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		RN Count	8
		Senior ResidentCount	3
		Support Staff Count	54
		Supervisor of Service Workers Count	4
		Therapist Count	9
		Van Driver Count	3
		WITS Coordinator Count	1
3-147	The Emmaus Institute Counseling Services		
		Executive Director, Licensed Pastoral Psychotherapist	1
		Administrator	1
		Licensed Pastoral Psychotherapist	2
		Pastoral Psychotherapist	1
		Licensed Independent Clinical Social Worker	2
		Pastoral Counselor	1
3-148	Merrimack River Medical Services		
		Physicians	2
		RN	3
		LPN	2
		Billing Clerk	2
		Medical Assistant	1
		Medical Receptionist	1
		APRN	1
		LICSW	1
		Practice Manager	1
		AVP of Nursing	1
		AVP of Operations	1
		Chief Corporate Compliance Officer	1
		MLADC	2
		Counselor	2
		LADC	2
3-149	The Youth Council		
		Executive Director	1
		Therapist	2
		Director of Special Projects	1
		Student Assistance Program Counselor	1
		Office Administrator	1
		Suspension Center Coordinator	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Court Diversion Program Coordinator	1
		Clinical Director	1
3-150	Gateways Community Services		
		Personal Care Providers (Seniors)	34
		Direct Support Professionals	230
		Respite Workers	10
		Caregivers	115
		Providers for Veterans	76
		Financial Case Manager / Rep Payee	3
		Service coordinators/Case Managers	40
		Applied Behavioral Analyst Provider	18
		Board Certified Behavioral Analyst	5
		Adult Day Program Aides	11
3-151	Keystone Hall		
		Admin Asst Count	3
		Case Manager Count	13
		Clinician Count	6
		Correctional Clinician Count	5
		Counselor Count	6
		CRSW Count	5
		Direct Clinical Care Count	4
		Director of Clinical Services Count	1
		Director of Adm Count	1
		Director of Intervention Services Count	1
		DQI Count	1
		Fine Specialist Count	1
		Intake Coordinator Count	1
		Intake Director Count	1
		LADC Count	1
		LPN Count	1
		Milieu Mgr Count	1
		Outpatient Coordinator Count	1
		Pres/CEO Count	1
		ProjHope Count	1
		Recpt Count	1
		Supervisor Crisis Line Count	1

B1-8b Potential Multi-Disciplinary Core Team Members
July 2017

Practice ID	Practice Name	Title/Role	# of Employees in Role
		Support Staff Count	27
3-153	Healthy at Home		
		RN	4
		LPN	1
		PT	1.2
		OT	0.5
		Home Health Aide	20
		Personal Care Services Provider	14
		Financial	2.3
		Medical Records	0.5
		Scheduler	1
		Administrator	1

B1-8ci Universal Screening

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Wave 1					
	Dartmouth Hitchcock Practices					
3-101	**Dartmouth-Hitchcock Nashua Internal Medicine**					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-102	**Dartmouth-Hitchcock Nashua Family Medicine**					
	Primary Care Provider	Up to 10	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-109	**Lamprey Health Care**					
	Primary Care Provider	Up to 15	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-118	**St. Joseph Hospital Pediatrics Sky Meadow**					
	Primary Care Provider	Up to 3*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-119	**St. Joseph Hospital Pediatrics Nashua**					
	Primary Care Provider	Up to 9*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-120	**St. Joseph Hospital Pediatrics Milford**					
	Primary Care Provider	Included in 3-119	Included in 3-119			
	Behavioral Health Providers	Included in 3-119	Included in 3-119			
	Assigned Care Managers or Community Health Workers	Included in 3-119	Included in 3-119			
	Foundation Medical Partners Practices					
3-124	**Foundation Medical Partners, Amherst Family Practice**					
	Primary Care Provider	Up to 7	0			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-125	**Foundation Medical Partners, Family Practice of Merrimack**					
	Primary Care Provider	Up to 3	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-126	**Foundation Medical Partners, Family Practice of South Nashua**					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-128	**Foundation Medical Partners, Primary Care of Hudson**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-129	**Foundation Medical Partners, Primary Care of Milford**					
	Primary Care Provider	Up to 7	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-131	**Foundation Medical Partners, Medicine-Pediatrics of Nashua**					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-133	**Foundation Medical Partners, Nashua Primary Care**					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-137	**Foundation Medical Partners, Foundation Internal Medicine**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	Up to 2	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-138	**Foundation Medical Partners, Foundation Pediatrics**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-152	**Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine**					
	Primary Care Provider	Up to 1	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-145	Greater Nashua Mental Health Center					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	Up to 42	0			
	Assigned Care Managers or Community Health Workers	Up to 62	0			
3-146	Harbor Health/Harbor Care Health and Wellness Center					
	Primary Care Provider	Up to 9	0			
	Behavioral Health Providers	Up to 11	0			
	Assigned Care Managers or Community Health Workers	Up to 24	0			
3-148	Merrimack River Medical Services					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-151	Keystone Hall					
	Primary Care Provider	0	0			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	Up to 22	0			
	Wave 2					
	Dartmouth Hitchcock Practices					
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-106	Dartmouth-Hitchcock Hudson					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-107	Dartmouth-Hitchcock Milford					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-108	Dartmouth-Hitchcock Merrimack					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-111	**St. Joseph Hospital Family Medicine, Nashua**					
	Primary Care Provider	Up to 4*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1*	0			
3-113	**St. Joseph Hospital Family Medicine & Specialty Services Hudson**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-115	**St. Joseph Hospital Family Medicine & Specialty Services Milford**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-116	**St. Joseph Hospital Internal Medicine**					
	Primary Care Provider	Up to 10*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-121	**St. Joseph Hospital OB/GYN Merrimack**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Foundation Medical Partners Practices					
3-127	**Foundation Medical Partners, Pepperell Family Practice**					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-134	**Foundation Medical Partners, Downtown Medical Associates**					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-135	**Foundation Medical Partners, Nashua Center for Healthy Adults**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics					
	Primary Care Provider	Up to 1	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-140	Foundation Medical Partners, Partners in Pediatrics					
	Primary Care Provider	Up to 2	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-141	Foundation Medical Partners, Foundation OB/GYN					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-143	Foundation Medical Partners, Women's Care of Nashua					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-153	Healthy at Home					
	Primary Care Provider	0	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Wave 3					
	Dartmouth Hitchcock Practices					
3-103	Dartmouth-Hitchcock Nashua Pediatrics					
	Primary Care Provider	Up to 10	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-105	Norris Cotton Cancer Center					
	Primary Care Provider	No information available	0			
	Behavioral Health Providers	No information available	0			
	Assigned Care Managers or Community Health Workers	No information available	0			
	St. Joseph Hospital Practices					
3-112	St. Joseph Hospital Family Medicine Nashua South					
	Primary Care Provider	Up to 4	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-117	St. Joseph Hospital Adult Medicine					
	Primary Care Provider	Up to 4*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1**	0			
3-122	St. Joseph Hospital OB/GYN Hudson					
	Primary Care Provider	Included as part of 3-121	Included as part of 3-121			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
3-123	St. Joseph Hospital Midwifery					
	Primary Care Provider	Included as part of 3-121	Included as part of 3-121			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
	Foundation Medical Partners Practices					
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-132	Foundation Medical Partners, Nashua West Adult Medicine					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua					
	Primary Care Provider	Up to 1	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-142	Foundation Medical Partners, NE GYN & Surgical Services					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
3-144	Foundation Medical Partners, Foundation Community Care					
	Primary Care Provider	Up to 2	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			

B1-8cii Co-Occurring Disorders

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Wave 1					
	Dartmouth Hitchcock Practices					
3-101	**Dartmouth-Hitchcock Nashua Internal Medicine**					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-102	**Dartmouth-Hitchcock Nashua Family Medicine**					
	Primary Care Provider	Up to 10	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-109	**Lamprey Health Care**					
	Primary Care Provider	Up to 15	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-118	**St. Joseph Hospital Pediatrics Sky Meadow**					
	Primary Care Provider	Up to 3*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-119	**St. Joseph Hospital Pediatrics Nashua**					
	Primary Care Provider	Up to 9*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-120	**St. Joseph Hospital Pediatrics Milford**					
	Primary Care Provider	Included in 3-119	Included in 3-119			
	Behavioral Health Providers	Included in 3-119	Included in 3-119			
	Assigned Care Managers or Community Health Workers	Included in 3-119	Included in 3-119			
	Foundation Medical Partners Practices					
3-124	**Foundation Medical Partners, Amherst Family Practice**					
	Primary Care Provider	Up to 7	0			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-125	**Foundation Medical Partners, Family Practice of Merrimack**					
	Primary Care Provider	Up to 3	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-126	**Foundation Medical Partners, Family Practice of South Nashua**					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-128	**Foundation Medical Partners, Primary Care of Hudson**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-129	**Foundation Medical Partners, Primary Care of Milford**					
	Primary Care Provider	Up to 7	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-131	**Foundation Medical Partners, Medicine-Pediatrics of Nashua**					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-133	**Foundation Medical Partners, Nashua Primary Care**					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-137	**Foundation Medical Partners, Foundation Internal Medicine**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	Up to 2	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-138	**Foundation Medical Partners, Foundation Pediatrics**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-152	**Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine**					
	Primary Care Provider	Up to 1	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-145	Greater Nashua Mental Health Center					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	Up to 42	0			
	Assigned Care Managers or Community Health Workers	Up to 62	0			
3-146	Harbor Health/Harbor Care Health and Wellness Center					
	Primary Care Provider	Up to 9	0			
	Behavioral Health Providers	Up to 11	0			
	Assigned Care Managers or Community Health Workers	Up to 24	0			
3-148	Merrimack River Medical Services					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-151	Keystone Hall					
	Primary Care Provider	0	0			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	Up to 22	0			
	Wave 2					
	Dartmouth Hitchcock Practices					
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-106	Dartmouth-Hitchcock Hudson					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-107	Dartmouth-Hitchcock Milford					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-108	Dartmouth-Hitchcock Merrimack					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-111	**St. Joseph Hospital Family Medicine, Nashua**					
	Primary Care Provider	Up to 4*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1*	0			
3-113	**St. Joseph Hospital Family Medicine & Specialty Services Hudson**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-115	**St. Joseph Hospital Family Medicine & Specialty Services Milford**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-116	**St. Joseph Hospital Internal Medicine**					
	Primary Care Provider	Up to 10*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-121	**St. Joseph Hospital OB/GYN Merrimack**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Foundation Medical Partners Practices					
3-127	**Foundation Medical Partners, Pepperell Family Practice**					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-134	**Foundation Medical Partners, Downtown Medical Associates**					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-135	**Foundation Medical Partners, Nashua Center for Healthy Adults**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics					
	Primary Care Provider	Up to 1	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-140	Foundation Medical Partners, Partners in Pediatrics					
	Primary Care Provider	Up to 2	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-141	Foundation Medical Partners, Foundation OB/GYN					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-143	Foundation Medical Partners, Women's Care of Nashua					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-153	Healthy at Home					
	Primary Care Provider	0	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Wave 3					
	Dartmouth Hitchcock Practices					
3-103	Dartmouth-Hitchcock Nashua Pediatrics					
	Primary Care Provider	Up to 10	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-105	Norris Cotton Cancer Center					
	Primary Care Provider	No information available	0			
	Behavioral Health Providers	No information available	0			
	Assigned Care Managers or Community Health Workers	No information available	0			
	St. Joseph Hospital Practices					
3-112	St. Joseph Hospital Family Medicine Nashua South					
	Primary Care Provider	Up to 4	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-117	St. Joseph Hospital Adult Medicine					
	Primary Care Provider	Up to 4*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1**	0			
3-122	St. Joseph Hospital OB/GYN Hudson					
	Primary Care Provider	Included as part of 3-121	Included as part of 3-121			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
3-123	St. Joseph Hospital Midwifery					
	Primary Care Provider	Included as part of 3-121	Included as part of 3-121			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
	Foundation Medical Partners Practices					
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-132	Foundation Medical Partners, Nashua West Adult Medicine					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua					
	Primary Care Provider	Up to 1	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-142	Foundation Medical Partners, NE GYN & Surgical Services					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
3-144	Foundation Medical Partners, Foundation Community Care					
	Primary Care Provider	Up to 2	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			

B1-8ciii Care planning and care coordination

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Wave 1					
	Dartmouth Hitchcock Practices					
3-101	**Dartmouth-Hitchcock Nashua Internal Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-102	**Dartmouth-Hitchcock Nashua Family Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-109	**Lamprey Health Care**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-118	**St. Joseph Hospital Pediatrics Sky Meadow**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-119	**St. Joseph Hospital Pediatrics Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-120	**St. Joseph Hospital Pediatrics Milford**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Included in 3-119	Included in 3-119			
	Assigned Care Managers or Community Health Workers	Included in 3-119	Included in 3-119			
	Foundation Medical Partners Practices					
3-124	**Foundation Medical Partners, Amherst Family Practice**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-125	**Foundation Medical Partners, Family Practice of Merrimack**					
	Primary Care Provider	N/A	N/A			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-126	**Foundation Medical Partners, Family Practice of South Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-128	**Foundation Medical Partners, Primary Care of Hudson**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-129	**Foundation Medical Partners, Primary Care of Milford**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-131	**Foundation Medical Partners, Medicine-Pediatrics of Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-133	**Foundation Medical Partners, Nashua Primary Care**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-137	**Foundation Medical Partners, Foundation Internal Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 2	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-138	**Foundation Medical Partners, Foundation Pediatrics**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-152	**Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine**					
	Primary Care Provider	N/A	N/A			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-145	Greater Nashua Mental Health Center					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 42	0			
	Assigned Care Managers or Community Health Workers	Up to 62	0			
3-146	Harbor Health/Harbor Care Health and Wellness Center					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 11	0			
	Assigned Care Managers or Community Health Workers	Up to 24	0			
3-148	Merrimack River Medical Services					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-151	Keystone Hall					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	Up to 22	0			
	Wave 2					
	Dartmouth Hitchcock Practices					
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-106	Dartmouth-Hitchcock Hudson					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-107	Dartmouth-Hitchcock Milford					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-108	Dartmouth-Hitchcock Merrimack					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-111	**St. Joseph Hospital Family Medicine, Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1*	0			
3-113	**St. Joseph Hospital Family Medicine & Specialty Services Hudson**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-115	**St. Joseph Hospital Family Medicine & Specialty Services Milford**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-116	**St. Joseph Hospital Internal Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-121	**St. Joseph Hospital OB/GYN Merrimack**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Foundation Medical Partners Practices					
3-127	**Foundation Medical Partners, Pepperell Family Practice**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-134	**Foundation Medical Partners, Downtown Medical Associates**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-135	**Foundation Medical Partners, Nashua Center for Healthy Adults**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-140	Foundation Medical Partners, Partners in Pediatrics					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-141	Foundation Medical Partners, Foundation OB/GYN					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-143	Foundation Medical Partners, Women's Care of Nashua					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-153	Healthy at Home					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Wave 3					
	Dartmouth Hitchcock Practices					
3-103	Dartmouth-Hitchcock Nashua Pediatrics					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-105	Norris Cotton Cancer Center					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	No information available	0			
	Assigned Care Managers or Community Health Workers	No information available	0			
	St. Joseph Hospital Practices					
3-112	St. Joseph Hospital Family Medicine Nashua South					
	Primary Care Provider	N/A	N/A			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-117	St. Joseph Hospital Adult Medicine					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1**	0			
3-122	St. Joseph Hospital OB/GYN Hudson					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
3-123	St. Joseph Hospital Midwifery					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
	Foundation Medical Partners Practices					
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-132	Foundation Medical Partners, Nashua West Adult Medicine					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-142	Foundation Medical Partners, NE GYN & Surgical Services					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
3-144	Foundation Medical Partners, Foundation Community Care					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			

B1-8civ Cultural competence and adaptation

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Wave 1					
	Dartmouth Hitchcock Practices					
3-101	**Dartmouth-Hitchcock Nashua Internal Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-102	**Dartmouth-Hitchcock Nashua Family Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-109	**Lamprey Health Care**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-118	**St. Joseph Hospital Pediatrics Sky Meadow**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-119	**St. Joseph Hospital Pediatrics Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-120	**St. Joseph Hospital Pediatrics Milford**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Included in 3-119	Included in 3-119			
	Assigned Care Managers or Community Health Workers	Included in 3-119	Included in 3-119			
	Foundation Medical Partners Practices					
3-124	**Foundation Medical Partners, Amherst Family Practice**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-125	**Foundation Medical Partners, Family Practice of Merrimack**					
	Primary Care Provider	N/A	N/A			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-126	**Foundation Medical Partners, Family Practice of South Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-128	**Foundation Medical Partners, Primary Care of Hudson**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-129	**Foundation Medical Partners, Primary Care of Milford**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-131	**Foundation Medical Partners, Medicine-Pediatrics of Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-133	**Foundation Medical Partners, Nashua Primary Care**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-137	**Foundation Medical Partners, Foundation Internal Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 2	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-138	**Foundation Medical Partners, Foundation Pediatrics**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-152	**Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine**					
	Primary Care Provider	N/A	N/A			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-145	Greater Nashua Mental Health Center					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 42	0			
	Assigned Care Managers or Community Health Workers	Up to 62	0			
3-146	Harbor Health/Harbor Care Health and Wellness Center					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 11	0			
	Assigned Care Managers or Community Health Workers	Up to 24	0			
3-148	Merrimack River Medical Services					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-151	Keystone Hall					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	Up to 22	0			
	Wave 2					
	Dartmouth Hitchcock Practices					
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-106	Dartmouth-Hitchcock Hudson					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-107	Dartmouth-Hitchcock Milford					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-108	Dartmouth-Hitchcock Merrimack					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-111	**St. Joseph Hospital Family Medicine, Nashua**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1*	0			
3-113	**St. Joseph Hospital Family Medicine & Specialty Services Hudson**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-115	**St. Joseph Hospital Family Medicine & Specialty Services Milford**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-116	**St. Joseph Hospital Internal Medicine**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-121	**St. Joseph Hospital OB/GYN Merrimack**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Foundation Medical Partners Practices					
3-127	**Foundation Medical Partners, Pepperell Family Practice**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-134	**Foundation Medical Partners, Downtown Medical Associates**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-135	**Foundation Medical Partners, Nashua Center for Healthy Adults**					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-140	Foundation Medical Partners, Partners in Pediatrics					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-141	Foundation Medical Partners, Foundation OB/GYN					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-143	Foundation Medical Partners, Women's Care of Nashua					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-153	Healthy at Home					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Wave 3					
	Dartmouth Hitchcock Practices					
3-103	Dartmouth-Hitchcock Nashua Pediatrics					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-105	Norris Cotton Cancer Center					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	No information available	0			
	Assigned Care Managers or Community Health Workers	No information available	0			
	St. Joseph Hospital Practices					
3-112	St. Joseph Hospital Family Medicine Nashua South					
	Primary Care Provider	N/A	N/A			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-117	St. Joseph Hospital Adult Medicine					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1**	0			
3-122	St. Joseph Hospital OB/GYN Hudson					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
3-123	St. Joseph Hospital Midwifery					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
	Foundation Medical Partners Practices					
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-132	Foundation Medical Partners, Nashua West Adult Medicine					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-142	Foundation Medical Partners, NE GYN & Surgical Services					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
3-144	Foundation Medical Partners, Foundation Community Care					
	Primary Care Provider	N/A	N/A			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			

B1-8cv Understanding Addiction

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Wave 1					
	Dartmouth Hitchcock Practices					
3-101	**Dartmouth-Hitchcock Nashua Internal Medicine**					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-102	**Dartmouth-Hitchcock Nashua Family Medicine**					
	Primary Care Provider	Up to 10	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-109	**Lamprey Health Care**					
	Primary Care Provider	Up to 15	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-118	**St. Joseph Hospital Pediatrics Sky Meadow**					
	Primary Care Provider	Up to 3*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-119	**St. Joseph Hospital Pediatrics Nashua**					
	Primary Care Provider	Up to 9*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-120	**St. Joseph Hospital Pediatrics Milford**					
	Primary Care Provider	Included in 3-119	Included in 3-119			
	Behavioral Health Providers	Included in 3-119	Included in 3-119			
	Assigned Care Managers or Community Health Workers	Included in 3-119	Included in 3-119			
	Foundation Medical Partners Practices					
3-124	**Foundation Medical Partners, Amherst Family Practice**					
	Primary Care Provider	Up to 7	0			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-125	**Foundation Medical Partners, Family Practice of Merrimack**					
	Primary Care Provider	Up to 3	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-126	**Foundation Medical Partners, Family Practice of South Nashua**					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	Up to 1	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-128	**Foundation Medical Partners, Primary Care of Hudson**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-129	**Foundation Medical Partners, Primary Care of Milford**					
	Primary Care Provider	Up to 7	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-131	**Foundation Medical Partners, Medicine-Pediatrics of Nashua**					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-133	**Foundation Medical Partners, Nashua Primary Care**					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-137	**Foundation Medical Partners, Foundation Internal Medicine**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	Up to 2	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-138	**Foundation Medical Partners, Foundation Pediatrics**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-152	**Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine**					
	Primary Care Provider	Up to 1	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-145	Greater Nashua Mental Health Center					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	Up to 42	0			
	Assigned Care Managers or Community Health Workers	Up to 62	0			
3-146	Harbor Health/Harbor Care Health and Wellness Center					
	Primary Care Provider	Up to 9	0			
	Behavioral Health Providers	Up to 11	0			
	Assigned Care Managers or Community Health Workers	Up to 24	0			
3-148	Merrimack River Medical Services					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-151	Keystone Hall					
	Primary Care Provider	0	0			
	Behavioral Health Providers	Up to 6	0			
	Assigned Care Managers or Community Health Workers	Up to 22	0			
	Wave 2					
	Dartmouth Hitchcock Practices					
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-106	Dartmouth-Hitchcock Hudson					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-107	Dartmouth-Hitchcock Milford					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-108	Dartmouth-Hitchcock Merrimack					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
	St. Joseph Hospital Practices					
3-111	**St. Joseph Hospital Family Medicine, Nashua**					
	Primary Care Provider	Up to 4*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1*	0			
3-113	**St. Joseph Hospital Family Medicine & Specialty Services Hudson**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-115	**St. Joseph Hospital Family Medicine & Specialty Services Milford**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-116	**St. Joseph Hospital Internal Medicine**					
	Primary Care Provider	Up to 10*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 2	0			
3-121	**St. Joseph Hospital OB/GYN Merrimack**					
	Primary Care Provider	Up to 6	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Foundation Medical Partners Practices					
3-127	**Foundation Medical Partners, Pepperell Family Practice**					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-134	**Foundation Medical Partners, Downtown Medical Associates**					
	Primary Care Provider	Up to 5	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-135	**Foundation Medical Partners, Nashua Center for Healthy Adults**					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics					
	Primary Care Provider	Up to 1	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-140	Foundation Medical Partners, Partners in Pediatrics					
	Primary Care Provider	Up to 2	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-141	Foundation Medical Partners, Foundation OB/GYN					
	Primary Care Provider	Up to 8	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-143	Foundation Medical Partners, Women's Care of Nashua					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-153	Healthy at Home					
	Primary Care Provider	0	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
	Wave 3					
	Dartmouth Hitchcock Practices					
3-103	Dartmouth-Hitchcock Nashua Pediatrics					
	Primary Care Provider	Up to 10	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-105	Norris Cotton Cancer Center					
	Primary Care Provider	No information available	0			
	Behavioral Health Providers	No information available	0			
	Assigned Care Managers or Community Health Workers	No information available	0			
	St. Joseph Hospital Practices					
3-112	St. Joseph Hospital Family Medicine Nashua South					
	Primary Care Provider	Up to 4	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-117	St. Joseph Hospital Adult Medicine					
	Primary Care Provider	Up to 4*	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1**	0			
3-122	St. Joseph Hospital OB/GYN Hudson					
	Primary Care Provider	Included as part of 3-121	Included as part of 3-121			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
3-123	St. Joseph Hospital Midwifery					
	Primary Care Provider	Included as part of 3-121	Included as part of 3-121			
	Behavioral Health Providers	Included as part of 3-121	Included as part of 3-121			
	Assigned Care Managers or Community Health Workers	Included as part of 3-121	Included as part of 3-121			
	Foundation Medical Partners Practices					
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	0	0			
3-132	Foundation Medical Partners, Nashua West Adult Medicine					
	Primary Care Provider	Up to 4	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua					
	Primary Care Provider	Up to 1	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			
3-142	Foundation Medical Partners, NE GYN & Surgical Services					
	Primary Care Provider	Up to 3	0			
	Behavioral Health Providers	0	0			

Practice ID	Practice Name	Number of Providers to be Trained by 2019	Number of Providers Trained as of 06/30/17	Number of Providers Trained as of 12/31/17	Number of Providers Trained as of 06/30/18	Number of Providers Trained as of 12/31/18
	Assigned Care Managers or Community Health Workers	0	0			
3-144	Foundation Medical Partners, Foundation Community Care					
	Primary Care Provider	Up to 2	0			
	Behavioral Health Providers	0	0			
	Assigned Care Managers or Community Health Workers	Up to 1	0			

B1-8cvi BH Integration Core Competencies

Training Topic/Participant	Total # of IDN Case Managers to Be Trained	Number of Case Managers Trained as of 06/30/17	Number of Case Managers Trained as of 12/31/17	Number of Case Managers Trained as of 06/30/18	Number of Case Managers Trained as of 12/31/18	Number of Case Managers Trained as of 6/30/19	Number of Case Managers Trained as of 12/31/19
Interpersonal Communication							
IDN Case Managers	up to 30	0					
Collaboration and Teamwork							
IDN Case Managers	up to 30	0					
Screening and Assessment							
IDN Case Managers	up to 30	0					
Care Planning and Care Coordination							
IDN Case Managers	up to 30	0					
Intervention							
IDN Case Managers	up to 30	0					
Cultural Competence and Adaptation							
IDN Case Managers	up to 30	0					
Systems Oriented Practice							
IDN Case Managers	up to 30	0					
Practice-Based Learning and Quality Improvement							
IDN Case Managers	up to 30	0					
Informatics							
IDN Case Managers	up to 30	0					

B1-8d Non-Direct Care Staff

Practice ID	Practice Name	Total # of Non-Direct Care Providers	# of Non-Direct Care Prov Trained as of 06/30/17	# of Non-Direct Care Prov Trained as of 12/31/17	# of Non-Direct Care Prov Trained as of 06/30/18	# of Non-Direct Care Prov Trained as of 12/31/18	# of Non-Direct Care Prov Trained as of 06/30/19	# of Non-Direct Care Prov Trained as of 12/31/19
	Dartmouth Hitchcock Practices							
3-101	**Dartmouth-Hitchcock Nashua Internal Medicine**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-102	**Dartmouth-Hitchcock Nashua Family Medicine**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-104	**Dartmouth-Hitchcock Nashua Obstetrics and Gynecology**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-106	**Dartmouth-Hitchcock Hudson**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-107	**Dartmouth-Hitchcock Milford**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-108	**Dartmouth-Hitchcock Merrimack**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-103	**Dartmouth-Hitchcock Nashua Pediatrics**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-105	**Norris Cotton Cancer Center**							

Practice ID	Practice Name	Total # of Non-Direct Care Providers	# of Non-Direct Care Prov Trained as of 06/30/17	# of Non-Direct Care Prov Trained as of 12/31/17	# of Non-Direct Care Prov Trained as of 06/30/18	# of Non-Direct Care Prov Trained as of 12/31/18	# of Non-Direct Care Prov Trained as of 06/30/19	# of Non-Direct Care Prov Trained as of 12/31/19
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
3-109	**Lamprey Health Care**							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with Practice Managers at the site	0					
	St. Joseph Hospital Practices							
3-111	**St. Joseph Hospital Family Medicine, Nashua**							
	Mental Health First Aid	6	0					
	Addressing challenges with coding	6	0					
	Cultural competency	6	0					
3-112	**St. Joseph Hospital Family Medicine Nashua South**							
	Mental Health First Aid	4	0					
	Addressing challenges with coding	4	0					
	Cultural competency	4	0					
3-113	**St. Joseph Hospital Family Medicine & Specialty Services Hudson**							
	Mental Health First Aid	5	0					
	Addressing challenges with coding	5	0					
	Cultural competency	5	0					
3-114	**St. Joseph Hospital Family Medicine & Specialty Services Merrimack**							
	Mental Health First Aid	5	0					
	Addressing challenges with coding	5	0					
	Cultural competency	5	0					
3-115	**St. Joseph Hospital Family Medicine & Specialty Services Milford**							
	Mental Health First Aid	6	0					
	Addressing challenges with coding	6	0					
	Cultural competency	6	0					
3-116	**St. Joseph Hospital Internal Medicine**							
	Mental Health First Aid	12	0					
	Addressing challenges with coding	12	0					
	Cultural competency	12	0					
3-117	**St. Joseph Hospital Adult Medicine**							
	Mental Health First Aid	8	0					
	Addressing challenges with coding	8	0					
	Cultural competency	8	0					
3-118	**St. Joseph Hospital Pediatrics Sky Meadow**							
	Mental Health First Aid	2	0					
	Addressing challenges with coding	2	0					

Practice ID	Practice Name	Total # of Non-Direct Care Providers	# of Non-Direct Care Prov Trained as of 06/30/17	# of Non-Direct Care Prov Trained as of 12/31/17	# of Non-Direct Care Prov Trained as of 06/30/18	# of Non-Direct Care Prov Trained as of 12/31/18	# of Non-Direct Care Prov Trained as of 06/30/19	# of Non-Direct Care Prov Trained as of 12/31/19
	Cultural competency	2	0					
3-119	**St. Joseph Hospital Pediatrics Nashua**							
	Mental Health First Aid	7	0					
	Addressing challenges with coding	7	0					
	Cultural competency	7	0					
3-120	**St. Joseph Hospital Pediatrics Milford**							
	Mental Health First Aid	Included with Pediatrics Nashua	0					
	Addressing challenges with coding	Included with Pediatrics Nashua	0					
	Cultural competency	Included with Pediatrics Nashua	0					
3-121	**St. Joseph Hospital OB/GYN Merrimack**							
	Physicians	3	0					
	Behavioral Health Providers	3	0					
	Assigned Care Managers or Community Health Workers	3	0					
3-122	**St. Joseph Hospital OB/GYN Hudson**							
	Mental Health First Aid	Included with OB/GYN Merrimack	0					
	Addressing challenges with coding	Included with OB/GYN Merrimack	0					
	Cultural competency	Included with OB/GYN Merrimack	0					
3-123	**St. Joseph Hospital Midwifery**							
	Mental Health First Aid	Included with OB/GYN Merrimack	0					
	Addressing challenges with coding	Included with OB/GYN Merrimack	0					
	Cultural competency	Included with OB/GYN Merrimack	0					
	Foundation Medical Partners Practices							
3-124	**Foundation Medical Partners, Amherst Family Practice**							
	Mental Health First Aid	3	0					
	Addressing challenges with coding	3	0					
	Cultural competency	3	0					
3-125	**Foundation Medical Partners, Family Practice of Merrimack**							
	Mental Health First Aid	3	0					
	Addressing challenges with coding	3	0					
	Cultural competency	3	0					
3-126	**Foundation Medical Partners, Family Practice of South Nashua**							
	Mental Health First Aid	5	0					
	Addressing challenges with coding	5	0					
	Cultural competency	5	0					
3-127	**Foundation Medical Partners, Pepperell Family Practice**							
	Mental Health First Aid	5	0					
	Addressing challenges with coding	5	0					
	Cultural competency	5	0					
3-128	**Foundation Medical Partners, Primary Care of Hudson**							
	Mental Health First Aid	7	0					
	Addressing challenges with coding	7	0					

Practice ID	Practice Name	Total # of Non-Direct Care Providers	# of Non-Direct Care Prov Trained as of 06/30/17	# of Non-Direct Care Prov Trained as of 12/31/17	# of Non-Direct Care Prov Trained as of 06/30/18	# of Non-Direct Care Prov Trained as of 12/31/18	# of Non-Direct Care Prov Trained as of 06/30/19	# of Non-Direct Care Prov Trained as of 12/31/19
	Cultural competency	7	0					
3-129	**Foundation Medical Partners, Primary Care of Milford**							
	Mental Health First Aid	7	0					
	Addressing challenges with coding	7	0					
	Cultural competency	7	0					
3-130	**Foundation Medical Partners, Southern New Hampshire Health System at Pelham**							
	Mental Health First Aid	3	0					
	Addressing challenges with coding	3	0					
	Cultural competency	3	0					
3-131	**Foundation Medical Partners, Medicine-Pediatrics of Nashua**							
	Mental Health First Aid	6	0					
	Addressing challenges with coding	6	0					
	Cultural competency	6	0					
3-132	**Foundation Medical Partners, Nashua West Adult Medicine**							
	Mental Health First Aid	6	0					
	Addressing challenges with coding	6	0					
	Cultural competency	6	0					
3-133	**Foundation Medical Partners, Nashua Primary Care**							
	Mental Health First Aid	5	0					
	Addressing challenges with coding	5	0					
	Cultural competency	5	0					
3-134	**Foundation Medical Partners, Downtown Medical Associates**							
	Mental Health First Aid	4	0					
	Addressing challenges with coding	4	0					
	Cultural competency	4	0					
3-135	**Foundation Medical Partners, Nashua Center for Healthy Adults**							
	Mental Health First Aid	1	0					
	Addressing challenges with coding	1	0					
	Cultural competency	1	0					
3-136	**Foundation Medical Partners, Internal Medicine Associates of Nashua**							
	Mental Health First Aid	4	0					
	Addressing challenges with coding	4	0					
	Cultural competency	4	0					
3-137	**Foundation Medical Partners, Foundation Internal Medicine**							
	Mental Health First Aid	3	0					
	Addressing challenges with coding	3	0					
	Cultural competency	3	0					
3-138	**Foundation Medical Partners, Foundation Pediatrics**							
	Mental Health First Aid	8	0					

Practice ID	Practice Name	Total # of Non-Direct Care Providers	# of Non-Direct Care Prov Trained as of 06/30/17	# of Non-Direct Care Prov Trained as of 12/31/17	# of Non-Direct Care Prov Trained as of 06/30/18	# of Non-Direct Care Prov Trained as of 12/31/18	# of Non-Direct Care Prov Trained as of 06/30/19	# of Non-Direct Care Prov Trained as of 12/31/19
	Addressing challenges with coding	8	0					
	Cultural competency	8	0					
3-139	**Foundation Medical Partners, Southern New Hampshire Pediatrics**							
	Mental Health First Aid	1	0					
	Addressing challenges with coding	1	0					
	Cultural competency	1	0					
3-140	**Foundation Medical Partners, Partners in Pediatrics**							
	Mental Health First Aid	2	0					
	Addressing challenges with coding	2	0					
	Cultural competency	2	0					
3-141	**Foundation Medical Partners, Foundation OB/GYN**							
	Physicians	6	0					
	Behavioral Health Providers	6	0					
	Assigned Care Managers or Community	6	0					
3-142	**Foundation Medical Partners, NE GYN & Surgical Services**							
	Mental Health First Aid	2	0					
	Addressing challenges with coding	2	0					
	Cultural competency	2	0					
3-143	**Foundation Medical Partners, Women's Care of Nashua**							
	Mental Health First Aid	8	0					
	Addressing challenges with coding	8	0					
	Cultural competency	8	0					
3-144	**Foundation Medical Partners, Foundation Community Care**							
	Mental Health First Aid	2	0					
	Addressing challenges with coding	2	0					
	Cultural competency	2	0					
3-152	**Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine**							
	Mental Health First Aid	2	0					
	Addressing challenges with coding	2	0					
	Cultural competency	2	0					
3-145	**Greater Nashua Mental Health Center**							
	Mental Health First Aid	23	0					
	Addressing challenges with coding	23	0					
	Cultural competency	23	0					
3-146	**Harbor Health/Harbor Care Health and Wellness Center**							
	Mental Health First Aid	54	0					
	Addressing challenges with coding	54	0					
	Cultural competency	54	0					
3-148	**Merrimack River Medical Services**							
	Mental Health First Aid	4	0					

Practice ID	Practice Name	Total # of Non-Direct Care Providers	# of Non-Direct Care Prov Trained as of 06/30/17	# of Non-Direct Care Prov Trained as of 12/31/17	# of Non-Direct Care Prov Trained as of 06/30/18	# of Non-Direct Care Prov Trained as of 12/31/18	# of Non-Direct Care Prov Trained as of 06/30/19	# of Non-Direct Care Prov Trained as of 12/31/19
	Addressing challenges with coding	4	0					
	Cultural competency	4	0					
3-151	**Keystone Hall**							
	Mental Health First Aid	4	0					
	Addressing challenges with coding	4	0					
	Cultural competency	4	0					
	Healthy at Home							
	Mental Health First Aid	TBD no later than 12/31/17 through meetings with IDN Member leaders at the organization	0					
	Addressing challenges with coding	TBD no later than 12/31/17 through meetings with IDN Member leaders at the organization	0					
	Cultural competency	TBD no later than 12/31/17 through meetings with IDN Member leaders at the organization	0					

IDN 3 Cross-IDN Case Management Team Meetings
Proposed Plan and Timeline
July 2017

The IDN plans to begin multi-disciplinary core team meetings in conjunction with the community-driven projects, which will begin to incorporate the physician practices and other IDN providers in piloting a case management process across the IDN.

The goal is to begin core team case management meetings no later than January 2018 in conjunction with the C1: Critical Time Intervention (CTI) program ramp up, then quickly thereafter with the E4: Integrated Dual Diagnosis Treatment (IDDT) program ramp up, which will engage many of the strategies and providers across the D3: Expansion in SUD Treatment Options and B1: Integrated Health.

It is expected that through starting with these two project strategies/programs, we will be able to engage providers and social support organizations across the IDN on a smaller scale in order to pilot the case management team meeting structure, focusing on breaking out of organizational silos. Therefore, we plan to engage two IDN-wide multi-disciplinary core teams throughout 2018, which will support the needs of complex patients in these programs while we ramp up our HIT platforms and pilot our communication and information sharing workflows and protocols.

The goal is to build upon case management meeting protocols/processes that likely occur within the two Federally Qualified Health Centers (FQHCs), Harbor Homes and Lamprey Health, as well as within the CMHC: Greater Nashua Mental Health Center. We also hope that with training associated with the A1: Behavioral Health Workforce Capacity and B1: Integrated Health in care coordination and management, we will begin a structure that will work across IDN partners using project strategies, rather than practices/organizations.

The table below outlines the monthly schedule of the proposed cross-IDN case management meetings, including the information we plan to track as we engage in cross-learning.

Month	IDN Project Strategy	IDN Provider Participants	IDN Next Steps
January 2018	CTI		
February 2018	CTI and IDDT		
March 2018	CTI and IDDT		
April 2018	CTI and IDDT		
May 2018	CTI and IDDT		
June 2018	CTI and IDDT		
July 2018	CTI and IDDT		
August 2018	CTI and IDDT		
September 2018	CTI and IDDT		
October 2018	CTI and IDDT		
November 2018	CTI and IDDT		
December 2018	CTI and IDDT		

B1-8f. Direct Secure Messaging

As a part of the Statewide HIT Taskforce recommendations for each IDN to meet as a minimum capability/ standard, IDN 3 will secure a contract with Service for all 29 of its IDN Member Entities, allowing for the ability to transmit patient information between providers.

B1-8g. Closed Loop Referrals

As part of the State HIT Taskforce recommendations for each IDN to meet as an optional capability/standard, IDN will secure a contract with , who will utilize HL7 FHIR formats through its platform for referrals.

will allow for IDN Member Entities to securely send content from one application to another known location, and process a single response from the system receiving the message. Direct messages will be triggered for referrals to providers. Setup of each provider will identify the status of direct messaging, as well as the system and agreement rules to be applied.

as a home workspace, will allow for any of our Member Entities to review incoming referrals while utilizing the IDN's patient privacy and consent policies (to be completed no later than September 2017). The *Patient Privacy and Consent Work Team* will work with the *Information Sharing and Standardized Workflow Protocols Work Team* to determine which Member Entities will have access to the workspace, what information they will be able to access to view, what information they will be able to provide, as well as the protocols for securing patient consent.

Subject: Admission of Clients

Policy:
Acceptance of clients who are referred to or request home care services is based on the reasonable expectation that the client's home care needs can be met by the home care agency staff in the client's place of residence. Once a client is accepted for services, the admission process will take place within 48 hours.

Purpose:

1. To establish specific admission requirements for acceptance of clients for home care services.
2. To assess referrals for appropriateness of admission to the home care agency.

Procedure:

1. The Agency's Director of Client Services assesses all referrals for appropriateness of admission to the home care agency by considering the following:
    a. Adequacy and suitability of agency personnel and resources to provide the services required by the client.
    b. A reasonable expectation that the client's medical, nursing, personal and social needs can be met adequately at home.
    c. The presence of adequate physical facilities in the client's home for his/her plan of care.
    d. The availability or absence of family or substitute family members able and willing to participate in the client's care when necessary to ensure the safety of the client.
    e. The client's home is located in the geographical area served by the home care agency.

2. All clients are accepted for care regardless of color, creed, age, or sex in accordance with Title VI of the Civil Rights Act.

3. Clients with dual eligibility, ie. Medicare/Medicaid and CFI, will be admitted with skilled services being billed to either Medicare or Medicaid and non skilled, custodial care services billed to CFI as authorized by the client's case manager.

Origin Date: 2000
Date revised: 04/04/07, 03/09/2014
Reviewed: 01/05/2011/2017

Dartmouth-Hitchcock | KNOWLEDGE MAP™

Behavioral Health Integration into Adult Primary Care Model Guideline

Table of Contents

EXECUTIVE SUMMARY: 2
D-H GUIDELINE ENDORSEMENT STATEMENT 4
RECOMMENDATIONS FOR D-H IMPLEMENTATION 4
APPENDIX 1: Screening Instruments 6
APPENDIX 2: Tasks of Collaborative Care 7
APPENDIX 3: Stepped Care Model[19] 8
REFERENCES: 9

Guideline Contact for Content/Document Changes:
Charles Brackett, MD, MPH
Telephone: 603-308-2268
Email: Charles.D.Brackett@hitchcock.org or knowledge.map@hitchcock.org

Guideline Authors:
Principal Guideline:
2016 American Psychiatric Association/Academy of Psychosomatic Medicine (APA/APM) Dissemination Of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model[1]

D-H Review and Adoption Committee:

Mark McGovern, PhD (Lebanon)
Inas Khayal, PhD (Lebanon)
Jennifer Raymond (Lebanon)
Cara Baskin, MPH (Lebanon)

Primary Care:
James Stahl, MD, MPH (Lebanon)
Jonathan Thyng, MD (Nashua)
Timothy Burdick, MD (Manchester)
Erik Shessler, MD (Manchester)
Andrew Tremblay, MD (Keene)
Virginia Alvord, MD (Lebanon)

Psychiatry:
Matthew Duncan, MD (Lebanon)
William Torrey, MD (Lebanon)

Approval Body: D-H Knowledge Map™
Release Date: February, 2017

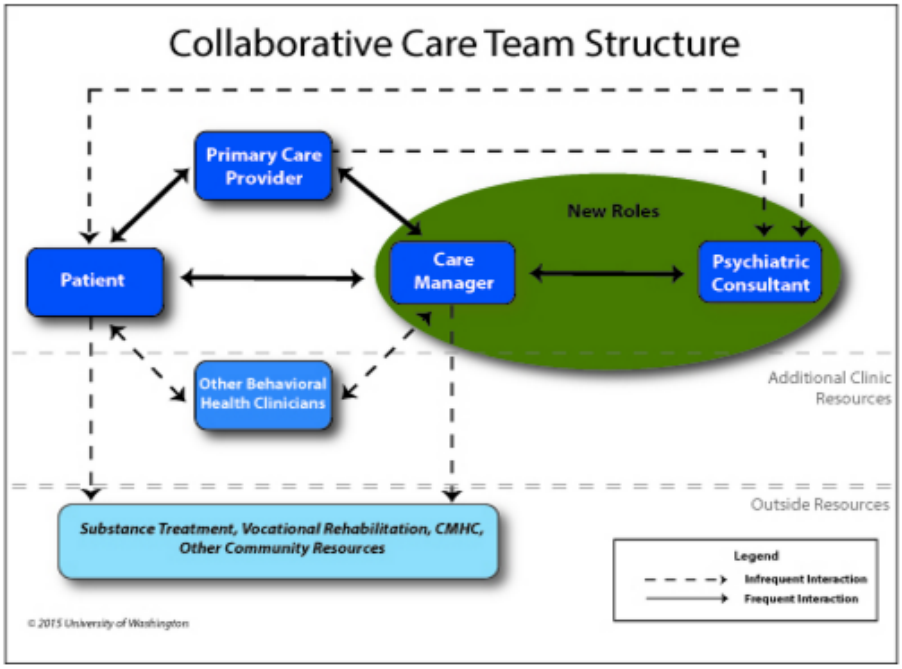
EXECUTIVE SUMMARY:

Mental and substance use disorders are common in the primary care setting, and frequently co-exist with and worsen the outcomes of chronic diseases. Behavioral health disorders are undertreated due to inadequate recognition, a shortage of behavioral health clinicians, stigma, and challenges navigating complex healthcare systems. Integrating behavioral health care into primary care provides a holistic care approach that reduces fragmentation, destigmatizes behavioral health disorders, lowers care costs, increases patient[2] and provider satisfaction, and improves both behavioral[2,3] and physical health outcomes. One model of integrated care, the Collaborative Care Model, follows the principles of Wagner's Chronic Care Model and has been extensively studied and widely adopted.

Essential Elements of the Collaborative Care Model:

1. Team-Driven Care

A multidisciplinary group of healthcare delivery professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.



(Source: University of Washington's AIMS Center[4])

The three main members of the team are:

- **Primary Care Provider (PCP):** oversees the overall patient care plan and is the ultimate decision-maker for the clinical team.
- **Care Manager**: the lynchpin linking the team members to the patient and to each other. CMs work to keep patients engaged in their care, assess treatment adherence and side effects, explore treatment preferences, facilitate referrals outside primary care, and collect clinical outcome metrics. Ideally, the CM would have mental health training, be able to provide brief counseling, and be hired specifically for this role (termed "behavioral health clinician" at DHMC Lebanon). Alternatively, existing clinic personnel could be trained for this role.
- **Consulting Psychiatrist**: reviews the CM's caseload at routine intervals, provides consultation and feedback to PCPs (through "curbside" or e-consults (initial consults from primary care) and other EHR

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

communication), and may evaluate and/or co-manage patients directly (through on-site care or off-site telemedicine).

Other members of the primary care based team can be added depending on the needs of the clinic- psychologists, social workers, licensed alcohol and drug counselors, and community health workers. Medical assistants can be involved in screening and self-management support.

2. Population-Focused Care

The Collaborative Care team is responsible for the provision of care and health outcomes of a defined population of patients. This may include the use of registries and aggregated data to highlight resource allocation, trends in care delivery, and outcome monitoring. A population-based approach is proactive, reaching out to patients rather than waiting for them to self-identify in an office, and links patients to other clinical or community-based resources as necessary. "Stepped care", where service intensity is titrated to the degree of patient complexity and response to treatment, is an essential component of population-based care- ensuring that limited specialty resources are applied where they are most needed.

3. Measurement-Guided Care

The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making and track treatment response. Use of measurement based care (MBC, treat to target) using the principles below has been shown to improve treatment outcomes by identifying non-responders through proactive longitudinal follow-up and reducing clinical inertia. In addition, the use of MBC is increasingly required by health plans and accreditation agencies.

Six components of effective measurement:

a. Measurement alone is not enough; outcomes must be incorporated into the clinical encounter.
b. Patient-reported outcomes are more accurate than clinician-reported outcomes.
c. Measures must be collected frequently to accurately assess the most recent clinical state.
d. Measures must be tightly correlated to the illness state and are typically diagnosis-specific.
e. Instruments must be reliable and sensitive to change.
f. Methods must be relatively simple to implement and low cost.

4. Evidence-Based Care

The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes. Evidence-based care is most effective when treatment algorithms are standardized and levels of treatment intensification are commonly accepted among practitioners as a standard of care. This "stepped care" approach (see appendix 3) allows for a more rapid application of a treatment intensity framework for individual patients and facilitates the caseload review process and population management. Clinical decision supports, such as treatment guidelines and educational materials for patients, clinicians and CMs, are essential to this work.

5. Accountability and Quality Improvement

Successful implementation and ongoing maintenance of an integrated care program requires many new system processes to achieve each of the previously outlined four core elements of the model. From the outset, programs should have a plan for periodically monitoring their success in achieving desired outcome measures as well as monitoring fidelity to the clinical model using process measures. In a constantly changing environment of care, a structured and continuous quality improvement strategy is critical for initial and ongoing success.

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

D-H GUIDELINE ENDORSEMENT STATEMENT

Scope:

This guideline is intended to support primary care clinicians and behavioral health clinicians embedded in primary care in their efforts to optimally identify, assess, triage and manage adult patients with behavioral health issues in a Collaborative Care Model in the ambulatory setting and to clarify D-H clinical standards for this work.

Definitions:

BH- Behavioral Health (includes mental health and substance use disorders)
CCM- Collaborative Care Model
CM- Care Manager (i.e. MSW, RN, Behavioral health clinician)
EHR- electronic health record
SUD- substance use disorder

RECOMMENDATIONS FOR D-H IMPLEMENTATION

Specific recommendations in the CCM associated with clinically significant outcomes improvement:

- Regularly scheduled CM supervision by a psychiatrist (i.e., weekly patient caseload review) was significantly correlated with improved outcomes.[5]
- CMs with mental health experience generate better clinical outcomes than CMs from other disciplines.[5-7]
- Physical co-location of the mental health team, while effective, is not critical to the effectiveness of the model.[8,9]

Potential Benefits:

- Improved recognition and management of BH disorders
- Improved access to BH services
- Reduced fragmentation of care
- Improved patient and clinician satisfaction
- Improved patient outcomes- both behavioral health and physical health

Potential Harms:

- Added care team time burden of screening lower risk sub-populations and downstream assessment and intervention
- Expanding accountable team risks imperfect hand offs and dropped care components if coordination is not tight

Costs Considerations

Main costs are personnel: the new roles of care manager/mental health clinician and the consulting or embedded psychiatrist. There will also be costs of training MAs for screening and training nurses without mental health care experience. Implementation studies of behavioral health integration have shown improved quality and reduced costs through decreased healthcare utilization. Four-year analysis of the IMPACT study demonstrated that $1 spent on collaborative care saved $6.50 in overall health care costs.[10] Intermountain found sites integrating BH into primary care had overall costs of $115 per patient per year less than usual care sites, compared to the cost of $10 per patient per year to implement the program.[11] Effective

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

January 2017, PCPs can bill Medicare for the services of the behavioral health care manager (with specialized training) and consulting psychiatrist working together in the collaborative care model.[12]

Implementation Tools

1. **Clinician Dissemination:**
    a. Clinical practice guidelines for the assessment and management of Depression, Anxiety, Unhealthy alcohol and substance use, and Medication Assisted Therapy of Opioid Use Disorder in Primary Care.
    b. Updating existing Preventive Care clinical practice guideline with recommendations for behavioral health screening tools, including frequency and score cut-offs
    c. A primary care clinician "Behavioral Health Playbook" that synthesizes the roles, tasks, workflows and treatment algorithms for the four behavioral health conditions, above.
2. **Clinical Support:**
    a. A "one stop" website to support clinicians in addressing behavioral health issues
3. **Patient Education and Resources:**
    a. D-H internet web-page that summarizes information, self-management support, self-help groups, counseling resources, etc. for all behavioral health disorders
4. **Behavioral Health Clinician/Case Manager/Nurse-supported Behavioral Health Care:**
    a. Care pathways
    b. Training for nurses without mental health care delivery experience
5. **eDH (EHR) Tools:**
    a. Build a behavioral health screening questionnaire in eDH (initial single question screens for depression, alcohol, and SUD triggering more detailed instruments (see appendix 1)
    b. Best practice advisories to alert clinicians to positive screens and offer guidance.
    c. Smartsets offering decision support, ordering efficiency, and patient information and resources
6. **Clinical Performance Measures** (see condition specific guidelines for condition specific outcomes**):**
    a. Process Measures: percent of patients with new diagnoses of depression, anxiety or SUD enrolled in collaborative care; percent of patients enrolled in collaborative care who are successfully contacted within 4 weeks of enrollment; patient satisfaction, clinician satisfaction, clinician confidence.

Qualifying Statements

Pathways & Guidelines: Clinical Practice Guideline and pathways are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

Copyright, citation, use, and adoption limitation/instructions:
May not be reproduced, distributed or modified for sale. May not be loaded into software platform outside of D-H in whole or in part without explicit permission.
If modified for local use, cite as:
Adapted from Dartmouth-Hitchcock Knowledge Map™ Behavioral Health Integration into Adult Primary Care Model Guideline. Copyright 2017.

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

APPENDIX 1: Screening Instruments

Initial Screening Instruments

Condition	Initial Screening Instrument	Frequency
Depression	PHQ-2[13]	If not done in previous 3 months
Substance Use Disorder	*In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?*[14]	Once annually (expert opinion)
Alcohol Use Disorder	*In the past year have you had 5 (4 for women) or more drinks in a day?*[15]	Once annually (expert opinion)

Secondary Screening Instruments

Condition	Secondary Screening Instrument
Depression	PHQ-2 score ≥3 triggers PHQ-9
Substance Use Disorder	"Yes" triggers DAST-10[16,17]
Alcohol Use Disorder	"Yes" triggers AUDIT[18]

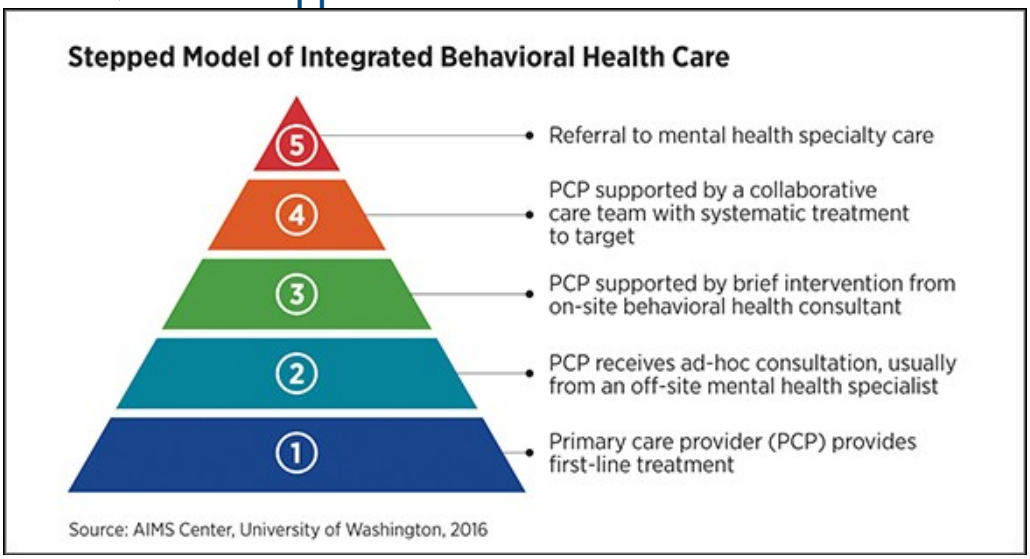
Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

APPENDIX 2: Tasks of Collaborative Care

Prepare System	**Provide System Level Supports for Care** • **Establish a Program Vision** • **Define Population Targeted by Collaborative Care** • **Choose Tracking Method/Registry** • **Train Team Members** • **Provide System Level Supports for Care**
Patient Care	Identify and Engage Patients • Identify People Who Need Help • Screen for Behavioral Health Problems Using Valid Measures • Engage Patient in Integrated Care Program
	Establish Diagnosis • Perform Behavioral Health Assessment • Identify & Treat Coexisting Medical Conditions • Diagnose Behavioral Health Disorders • Patient Education about Symptoms & Diagnosis
	Initiate Treatment • Patient Education about Recommended Treatment • Develop & Update Behavioral Health Treatment Plan • Brief Counseling, Behavioral Activation • Prescribe Psychotropic Medications – as indicated • Evidence-based Psychotherapy (e.g., PST, CBT, IPT) – as indicated • Facilitate Referral to Specialty Care or Social Services – as indicated
	Follow-Up Care and Treat to Target • Track Treatment Engagement & Adherence using Registry • Reach out to Patients who are Non-adherent or Disengaged • Track Patients' Symptoms with Valid Outcome Measures (e.g., PHQ-9) • Track Medication Side Effects & Concerns • Track Outcome of Referrals & Other Treatments • Assess Need for Changes in Treatment • Provide Caseload-Focused Psychiatric Consultation Focused on Non-responding Patients • Adjust Treatment if Patients are Not Responding • Facilitate Changes in Treatment Plan • Provide In-Person or Telehealth Psychiatric Assessment of Challenging Patients
	Complete Treatment and Provide Relapse Prevention • Assess for Completion of Goals • Create & Support Relapse Prevention Plan • Communicate Plan to Team
Ongoing System Supports	Provide System Level Supports for Care • Provide Administrative Support for Program (e.g., Scheduling, Resources) • Coordinate Communication Among Team Members/Providers • Engage in Continuous Quality Improvement Efforts, Focusing on Patient Panels (Entire Population Served)

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

APPENDIX 3: Stepped Care Model[19]



Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

REFERENCES:

1. *American Psychiatric Association; Academy of Psychosomatic Medicine. Dissemination Of Integrated Care Within Adult Primary Care Setting: The Collaborative Care Model. 2016. Available from: file://localhost/Users/carabaskin/Downloads/APA-APM-Dissemination-Integrated-Care-Report.pdf. Accessed October, 2016.*
2. Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *Jama.* 2002;288(22):2836-2845.
3. Archer J, et al. Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews.* 2012.
4. University of Washington AIMS Center. Team Structure. [web page]. 2015; http://aims.uw.edu/collaborative-care/team-structure. Accessed October, 2016.
5. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *The British journal of psychiatry : the journal of mental science.* 2006;189:484-493.
6. Thota AB, Sipe TA, Byard GJ, et al. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *American journal of preventive medicine.* 2012;42(5):525-538.
7. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Archives of internal medicine.* 2006;166(21):2314-2321.
8. Simon GE, Ralston JD, Savarino J, Pabiniak C, Wentzel C, Operskalski BH. Randomized trial of depression follow-up care by online messaging. *J Gen Intern Med.* 2011;26(7):698-704.
9. Fortney JC, Pyne JM, Edlund MJ, et al. A randomized trial of telemedicine-based collaborative care for depression. *J Gen Intern Med.* 2007;22(8):1086-1093.
10. Unutzer J, Katon WJ, Fan MY, et al. Long-term cost effects of collaborative care for late-life depression. *The American journal of managed care.* 2008;14(2):95-100.
11. Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. *Jama.* 2016;316(8):826-834.
12. University of Washington Psychiatry and Behavioral Sciences AIMS Center. Cheat Sheet on CMS FInal Rule for 2017 Medicare Payments for Integrated Behavioral Health Services. [web page]. 2017; https://aims.uw.edu/sites/default/files/CMS_FinalRule_2017_CheatSheet.pdf. Accessed January 12, 2017.
13. Kroenke K, Spitzer RL, Williams JB. The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic medicine.* 2002;64(2):258-266.
14. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. *Archives of internal medicine.* 2010;170(13):1155-1160.
15. *National Institute on Alcohol Abuse and Alcoholism (NIAAA). Helping Patients Who Drink Too Much: A Clinician's Guide. 2005. Available from:* http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf*. Accessed September, 2016.*
16. Skinner HA. The drug abuse screening test. *Addictive behaviors.* 1982;7(4):363-371.
17. National Institute on Drug Abuse. DAST-10. [web page]. https://www.drugabuse.gov/sites/default/files/files/DAST-10.pdf. Accessed September, 2016.
18. *Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. The Alcohol Use Disorders Identification Test (AUDIT) Guideliens for Use in Primary Care (2nd ed.) 2001. Available from:* http://www.talkingalcohol.com/files/pdfs/WHO_audit.pdf*. Accessed September, 2016.*

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

19. University of Washington AIMS Center. Stepped Model of Integrated Behavioral Health Care. [web page]. 2016; https://aims.uw.edu/stepped-model-integrated-behavioral-health-care. Accessed October, 2016.

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

Dartmouth-Hitchcock KNOWLEDGE MAP™

Depression Management

Adult, Ambulatory Clinical Practice Guideline Pocket Guide

DEPRESSION MANAGEMENT GUIDELINE USE

Full Dartmouth-Hitchcock Depression Management Adult, Ambulatory Clinical Practice Guideline:
http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/depression_cpg_final.pdf?sfvrsn=2

Depression Management Adult, Ambulatory Clinical Practice Brief:
http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/depression_brief-final.pdf?sfvrsn=2

Patient Resources

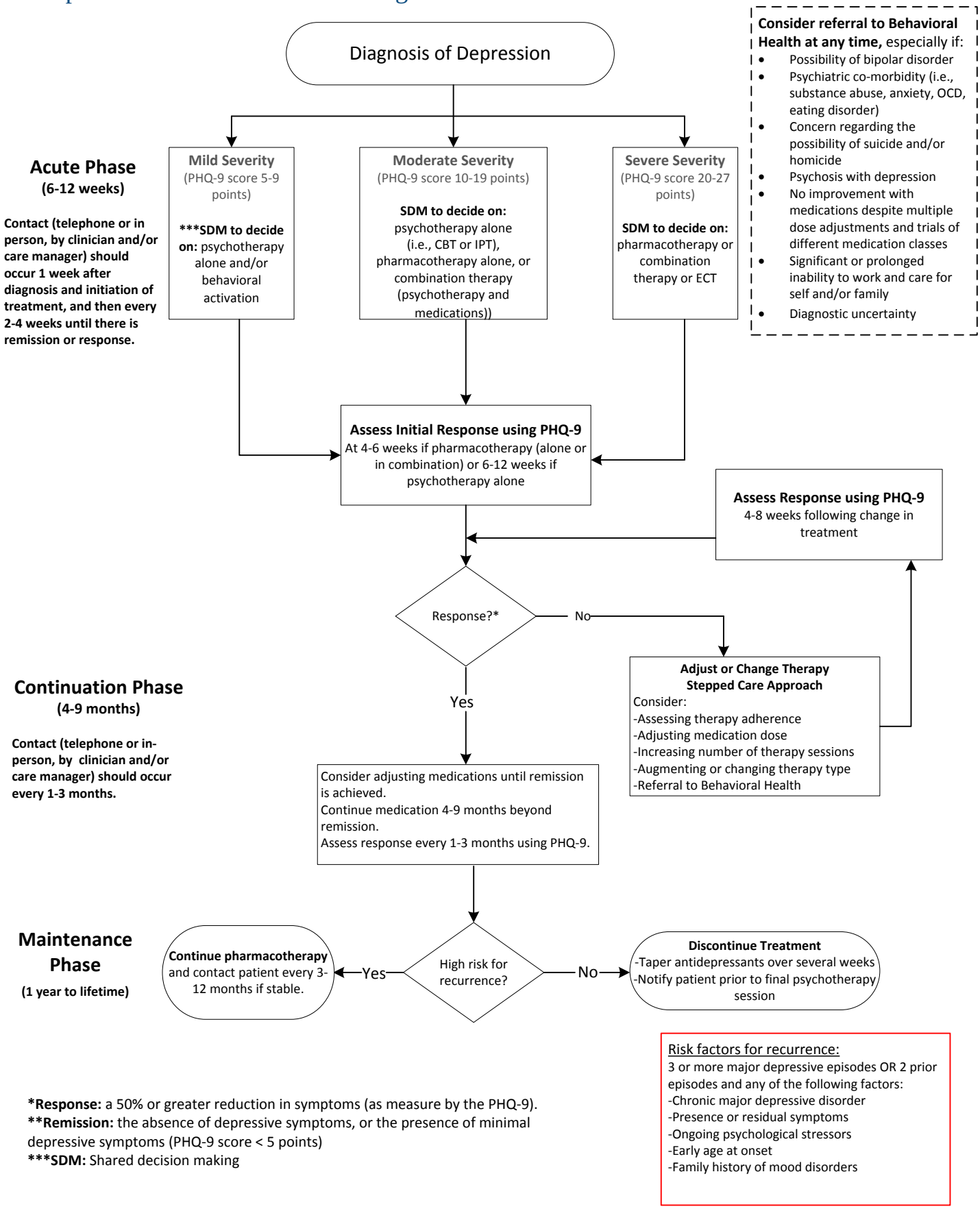
- A D-H internet web-page will be built that summarizes information, self-help strategies, self-help groups, counseling resources, etc. for depression (below).
- Healthwise resources on D-H internet site: dozens of topics available
- Other web resources
  - Information
    - www.nimh.nih.gov/health/topics/depression/index.shtml
    - www.psychiatry.org/patients-families/depression
    - www.suicidepreventionlifeline.org
  - Finding a therapist
    - https://therapists.psychologytoday.com
  - CBT based self-management
    - http://www.moodjuice.scot.nhs.uk
    - https://moodgym.anu.edu.au/welcome
    - http://www.beatingtheblues.co.uk/patients/
- Apps
  - Pacifica- anxiety, stress and depression relief
  - MoodKit- CBT for depression, anxiety, anger management
- Books
  - The Cognitive Behavioral Workbook for Depression- William Knauss, EdD

Pathways & Guidelines: Clinical Practice Guideline and pathways are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

Copyright, citation, use, and adoption limitation/instructions:
May not be reproduced, distributed or modified for sale. May not be loaded into software platform outside of D-H in whole or in part without explicit permission.
If modified for local use, cite as:
Adapted from Dartmouth-Hitchcock Knowledge Map™ Depression Management Adult, Ambulatory Clinical Practice Guideline. Copyright 2017.

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

Depression Treatment in Adults Algorithm



Risk factors for recurrence:
3 or more major depressive episodes OR 2 prior episodes and any of the following factors:
-Chronic major depressive disorder
-Presence or residual symptoms
-Ongoing psychological stressors
-Early age at onset
-Family history of mood disorders

***Response:** a 50% or greater reduction in symptoms (as measure by the PHQ-9).
****Remission:** the absence of depressive symptoms, or the presence of minimal depressive symptoms (PHQ-9 score < 5 points)
*****SDM:** Shared decision making

Copyright © 2017 Dartmouth-Hitchcock Knowledge Map™. Updated: January 2017

The YOUTH COUNCIL
Helping families flourish

Meet Leah...

Leah Elliott, MSW

Nashua School District contracted with The Youth Council to provide specialized screening and intervention services for students who are struggling with stressors that may lead or have led them to engage in risky behavior.

After working for five years at the Lighthouse School, Leah Elliott, MSW, joined our team in 2016 to: provide an array of assessment and referral services for teens; help them set goals and develop action plans to improve their success; link youth to school and community-based supports; and provide short-term supportive counseling for individuals and groups of teens at Nashua High School North and South. Leah may also be available at her office in downtown Nashua for meetings with parents outside the school day.

In order to help your son or daughter achieve maximum success, staff at Nashua High School North or South would like to refer your student to Leah to set goals and develop an action plan for improving his/her success. Recommendations may include linking him/her to school- and community-based services, participating in a comprehensive clinical assessment to determine any additional concerns, as well as attending short-term school-based counseling, groups and/or check-in appointments.

Please contact Leah directly with any questions at:

SOUTH	966-1444	ElliottL@nashua.edu	Room C2013
NORTH	966-2447	ElliottL@nashua.edu	Room B122

If you are interested in participating in Student Assistance Program (SAP) Services, please review the Informed Consent information below and return the signature section to Leah or your child's guidance counselor.

Informed Consent, Client Rights & Responsibilities for Student Assistance Program

TO PARENTS AND STUDENTS:

You are receiving this information because you may be interested in participating in the Student Assistance Program ("SAP") at Nashua High School North or South. The SAP Program is designed to help students develop skills to cope with the pressures of high school ultimately leading to increased academic success. The Program is offered by the Schools in conjunction with a counselor from The Youth Council. The School and The Youth Council are committed to providing quality services to students. To avoid any confusion or misunderstandings, this form provides important information about all aspects of the SAP Program. In addition, The Youth Council Counselor can provide you with some basic information about the services. Parents and students should read this information carefully and discuss any questions you have before signing below.

The Youth Council ■ 112 West Pearl Street ■ Nashua, NH 03060

1. QUALIFICATIONS AND SCOPE OF PRACTICE

As a Mental Health Counselor, I, Leah Elliott, MSW, am governed by the Code of Ethics of the American Mental Health Counselors Association. A copy of the Code of Ethics is available upon request.

As stated above, the SAP Program is a short-term assessment and referral program designed to assist students in developing coping skills and achieving academic success. SAP Program Counselors are trained to initially assess students to determine what services would best assist the student in achieving these goals. After the initial assessment, the SAP Program Counselor may refer the student to one of the following:

- In school group counseling
- In-school short term individual counseling
- Services with an agency outside of the school

Parents and students should be aware that the SAP Program is designed to provide only short term, goal specific counseling. Please also be aware that SAP Program Counselors may communicate with the school guidance counselors as appropriate in order to provide the best service to the students. Although the SAP Program Counselors are committed to helping students, some students will require services that are beyond the scope of the SAP Program. You may choose to obtain more extensive services from someone outside of the School. You also have the choice not to obtain any services at all. If you have any questions, please discuss all services and recommendations with the SAP Program Counselor.

2. MENTAL HEALTH BILL OF RIGHTS

Pursuant to the New Hampshire Mental Health Bill of Rights, clients have certain rights. A copy of the Mental Health Bill of Rights is attached to this document and is displayed in the offices of the SAP counselor. If you have any questions about the Mental Health Bill of Rights or this document, please discuss them with your counselor.

3. CONFIDENTIALITY AND PRIVACY

The Youth Council and the School will make every effort to protect the privacy of students enrolled in the SAP Program. Since trust between the student and SAP Counselor is a crucial component to your child's success in the program, The Youth Council and the School ask that parents respect the privacy of students who may not wish to share certain information about their counseling. Please be aware that students who share any information pertaining to alcohol and other drugs are protected by Federal laws and regulations (42 C.F.R. Part 2). This information cannot be disclosed to anyone, including parents, without written consent from the student. If you have concerns about the limits of privacy or confidentiality, please discuss them with your counselor before starting counseling.

4. REPORTING REQUIREMENTS

Parents and students are reminded that Nashua High School North and South require certain information to be disclosed by the SAP Program Counselor to employees or agents of the School, as well as to parents, as required by mandatory reporting laws. Counselors will disclose only the minimum information necessary, on a need to know basis. Under New Hampshire law, counselors are required to report certain information including, for example:

- A serious threat of harm to yourself, someone else, or property;
- A suspicion of abuse or neglect of a child or incapacitated adult;
- Knowledge of student hazing, bullying, and sexual harassment;
- Suspicion of a student under the influence of alcohol or other drugs;
- Witnessing or having information from a victim of a criminal act in a safe school zone.

5. PROFESSIONAL BOUNDARIES

Counselors are obligated to establish and maintain appropriate professional boundaries (relationships) with students at all times. Do not hesitate to raise any questions you may have regarding professional boundaries. Reports of misconduct should be directed to the New Hampshire Board of Mental Health Practice, 121 South Fruit Street, Concord, NH 03301, 603-271-6762.

6. LIMITS OF AVAILABILITY & PROVISIONS FOR EMERGENCY COVERAGE

SAP counselors do not provide any emergency services. If an emergency should arise while a student is attending school, the situation will be handled by school personnel. SAP counselors are only available when school is in session.

7. ELECTRONIC COMMUNICATION

SAP counselors are not on site every day and therefore are unable to check and return e-mails on a regular basis. Please contact your guidance counselor if you have an urgent concern and cannot wait for a reply. In addition, SAP counselors are not school district employees and do not have a district e-mail address. E-mails are provided by a third party service which means they are not confidential and caution should be used when communicating in this way.

Please return the form below:

ACKNOWLEDGEMENT AND ACCEPTANCE

My signature below indicates that I have read and understand this document and agree to abide by its terms.

I, _____ (parent/guardian), give permission for my son/daughter, _____, to receive services.

OR

I, _____, as an adult, consent to voluntarily participate in services.

This agreement will stay in effect until services are completed or if permission is revoked either verbally or in writing.

_____ _____ _____ _____

Signature of parent/guardian Date Signature of client Date

B1-9a. Progress Toward Coordinated Care Practice Designations

Contracts will be signed with IT vendors as soon as approval is received by DHHS and funds are disbursed. Work will begin with the providers to build the platforms and connections for the technology on schedule with the vendor, including training.

B1-9b. Additional Integrated Practice Designation Requirements

These additional requirements related to Medication Assisted Treatment (MAT) and treatment for mild/moderate depression will be identified/developed by the appropriate practices as the demonstration project progresses. At a minimum, these protocols will be utilized in the co-located pilot between Lamprey Health and Greater Nashua Mental Health Center. However, our partners within the Partnership for Successful Living, Foundation Medical Partners, and St. Joseph Physician Practices will work toward identifying/developing these protocols by the end of the demonstration period, with support from the DSRIP Project Manager and the *Provider Integrated Practice Designation* and *Information Sharing and Standardized Workflow Protocols Work Teams*.

B1-9c Practices with HIT

Practice ID	Provider/Practice	At-Risk Patients	Plan of Care	Monitor/Manage	Closed Loop Referrals
	Dartmouth Hitchcock Practices				
3-101	Dartmouth-Hitchcock Nashua Internal Medicine	N	N	N	N
3-102	Dartmouth-Hitchcock Nashua Family Medicine	N	N	N	N
3-103	Dartmouth-Hitchcock Nashua Pediatrics	N	N	N	N
3-104	Dartmouth-Hitchcock Nashua Obstetrics and Gynecology	N	N	N	N
3-105	Norris Cotton Cancer Center	N	N	N	N
3-106	Dartmouth-Hitchcock Hudson	N	N	N	N
3-107	Dartmouth-Hitchcock Milford	N	N	N	N
3-108	Dartmouth-Hitchcock Merrimack	N	N	N	N
3-109	**Lamprey Health Care**	N	N	N	N
	St. Joseph Hospital Practices				
3-111	St. Joseph Hospital Family Medicine, Nashua	N	N	N	N
3-112	St. Joseph Hospital Family Medicine Nashua South	N	N	N	N
3-113	St. Joseph Hospital Family Medicine & Specialty Services Hudson	N	N	N	N
3-114	St. Joseph Hospital Family Medicine & Specialty Services Merrimack	N	N	N	N
3-115	St. Joseph Hospital Family Medicine & Specialty Services Milford	N	N	N	N
3-116	St. Joseph Hospital Internal Medicine	N	N	N	N
3-117	St. Joseph Hospital Adult Medicine	N	N	N	N
3-118	St. Joseph Hospital Pediatrics Sky Meadow	N	N	N	N
3-119	St. Joseph Hospital Pediatrics Nashua	N	N	N	N
3-120	St. Joseph Hospital Pediatrics Milford	N	N	N	N
3-121	St. Joseph Hospital OB/GYN Merrimack	N	N	N	N
3-122	St. Joseph Hospital OB/GYN Hudson	N	N	N	N
3-123	St. Joseph Hospital Midwifery	N	N	N	N
	Foundation Medical Partners Practices				
3-124	Foundation Medical Partners, Amherst Family Practice	N	N	N	N
3-125	Foundation Medical Partners, Family Practice of Merrimack	N	N	N	N
3-126	Foundation Medical Partners, Family Practice of South Nashua	N	N	N	N
3-127	Foundation Medical Partners, Pepperell Family Practice	N	N	N	N

Practice ID	Provider/Practice	At-Risk Patients	Plan of Care	Monitor/Manage	Closed Loop Referrals
3-128	Foundation Medical Partners, Primary Care of Hudson	N	N	N	N
3-129	Foundation Medical Partners, Primary Care of Milford	N	N	N	N
3-130	Foundation Medical Partners, Southern New Hampshire Health System at Pelham	N	N	N	N
3-131	Foundation Medical Partners, Medicine-Pediatrics of Nashua	N	N	N	N
3-132	Foundation Medical Partners, Nashua West Adult Medicine	N	N	N	N
3-133	Foundation Medical Partners, Nashua Primary Care	N	N	N	N
3-134	Foundation Medical Partners, Downtown Medical Associates	N	N	N	N
3-135	Foundation Medical Partners, Nashua Center for Healthy Adults	N	N	N	N
3-136	Foundation Medical Partners, Internal Medicine Associates of Nashua	N	N	N	N
3-137	Foundation Medical Partners, Foundation Internal Medicine	N	N	N	N
3-138	Foundation Medical Partners, Foundation Pediatrics	N	N	N	N
3-139	Foundation Medical Partners, Southern New Hampshire Pediatrics	N	N	N	N
3-140	Foundation Medical Partners, Partners in Pediatrics	N	N	N	N
3-141	Foundation Medical Partners, Foundation OB/GYN	N	N	N	N
3-142	Foundation Medical Partners, NE GYN & Surgical Services	N	N	N	N
3-143	Foundation Medical Partners, Women's Care of Nashua	N	N	N	N
3-144	Foundation Medical Partners, Foundation Community Care	N	N	N	N
3-152	Foundation Medical Partners, Main St. Pediatrics & Adolescent Medicine	N	N	N	N
3-145	Greater Nashua Mental Health Center	N	N	N	N
3-146	Harbor Health/Harbor Care Health and Wellness Center	N	N	N	N
3-148	Merrimack River Medical Services	N	N	N	N
3-151	Keystone Hall	N	N	N	N
3-153	Healthy at Home	N	N	N	N

B1-9d. Documented Work Flows

Documented workflows will be identified/developed first by the community-driven projects (C1, D3, and E4) in conjunction with the practices who will interact with the patients supported by the project strategies. It is expected that the CTI (C1) workflows will be created first, given the training schedule of the CTI staff, then the IDDT (E4) and D3 project strategies, no later than December 31, 2017.

The Clinical Governance Committee will work in collaboration with the IT/Data Governance Committee, as well as the Administrative Lead to support the workflow development.

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

Below are the targeted, total goal, and number of practices/providers expected to achieve designation as a Coordinated Care Practice or Integrated Care Practice. We expect to make continual progress toward achieving our projected number of designated Coordinated Care Practices and Integrated Care Practices throughout the demonstration period. For additional information related to the three waves (Fall 2017/Winter 2018; Spring 2018; Summer 2018), see attachment_B1.b.

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	49	0	0	37	12
Integrated Care Practice	5 (by end of 2020)	0	0	0	0

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	•Dartmouth Hitchcock Nashua Family Medicine • Dartmouth Hitchcock Nashua Internal Medicine • Dartmouth Hitchcock Hudson • Dartmouth Hitchcock Merrimack • Dartmouth Hitchcock Milford • Dartmouth Hitchcock Nashua Obstetrics and Gynecology • Dartmouth Hitchcock Nashua Pediatrics • Norris Cotton Cancer Center • Foundation			

	Medical Partners, Foundation Pediatrics • Foundation Medical Partners, Medicine-Pediatrics of Nashua • Foundation Medical Partners, Pediatrics and Adolescent Medicine • Foundation Medical Partners, Partners in Pediatrics • Foundation Medical Partners, Southern NH Pediatrics • Foundation Medical Partners, Primary Care of Milford • Foundation Medical Partners, Family Practice of Merrimack • Foundation Medical Partners, Family Practice of Hudson • Foundation Medical Partners, Family Practice of South Nashua • Foundation Medical Partners Amherst Family Practice •Foundation Medical Partners Nashua Primary Care •Foundation Medical Partners Foundation Internal Medicine •Foundation Medical Partners			

	Foundation OB/GYN •Foundation Medical Partners Nashua Center for Healthy Adults •Foundation Medical Partners Women's Care of Nashua •Foundation Medical Partners Downtown Medical Associates •Foundation Medical Partners Pepperell Family Practice •Foundation Medical Partners NE GYN and Surgical Services •Foundation Medical Partners Southern NH Health System at Pelham •Foundation Medical Partners Nashua West Adult Medicine •Foundation Medical Partners Internal Medicine Associates of Nashua •Foundation Medical Partners Foundation Community Care • Gateways Community Services •Harbor Health/Harbor Care Health and Wellness Center • Healthy at Home •Keystone Hall •Merrimack River Medical Services •St. Joseph Hospital			

	Pediatrics Nashua •St. Joseph Hospital Pediatrics Milford •St. Joseph Hospital Pediatrics Sky Meadow •St. Joseph Hospital OB/GYN Merrimack • St. Joseph Hospital Family Medicine, Nashua •St. Joseph Hospital Family Medicine Nashua South • St. Joseph Hospital Internal Medicine • St. Joseph Hospital Family Medicine and Specialty Services Milford • St. Joseph Hospital Family Medicine and Specialty Services Hudson • St. Joseph Hospital Adult Medicine • St. Hospital Family Medicine and Specialty Services Merrimack • St. Joseph Hospital OB/GYN Hudson • St. Joseph Hospital Midwifery			

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	• Foundation Medical Partners Foundation Pediatrics • Foundation Medical Partners Medicine Pediatrics of Nashua • Pediatrics and Adolescent Medicine • Greater Nashua Mental Health Center • Lamprey Health Care			

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

Core Components

Based upon the recommendations of the Clinical Governance Committee, the Executive Steering Committee selected *C1: Critical Time Intervention (CTI)* as the first of three community-driven projects, which was validated with the results of the fall 2016 Community Needs Assessment surveys. Citing data indicative of the number of patients who visit the Emergency Department of both Southern NH Medical Center and St. Joseph Hospital repeatedly seeking treatment, the Committee identified the establishment of care teams as a priority. They recognize care transition teams have been successful in other communities and look to replicate that success in the Nashua Region.

Target Population

The Critical Time Intervention (CTI) program for IDN 3 will focus on those adult patients diagnosed with a primary Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI). Generally, we will not serve individuals with a primary diagnosis of an intellectual/developmental disability, substance use disorder, or personality disorder, however, there may be special cases where we may work closely with our IDN partners at Gateways Community Services or Granite State Independent Living (GSIL) if there is a patient who is experiencing numerous visits to the Emergency Department and meets the criteria for CTI otherwise. We have built in some consultation funding for Gateways to support care teams who might be working with a client with an intellectual or developmental disability.

Other criteria for the target population for CTI include those not already connected to a mental health provider and having at least three of the following functional impairments:

- At risk of homelessness or currently homeless
- Lack of positive social support/natural supports network
- Inability to perform activities of daily living adequately
- Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
- Inability to manage money
- Substance use with negative impact
- Unemployment/underemployed/lack of employment skills.

The care transition that we will initially focus on will be from our two hospital Emergency Departments (Southern NH Medical Center and St. Joseph Hospital) and NH Hospital back into the community.

Critical Time Intervention (CTI) Team and Strategies

The CTI team will be housed under the umbrella of Greater Nashua Mental Health Center. Staff will include a Clinical Supervisor (1 FTE) and 2.5 CTI Specialists (Case Managers). This team will work with approximately to 60 clients at a time, but this may go up at various points due to the level of the intervention patients are (for example, Phase 3 is less time intensive than Phase 1). With each CTI encompassing approximately 9 months per patient, the IDN is expecting to reach between 80 and 100 patients per year.

The IDN also determined it would be important to include funds to support the patients as they go through their transitions, as they may have the need for basic staples, such as food, bus passes, clothing, furniture, etc. This allows the CTI Specialists and Clinical Supervisor to have funding to support those needs as they arise, rather than having to seek out other sources of donations from local organizations.

Implementation Plan

a. Project Budget

The majority of the funds associated with the budget for this project are for the staff salary and benefits ( ), with a sub-contract for interpretation services for those patients for which English is not their first language. Additionally, computers, cell phones, staff mileage reimbursement and client services funds (for incidentals during transitions including food, clothing, bus passes, etc.) are included. Finally, indirect costs (are included in the budget to account for malpractice insurance, supervision (administrative), internal utilization review for quality purposes, heat, water, etc. that are part of doing business to support the project.

b. Workforce Plan: Staffing plan, recruitment and retention strategies

All positions will be employees of Greater Nashua Mental Health Center and include a Clinical Supervisor/Coordinator (1 FTE) and CTI Specialists (2.5 FTEs). None of these positions have been filled as of June 20, 2017 and will need to be hired.

IDN 3 plans to hold a job fair in early fall 2017 to provide an opportunity for all IDN Member Entities to reach potential employees for their IDN-funded positions. We expect that with so many open positions in the region that support the goals of the IDN, there may be an opportunity to also fill those, as well.

The IDN will be contracting with to complete the development of its website which will include a job board where IDN Member Entities can complete forms to submit positions to post on the site throughout the demonstration. will also be providing support for broadening our reach to professional organizations and other potential marketing opportunities to advertise the available IDN positions, especially for those potential members of the workforce who are not local and won't be attending the job fair. Additional recruitment strategies will be used, including posting positions to the Greater Nashua Mental Health Center's website and offering sign-on bonuses, loan repayment, relocation expenses reimbursement and retention bonuses, depending upon the position.

Retaining staff will continue to be a challenge. The goal is to provide ongoing professional development funded by the IDN, as well as opportunities for the team members to network with other peers to get support.

c. Projected Annual Client Volumes

The IDN has projected annual patient engagement volumes to be between 80 and 100 per year, with less in 2017 and 2018 as the project ramps up. Below are targets for years 2017 – 2020:

- 2017: 30

- 2018: 80
- 2019: 100
- 2020: 120

d. Key Organizational/Provider Participants

- Greater Nashua Mental Health Center
- Southern NH Medical Center
- St. Joseph Hospital
- NH Hospital

Design and Development of Clinical Services Infrastructure

a. Standardized Protocols for Care Transition Team model, including patient identification criteria, standardized care transition plan, case worker guidelines and standard processes for each of the program's three phases

See Section C-6 below

b. Roles and responsibilities for CTI team members

The CTI team will be employed by the Greater Nashua Mental Health Center with the IDN Clinical Governance Committee overseeing implementation, troubleshooting issues, providing education, and evaluating areas of improvement.

Other IDN members may participate in CTI training to implement the model within their own case management structures as the CTI model best practices and lessons learned are achieved with a Train-the-Trainer training scheduled for late summer 2018 to build sustainability in the region for broadening the reach of organizations who would like to utilize CTI in their clinical infrastructure.

CTI Staffing includes a Master's Level Licensed Clinical Supervisor (1 FTE), who will carry a caseload of up to 10 patients, depending upon the number of patients in each CTI phase. He/she will also be responsible for weekly supervision of CTI staff. There will initially be 2.5 FTEs of CTI Specialists (Bachelor's level) who will carry a maximum caseload of 20 patients each, depending on the number of patients in each CTI phase, assuming Phase I (the first 30 days involves the most intense one-on-one support).

c. Training plan

See Section C-9 below

d. Training curricula

See Section C-10 below

e. Agreements with collaborating organizations, including NH Hospital, if applicable

See Section C-5

f. Evaluation plan, including metrics that will be used to measure program impact

We will continue to refine our evaluation plan as we complete the training with . This will include the development of evaluation tools and indicators. Our initial projected outcomes we hope to measure throughout the demonstration include:

- Short-term (knowledge, skills, resources change)
  - Increase in patients with PCPs

- Intermediate (behavior change)
  - Patient engagement in a stable housing plan
  - Reduction in repeat ED visits
  - Reduction in NH Hospital utilization
  - Increase in utilization of community-based services, such as housing assistance, legal assistance, family and support services

- Long-term (systems change)
  - Decrease in no-show for initial appointments

g. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

Tracking and monitoring individuals served by the program will initially be done through the use of case management/coordination planning and progress notes through individual patient care plans. Once up and running, the Shared Care Plan platform hosted by will provide for timely information sharing among providers and through will allow for case management workflows and triggers. CTI also has a patient tracking tool that we are investigating and plan to learn more about during the training with .

Adherence to impact measures will be monitored and tracked timely use of the Shared Care Plan, Event Notification Service and data aggregation provided by

Fidelity to evidence-supported project elements will be accomplished by adhering to the fidelity process outlined through the training and support from .

Expected Challenges and Solutions

We expect to work very quickly over the next several months to address some of the challenges to ensuring success for care transition teams. These include:

- Investing funding and time into the behavioral health workforce, including recruiting and hiring, as well as training and retaining individuals who understand the value of integrated care and are working in a workplace that supports this coordinated approach
- Developing and implementing intake procedures, treatment planning, and referral protocols that systematically solicit patient consent to confidentially share information among providers

through educating the patient as well as the providers and social service support organizations serving the patient

- Integrating electronic health records (or at least shared care plans) across service providers who touch the attributed patients in our IDN
- Investing in enhanced technology and shared record-keeping to ensure systematic information sharing and communication for care coordination across the multi-disciplinary teams being formed in practices across the IDN as part of the B1 Integrated Health project
- Participating in monthly case management meetings for those patients with significant behavioral health or chronic conditions that include all of their providers and social service support team members.

attachment_C1.1b

C1 Critical Time Intervention (CTI) Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
DONE	Develop Implementation Plan	465d	03/21/17	12/31/18
DONE	Develop Implementation Timeline	205d	03/21/17	01/01/18
	Develop Project Budget	40d	06/02/17	07/27/17
DONE	Get final training budget from	1d	06/02/17	06/02/17
DONE	Review with Clinical Committee	1d	06/05/17	06/05/17
DONE	Present to Finance Committee for approval	11d	07/10/17	07/24/17
DONE	Present to Executive Committee for approval	1d	07/27/17	07/27/17
DONE	Budget approved	1d	07/27/17	07/27/17
	Develop Workforce Plan	465d	03/21/17	12/31/18
DONE	Develop CTI staffing plan	74d	03/21/17	06/30/17
	Develop job descriptions	29d	08/01/17	09/08/17
	Hire CTI Staff	64d	08/01/17	10/27/17
	Hire 1 FTE CTI Supervisor (CTI Coordinator)	44d	08/01/17	09/29/17
	Hire 1 FTE CTI Case Worker #1 (CTI Specialist)	41d	09/01/17	10/27/17
	Hire 1 FTE CTI Case Worker #2 (CTI Specialist)	41d	09/01/17	10/27/17
	Hire .5 FTE CTI Case Worker #3 (CTI Specialist)	41d	09/01/17	10/27/17
	Recruitment and Retention Strategies	392d	07/01/17	12/31/18
	IDN 3 Website development with Career Board	51d	07/01/17	09/08/17
	Contract with	51d	07/01/17	09/08/17
	Conduct IDN Job Fair	392d	07/01/17	12/31/18
	Contract with	51d	07/01/17	09/08/17
	Contract with Crowne Plaza	21d	08/18/17	09/15/17
	Compile job descriptions to populate Career Board on IDN website	40d	08/01/17	09/25/17
	Mass media marketing with radio ads, social media ad sponsorship, flyers shared electronically	41d	08/01/17	09/26/17
	Secure table confirmations from IDN Member Entities and education institutions for event at Crowne Plaza	40d	08/01/17	09/25/17
	Secure RSVPs from potential participants for event landing page on website	41d	08/01/17	09/26/17
	Hold event at Crown Plaza	1d	09/26/17	09/26/17
	IDN-funded Recruitment/Hiring Strategies	373d	07/27/17	12/31/18
	Sign-on bonuses and relocation reimbursement	373d	07/27/17	12/31/18
DONE	Projected Annual Client Engagement Volumes	41d	05/05/17	06/30/17
DONE	Solicit input from IDN project partners across the state and	41d	05/05/17	06/30/17
DONE	Develop projections	41d	05/05/17	06/30/17
	Identify Organizational/Provider Participants	74d	03/21/17	06/30/17
DONE	Greater Nashua Mental Health Center	74d	03/21/17	06/30/17
DONE	St. Joseph Hospital	74d	03/21/17	06/30/17
DONE	Southern NH Medical Center	74d	03/21/17	06/30/17
DONE	New Hampshire Hospital	74d	03/21/17	06/30/17
	Clinical Services Infrastructure	465d	03/21/17	12/31/18
	Identify/Develop standardized protocols for Care Transition Team Model	175d	05/01/17	12/29/17
	Clinical Governance Committee and CTI training (Staff training #1 currently targeted for early November 2017 and Supervisor training #1 currently targeted for early December 2017)	175d	05/01/17	12/29/17
	Develop standardized protocols for patient identification criteria	175d	05/01/17	12/29/17

C1 Critical Time Intervention (CTI) Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Develop standardized patient care transition plan	130d	07/03/17	12/29/17
	Develop CTI Case Worker guidelines	45d	10/30/17	12/29/17
	Develop standard processes for each of the program's three phases	45d	10/30/17	12/29/17
	Roles and Responsibilities for CTI team members	124d	03/21/17	09/08/17
DONE	Create job description for 1 FTE Master's level CTI Clinical Supervisor position (CTI Coordinator)	124d	03/21/17	09/08/17
DONE	Create job description for 2.5 FTEs Bachelor's level CTI Case Manager position (CTI Specialist)	124d	03/21/17	09/08/17
	Training Plan	465d	03/21/17	12/31/18
DONE	Identify curricula/training partner--	51d	03/21/17	05/30/17
	Develop training and support schedule	74d	03/21/17	06/30/17
	Finalize training and support schedule	66d	07/01/17	09/29/17
	Register CTI team for training	41d	09/01/17	10/27/17
	Training events	144d	06/06/17	12/22/17
DONE	Statewide Kick-off	1d	06/06/17	06/06/17
	Staff Training #1: 2-day training for all CTI team members	24d	10/30/17	11/30/17
	Supervisor Training #1: 2-day training for all CTI supervisors (required to have participated in staff training)	20d	11/27/17	12/22/17
	Community of Practice (CoP) meetings (via webinar/phone--2 hours)	261d	12/01/17	11/30/18
	December 2017	21d	12/01/17	12/29/17
	January 2018	22d	01/02/18	01/31/18
	February 2018	20d	02/01/18	02/28/18
	April 2018	22d	04/01/18	04/30/18
	May 2018	23d	05/01/18	05/31/18
	July 2018	23d	07/01/18	07/31/18
	August 2018	23d	08/01/18	08/31/18
	October 2018	23d	10/01/18	10/31/18
	November 2018	22d	11/01/18	11/30/18
	Community of Practice (CoP) meetings (in person--3 hours)	218d	03/01/18	12/31/18
	March 2018	22d	03/01/18	03/30/18
	June 2018	21d	06/01/18	06/29/18
	September 2018	21d	09/01/18	09/28/18
	December 2018	1d	12/31/18	12/31/18
	Training Events	69d	02/26/18	05/31/18
	Staffing Training #2: 2-day training for additional CTI team members	46d	02/26/18	04/30/18
	Supervisor Training #2: 2-day training for all CTI supervisors (required to have participated in staff training)	66d	03/01/18	05/31/18
	CTI Train-the-Trainer	88d	08/01/18	11/30/18
	Train-the-Trainer training	43d	08/01/18	09/28/18
	Staff Training #3 (TBD)	45d	10/01/18	11/30/18
	Supervisor Training #3 (TBD)	45d	10/01/18	11/30/18
	Agreements with Collaborating Organizations	85d	07/03/17	10/27/17
	Greater Nashua Mental Health Center	85d	07/03/17	10/27/17
	Sign agreement with NH Hospital	85d	07/03/17	10/27/17

C1 Critical Time Intervention (CTI) Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Sign agreement with Southern NH Medical Center	85d	07/03/17	10/27/17
	Sign agreement with St. Joseph Hospital	85d	07/03/17	10/27/17
	Develop Evaluation Plan	175d	05/01/17	12/29/17
	Identify CTI benchmark outcome metrics	175d	05/01/17	12/29/17
	Identify mechanisms (registries) to track and monitor	305d	05/01/17	06/29/18
	HIT platforms (--data aggregator; -ENS/SCP; -DSM; --data query, e-referrals, etc.)	305d	05/01/17	06/29/18
	Individuals served by the program	305d	05/01/17	06/29/18
	Adherence	305d	05/01/17	06/29/18
	Impact measures	305d	05/01/17	06/29/18
	Fidelity to evidence supported project elements (re-hospitalization data)	305d	05/01/17	06/29/18
	Operationalization of Program	131d	07/01/17	12/29/17
	Implementation of workforce plan	131d	07/01/17	12/29/17
	Deployment of training plan	131d	07/01/17	12/29/17
	Implementation of any required updates to clinical protocols, or other operating policies and procedures	131d	07/01/17	12/29/17
	Use of assessment, treatment, management and referral protocols	131d	07/01/17	12/29/17
	Initiation of Data Reporting	131d	07/01/17	12/29/17
	Number of individuals served (during reporting period and cumulative) vs. projected	131d	07/01/17	12/29/17
	Number of staff recruited and trained (during reporting period and cumulative) vs. reported	131d	07/01/17	12/29/17
	Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	131d	07/01/17	12/29/17
	Ongoing Data Reporting	129d	01/02/18	06/29/18
	Number of individuals served (during reporting period and cumulative) vs. projected	129d	01/02/18	06/29/18
	Number of staff recruited and trained (during reporting period and cumulative) vs. reported	129d	01/02/18	06/29/18
	Staff vacancy and turnover rate for period and cumulative vs. projected	129d	01/02/18	06/29/18
	Impact measures as defined in evaluation plan	129d	01/02/18	06/29/18
	Ongoing Data Reporting			
	Number of individuals served (during reporting period and cumulative) vs. projected	132d	07/01/18	12/31/18
	Number of staff recruited and trained (during reporting period and cumulative) vs. reported	132d	07/01/18	12/31/18
	Staff vacancy and turnover rate for period and cumulative vs. projected	132d	07/01/18	12/31/18
	Impact measures as defined in evaluation plan	132d	07/01/18	12/31/18

C1-2. IDN Community Project: Evaluation Project Targets

Below are project targets for performance measures for CTI. As mentioned previously, as we participate in the training and engage in the Community of Practice, we expect to further refine our metrics and develop tools and indicators for evaluating our outcomes.

Project Strategy	Client Engagement 2017	Client Engagement 2018
Critical Time Intervention (CTI)	Up to 10, depending upon workforce recruitment, training timing and referral protocols being in place	Up to 100

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased knowledge of screening tools to utilize to assess individuals with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) in the attributed sub-population.	Up to 5 IDN clinical and/or behavioral health providers will be trained in the available tools and techniques to assess appropriateness of attributed IDN patients participating in Critical Time Intervention (CTI) program strategies in the IDN by December 31, 2018.			
Increased knowledge of standard assessment, treatment and management protocols for patients with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) being discharged back into the community.	Up to 5 behavioral health providers will be trained in the available tools to assess, treat and manage attributed IDN patients participating in Critical Time Intervention (CTI) strategy in the IDN by July 31, 2018.			
Increased knowledge of standard referral protocols for patients with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) to be discharged back into the community.	Up to 5 behavioral health providers will be in the available tools to refer attributed IDN patients participating in the Critical Time Intervention (CTI) strategy by July 31, 2018.			
Increase in the capacity of the IDN providers to support the transitions of the target sub-population from hospital settings to the community.	Up to 10 care coordinators/case managers will be trained in the use of the available HIT platforms (ENS, DSM, SCP and data aggregation) to support information sharing and communication.			
Increased knowledge of the IDN's resources to support the physical health and mental health, as well as those that support the social determinants of health, including economic, legal, educational and social, as well as housing and transportation.	Up to 6 case management meetings will be held in the IDN to support the knowledge-building and resource-building skills of behavioral health case management and care coordinators.			

C1-3. IDN Community Project: Workforce Staffing

The table below identifies the staffing needed to implement CTI for IDN 3. CTI staff (CTI Coordinator and CTI Specialists) will be employees of Greater Nashua Mental Health Center (GNMHC).

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
Psychiatrist/Psychiatric Advanced Practice Registered Nurse (APRN)	12	11			
Master's Level Licensed Clinical Supervisor (CTI Coordinator)	1	0			
Bachelor's Level CTI Specialist (Case Manager)	2.5	0			
Community Health Worker	8	40			
DSRIP Practice Integration Project Manager	1	0			
DSRIP Quality Improvement Manager	1	0			
DSRIP Data Manager	1	.15			
Recovery/Transitional Care Case Manager	1	.5			

C1-4a. IDN Community Project: Budget

The majority of the funds associated with the budget for this project are for the staff salary and benefits ( ), with a sub-contract for interpretation services for those patients for which English is not their first language. Additionally, computers, cell phones, staff mileage reimbursement and client services funds (for incidentals during transitions including food, clothing, bus passes, etc.) are included. Finally, indirect costs ( ) are included in the budget to account for malpractice insurance, supervision (administrative), internal utilization review for quality purposes, heat, water, etc. that are part of doing business to support the project.

Category of Funding	Entity Funded	Amount of Funding 2017 - 2020
CTI Team Staffing	GNMHC	$594,880
Sub-contract for Interpretation Services	TBD	$9,000
Supplies/Client Supports	GNMHC	$29,740
Mileage Reimbursement	GNMHC	$18,060
Indirect Costs	GNMHC	$97,752
Total		**$754,542**

C1: Critical Time Intervention
2017 -2020 Budget

Category and Item	Item Notes	2017-2018 Budget Available	2019-2020 Budget Available
Totals		**$379,969.00**	**$567,237.00**
CTI Team Staffing			
Subcontracting			
Supplies			
Mileage Reimbursement			
Overhead			

attachment_C1.4b

C1: Critical Time Intervention
2017 -2020 Budget

Sept 2017 - June 2018 (10 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	Total Requested 2017 - 2020	Total Available 2017 - 2020
$208,812	$217,691.10	$217,691.10	$123,835.03	$768,029	**$947,206**
$152,905.00	$161,110.00	$161,110.00	$92,943.00	$568,068.00	
$2,500.00	$3,000.00	$3,000.00	$1,500.00	$10,000.00	
$12,150.00	$9,780.00	$9,780.00	$4,890.00	$36,600.00	
$5,017.00	$6,020.00	$6,020.00	$3,010.00	$20,067.00	
$36,240.12	$37,781.10	$37,781.10	$21,492.03	$133,294.35	

C1-5. IDN Community Project: Key Organizational and Provider Participants

Each of these organizations/providers have agreed to participate in the CTI project, however, we have not secured final agreements from each of them yet. We expect to do that no later than September 30, 2017.

Organization/Provider	Agreement Executed (Y/N)
Greater Nashua Mental Health Center	N (in process)
Southern NH Medical Center	N (in process)
St. Joseph Hospital	N (in process)
NH Hospital	N (in process)

C1-6. IDN Community Project: Standard Assessment Tools

Although Project C1: Care Transitions does not require the use of a standardized assessment tool, the following tools in the table below are under consideration as the team completes the CTI training and works with its partners and the Clinical Governance Committee to finalize patient screening and assessment protocols.

Standard Screening/Assessment Tool Name	Brief Description
Patient Health Questionnaire (PHQ 2)	The PHQ-2 measures the frequency of depressed mood and anhedonia over the past two weeks
Patient Health Questionnaire (PHQ 9)	Multipurpose instrument used for screening, diagnosing, monitoring and measuring the severity of depression
Mental Health Screening Form III (MHSF-III)	Questionnaire designed to assist with the identification of problems that may be getting in the way of a person's general wellbeing and ability to successfully engage in life pursuits.
Screens to identify functional impairments	Under consideration
CTI Brief Assessment	A. the individual's presenting problem; B. the individual's needs and strengths; C. a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission; D. a pertinent social, family, and medical history; and E. evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the individual's needs.
CTI Self-Assessment	The Self-Assessment is a quality improvement tool that is used to measure adherence to the model: -completed by the team every 6 months from the date that the team starts -used to provide a mechanism for quality improvement feedback and guided consultation

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

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

Protocol Name	Brief Description	Use (Current/Under development)
CTI Patient Assessment	Recovery Care Case Managers (employees of each hospital as part of the D3 Project) located in each of the Emergency Departments will identify patients who present in each of the EDs, engaging with them to complete the PHQ 2 and if applicable, PHQ 9. They will then screen for appropriateness to the CTI program or determine appropriateness for referrals to other applicable programs. Patients referred to CTI (See attached_C1.7b CTI Referral Form) will under a brief assessment, using the tool provided through the training with	Under Development
	The NH Hospital Care Coordinator/Discharge Coordinator will determine appropriateness of referral to the CTI program based upon criteria for the target population upon discharge from their services, connecting with the CTI Supervisor. More details for this protocol will be outlined as the CTI team completes its training and partners with NH Hospital to enter into agreements.	Under Development
CTI Patient Treatment and Management	Patient is provided with intensive case management over 9 months with the CTI Specialist, with close relationships with primary care providers, mental health providers, and community-based social service providers.	Under Development
CTI Referral	Throughout Phase II of the CTI model, the CTI Specialist works with patient to make active referrals to a primary care physician (if patient lacks one) and mental health counseling while implementing a transition plan. Emotional support is consistently provided in moving the patient toward more self-sufficiency.	Under Development

Critical Time Intervention (CTI) Referral Form

Please include CCA and Release of information consent if available

Fax completed forms to Janice Bainbridge at 919.445.0414

CTI team notes (for internal use only):

_____

_____

Client eligibility:

☐ Client has a mental health diagnosis or evidence of a psychiatric disorder with impairments in functioning and need for case management

AND the following

☐ Client is a resident of Orange, Chatham, or Alamance County and is within 30 miles of UNC

☐ Client is experiencing a *critical transition* (defined by *at least one* of the following):

☐ Homelessness with identified housing available ready for move in within 45 days

☐ Discharge from institutional care (hospital, jail)

☐ Transition from residential setting into independent housing

---

Referral source information

Referral date: _____ *Referral source name:* _____

Referral source phone number: _____ *Referral source organization:* _____

Client information

Client name: _____ *DOB:* _____

Address: *Phone number:* _____

_____

_____

☐ Male ☐ Female ☐ Hispanic ☐ Non-Hispanic

☐ White ☐ African-American ☐ Asian-American ☐ Native-American ☐ Other

☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ None

Is client receiving SSI or SSDI? ☐ Yes ☐ No

Current areas of unmet need:

☐ Housing ☐ Benefits ☐ MH/SA treatment ☐ Money mgmt. ☐ Family/social support

☐ Medical care

Is the client enrolled with Cardinal Innovations? ☐ Yes ☐ No *CI #*_____

Clinical information

Reason for referral:

_____

_____

_____

Client's current providers: _____

Primary MH diagnosis and/or observations: _____

_____

_____

Substance use:

_____

_____

Physical health issues:

_____

_____

Medications:

_____

_____

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

The project team members and their roles and responsibilities are outlined below.

Project Team Member	Roles and Responsibilities
CTI Supervisor/Coordinator (1 FTE)	Provides day-to-day supervision of CTI Specialists as well as weekly case conference meetings with CTI Team; oversees referrals and discharges to program; monitors fidelity of the program
CTI Specialist (2.5 FTEs)	Provides screening and assessment of patient; works with patient to create goals and plan for transition, including securing a primary care physician, mental health clinician and community-based supports for those needs that address their social determinants of health; maintains relationships with patient's providers and caregivers, providing transportation and ensuring follow-up when needed

C1-9a. Provide the training plan and curricula for each Community Driven Project as required in A-1.3.

Through a NH contract with a Scope of Work (SOW) for each IDN region in NH conducting the CTI project (IDN 1, 3, 4, 6 and 7),
will provide training and technical assistance for at least the time period of June 1, 2017 through December 31, 2018. These activities include:

Phase 1 **CTI Statewide Kick-off Event**

Held on June 6, 2017 at the Common Man in Plymouth NH, staff members presented background about how CTI has been implemented around the country, including evidence related to its impact. They provided a brief overview of the CTI model and addressed questions from attendees representing all from IDN regions. IDN regions then shared their plans and next steps as they are developing their partnership agreements and clinical infrastructure for implementing the project.

Phase 2 **CTI Staff Training and CTI Supervisor Training**

Staff Training

The CTI Staff Training will include the CTI Supervisor and 2.5 CTI Specialists from IDN 3, as well as one or two additional IDN members from the Administrative Lead Team and/or Clinical Governance Committee. Teams from the other four IDN regions will also be in attendance. The training will be held over two days at a central location during the month of November 2017 (final dates TBD). will plan, organize and deliver the training (including materials) on the CTI model via a face-to-face meeting.

It was determined that in the event that all regions were not able to recruit and hire their CTI staff in time for the November training, that there would be a second CTI Staff Training held sometime between late February and April 2018 to address additional training needs.

Supervisor Training

The CTI Supervisor Training will be held during the month of December 2017 (dates TBD) over a two-day period for those clinical supervisors for the CTI teams. All participants must have previously completed the CTI Staff Training. The CTI Implementation Self-Assessment Measure will be provided as a part of this training to support the monitoring of program fidelity. IDN 3's CTI Supervisor will attend the training as well as one or two additional members of the IDN from the Administrative Lead Team or Clinical Governance Committee. will plan, organize and deliver the two-day face-to-face training for Master's Level Supervisors who will be providing clinical supervision to CTI teams.

It was determined that in the event that all regions were not able to recruit and hire their CTI staff in time for the November training, that there would be a second CTI Supervisor Training held sometime between March and May 2018 to address additional training needs.

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

All-IDN Community of Practice (CoP) Meetings

CoP meetings will occur monthly following program implementation. These meetings of CTI Specialist (Case Managers) and potentially CTI Supervisors will allow for the opportunity to receive technical support

during the implementation phase. A locally-based consultant will facilitate these meetings, with the goal of reducing their role as they help local trainers (after the Train-the-Trainer session in 2018) assume primary leadership responsibilities.

- Monthly web/phone meetings (2 hours):
  - December 2017 through November 2018 (not held during months with quarterlymeetings)
- Quarterly in-person meetings (3 hours each):
  - March 2018
  - June 2018
  - September 2018
  - December 2018

Implementation Coaching Support for Individual IDN CTI Teams

will provide monthly telephone consultation to the IDN 3 CTI Team, ensuring program staff ample opportunity to receive and offer feedback. They will provide assistance in identifying and overcoming challenges specific to our region and our attributed patient population. Additionally, feedback may be provided on data collected via self-assessment tools that we can use to monitor fidelity to the CTI model. We will contract with for 6 hours of IDN-specific coaching beyond the CoP meetings/coaching support.

***Phase 4* Train-the-Trainer**

A combined /T3 team from Boston MA will provide a two-and-a-half-day in person Train-the-Trainer training (including materials) to previously trained CTI Clinical Supervisors who will assume responsibility for ongoing staff training and consultation after role ends. It is expected that participants will have completed basic training in the CTI model and have prior training experience. IDN 3 will like send two trainees to this training, to be held in August or September 2018 (dates TBD).

Project Team Member	Training/Support Target Date	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
CTI Coordinator (Supervisor)					
Training					
CTI Staff Training	November 2017	N			
CTI Supervisor Training	December 2017	N			
Community of Practice					
Community of Practice Call	December 2017	N			
Community of Practice Call	January 2018	N			
Community of Practice Call	February 2018	N			
Community of Practice In-Person Meeting	March 2018	N			
Community of Practice Call	April 2018	N			
Community of Practice Call	May 2018	N			
Community of Practice In-Person Meeting	June 2018	N			
Community of Practice Call	July 2018	N			
Community of Practice Call	August 2018	N			
Community of Practice In-Person Meeting	September 2018	N			
Community of Practice Call	October 2018	N			
Community of Practice Call	November 2018	N			
Community of Practice In-Person Meeting	December 2018	N			
CTI Specialist (Case Manager)					
Training					
CTI Staff Training	November 2017	N			
Community of Practice					
Community of Practice Call	December 2017	N			
Community of Practice Call	January 2018	N			
Community of Practice Call	February 2018	N			
Community of Practice In-Person Meeting	March 2018	N			
Community of Practice Call	April 2018	N			

Community of Practice Call	May 2018	N			
Community of Practice In-Person Meeting	June 2018	N			
Community of Practice Call	July 2018	N			
Community of Practice Call	August 2018	N			
Community of Practice In-Person Meeting	September 2018	N			
Community of Practice Call	October 2018	N			
Community of Practice Call	November 2018	N			
Community of Practice In-Person Meeting	December 2018	N			
CTI Specialist (Case Manager)					
Training					
CTI Staff Training	November 2017	N			
Community of Practice					
Community of Practice Call	December 2017	N			
Community of Practice Call	January 2018	N			
Community of Practice Call	February 2018	N			
Community of Practice In-Person Meeting	March 2018	N			
Community of Practice Call	April 2018	N			
Community of Practice Call	May 2018	N			
Community of Practice In-Person Meeting	June 2018	N			
Community of Practice Call	July 2018	N			
Community of Practice Call	August 2018	N			
Community of Practice In-Person Meeting	September 2018	N			
Community of Practice Call	October 2018	N			
Community of Practice Call	November 2018	N			
Community of Practice In-Person Meeting	December 2018	N			
CTI Specialist (Case Manager)					
Training					

CTI Staff Training	November 2017	N			
Community of Practice					
Community of Practice Call	December 2017	N			
Community of Practice Call	January 2018	N			
Community of Practice Call	February 2018	N			
Community of Practice In-Person Meeting	March 2018	N			
Community of Practice Call	April 2018	N			
Community of Practice Call	May 2018	N			
Community of Practice In-Person Meeting	June 2018	N			
Community of Practice Call	July 2018	N			
Community of Practice Call	August 2018	N			
Community of Practice In-Person Meeting	September 2018	N			
Community of Practice Call	October 2018	N			
Community of Practice Call	November 2018	N			
Community of Practice In-Person Meeting	December 2018	N			
CTI Train-the-Trainer					
Training					
Train-the-Trainer	August/September 2018	N			

NORTH CAROLINA

***Critical Time Intervention**: model elements, phases/roles of team members, documentation*

"Here is what we seek: a compassion that can stand in awe at what (people) have to carry rather than stand in judgment about how they carry it."

Fr. Greg Boyle, Tattoos on the Heart

2

Shared Decision-Making

Collaborative process that allows the individual and provider to make health care decisions together taking best scientific evidence into account as well as the individual's values and preferences.

3

Shared Decision-Making

- The individual and CTI worker see each other as experts
- The individual is the expert on their own health history, values, aspirations and treatment preferences
- The CTI worker is the expert on the nature, course and treatment of the illness, treatment options and related accessible resources

4

What is Critical Time Intervention?

History

- Developed by Dan Herman, PhD, at Columbia University and the NY Psychiatric Institute; now at Hunter College School of Social Work
- http://www.criticaltime.org/

Key Elements

- Intensive case management model originally developed for individuals with mental illness who were transitioning out of homelessness
- 9 month intervention to ensure a successful transition

4 CORE PRINCIPLES OF CRITAL TIME INTERVENTION (CTI)

As an evidence-based practice there are four core principles that define CTI and set it apart from other services:

1. **Focuses on a critical transition period, and is time-limited**
2. **Enhances continuity of care and prevents recurrent homelessness and hospitalizations**
3. **Identifies and strengthen formal and natural community supports**
4. **Complements rather than duplicates existing services**

6

Highlights of CTI Service Definition

WHO CAN GET CTI?

Critical Time Intervention (CTI) 9 month intensive case management model designed to assist adults age 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately.

-DMH/DD/SAS CTI Service Definition, 7/2016

Eligibility Criteria

To be eligible for CTI, an individual must meet the following criteria:

A. A primary SPMI/SMI diagnosis. Individuals with a primary diagnosis of an intellectual/developmental disability, substance use disorder or personality disorder are not the intended eligibility group, and

B. Is not already connected to community based care that is currently meeting their clinical needs and

Eligibility Criteria continued

C. Has at least three of the following functional impairments:

- At risk of homelessness or homeless
- Lack of positive social support/natural supports network
- Inability to perform activities of daily living adequately
- Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
- Inability to manage money
- Substance use with negative impact
- Unemployment/underemployed/lack of employment skills

CRITICAL TRANSITIONS

Includes:

- Discharge from psychiatric inpatient settings
- Release from correctional settings
- Transition out of foster care settings into adult services
- Transition from homelessness into housing
- Transition from highly structured residential settings, such as adult care homes, into independent living
- CTI defines a critical transition as occurring within no more than 45 days from the start of service.

Excludes:

- **NOT connected to treatment services**
- **NOT a step down from services (ACT, CST)**
- **NOT for individuals waiting for other treatment services**
- **NOT for previous recipients of CTI**

Discharge from CTI

- An individual receiving CTI is discharged at the end of 9 months even if they have not met all the goals that they had identified.
- Individuals receiving CTI can be referred to enhanced services, such as ACT and CST, in Phase 3 to ensure continued care and coordination.
- If the CTI team loses contact with an individual the case is not closed. A continued effort to locate them is made; if and when they re-engage the individual re-enters services at the phase that they would have been had they not disengaged.
- An individual's case is closed only if they have expressed that they no longer want to receive the service.

Special Circumstances

- Forensic Population
- Previous recipients of CTI

Who is on the team?

Clinical Supervisor/Fieldwork Coordinator – 1.0 full time dedicated licensed clinician, trained in CTI

Responsible for both supervision & coordination roles

CTI Workers – one FTE per 20 cases

Increase staffing as more individuals are enrolled in program

Dual role of Clinical Supervisor - both coordination & supervision roles

- Coordination role
  - sets up a system of communication among workers in field
  - oversees fieldwork by CTI workers to ensure that they:
    - carry out tasks on To Do list from supervision meetings
    - provide field updates to team during next supervision meeting
    - follow protocols for workers' safety, response to suicidal ideation/attempts, protecting confidentiality
  - provides ongoing assistance in the field
  - keeps vacation schedules & arranges coverage for sick workers

Dual role of Clinical Supervisor - both coordination & supervision roles

Supervision role

- improves team's understanding & practice of:
  - CTI model
  - recovery-oriented care
  - clinical skills
- monitors quality & timeliness of chart work by CTI workers
- fills out Team Supervision and Caseload Review form each week
- during weekly team supervision meetings, ensures that:
  - meetings run efficiently
  - team members develop confidence and feel supported
  - all team members participate in planning agenda and in discussions
  - all agenda items are covered including updates from field
  - updates Phase-Date form and distributes copies to CTI workers

Establishing the Team Culture

During supervision meetings team members give each other feedback reinforcing:

- recovery orientation
- strengths-based approach
- shared decision-making
- CTI principles and practices

Team supervision meeting - Discussions

Be sure to include the following:

- Review To Do list from previous meeting/provide updates
- Review of active caseload
- Full review can be completed over 1-3 supervision meetings, depending on amount of time left over after other urgent business & high-priority discussions.
- Make plan for resolving any emerging barriers to implementation of CTI
- Hold in-depth discussions of "high-priority" cases
  - cases are selected according to reasons listed on supervision form
  - names are recorded on board at beginning of meeting
- Create a To Do list for upcoming weekly activities

Team supervision meeting - Discussions

All team members:

- provide feedback to each other that reinforces CTI principles & practices
- use Phase-Date form as guide to:
  - thinking in terms of phase-appropriate tasks
  - staying focused on the CTI areas identified for each client's current phase
- discuss phase plan for upcoming transitions to new phase
  - before meeting when CTI worker and client finalize phase plan

Team supervision meeting - Discussions

- give new case presentation when ready (i.e., after meeting with individual and completing brief initial assessment)
- plan for three final transfer of care steps
  1. meeting with individual and members of support network (3 weeks before end of CTI)
  2. final meeting with individual right before graduation/celebration event
  3. graduation/celebration

19

DIGNITY OF RISK

- Dignity of Risk is the right to take risks when engaging in life experiences, and the right to fail in taking these.
- Dignity of Risk is an important concept. It places an emphasis on personal choice and self determination - two concepts that are central to recovery.
- Anthony (2000) states: "*the notion that one has options from which to choose is often more important than the particular option one initially selects.*"
- Pat Deegan (1996): "Self-determination, or taking responsibility for one's own recovery, is the core component of recovery. Part of that responsibility involves the self-management of wellness and medication, autonomy in one's life choices and the willingness to take informed and planned risks in order to grow."

20

ACTIVITY

21

Incorporating Recovery-Oriented Approaches

Activity: Changing your focus

Groups of 2-3

Rewrite/transform the statement you're about to read into one that is person-centered, recovery-oriented, strengths-based

Elicit examples from several groups

22

Incorporating Recovery-Oriented Approaches

Traditional view of behaviors as negative

"I have a client who is manipulative and is always splitting staff. She goes to one person and asks for something and then goes to someone else and asks for the same thing when she has already heard "no." She keeps a lot of secrets about her past and lies about where she has been or what she has been doing when she misses appointments."

23

Incorporating Recovery-Oriented Approaches

CTI team's view of behaviors as adaptive

"Amy has experienced very hurtful relationships in the past. She has difficulty trusting people and is understandably reluctant to reveal what's really going on with her. Hopefully, as our relationship develops, she will become more trusting over time."

24

Pre-CTI

Up to 10 hours of service to

- Assess the individual in the community
- Discuss the service with the individual
- Discuss as a team the appropriateness of the referral
- Engage the individual and build rapport
- Enroll the individual into CTI by completing brief assessment or CCA and necessary documentation
- Refer to ACT/CST or other treatment program if clinically necessary

25

Phase 1

Transition to the Community
Months 1-3 (90 days)

In this phase, there is frequent contact with the individual in the community, focusing on active engagement with behavioral health services, and identifying and addressing housing-related issues in order to prevent future episodes of homelessness or housing instability. A transition plan is implemented while providing emotional support.

26

Phase 2

Tryout
Months 4-6 (90 days)

In this phase, the team increasingly encourages individuals to manage problems independently after connecting them to supportive services.

Phase 3

Transfer of Care
Months 7-9 (90 days)

This phase, promotes the transfer from CTI to other community supports, both formal and informal and termination of CTI services occurs with a support network safely in place.

27

CTI Principles and Practices

Programs can modify many aspects of CTI, but not "non-negotiables"

Linking to long-term supports	Community-based
Nine-month duration	Designed around a transition
Small caseloads	Team supervision
Time-limited	Monitoring
Limited Focus	Strengths-based recovery orientation
3-phased approach with decreasing intensity	Shared decision-making
No early discharge	Team-based supervision

28

Teams

- 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
- A full time CTI worker should have a caseload of 1:20
- A full time Fieldwork Coordinator/Clinical Supervisor should have a maximum caseload of 1:10
- It is important that when individuals are admitted to the team that caseloads be staggered, thus having CTI workers with individuals in all three phases on their caseloads.

29

What do we mean by small caseload size?

•Maximum of 20 per CTI worker

•Need to adjust to Standard Caseload Equivalent (SCE)

•due to different level of intensity of work during each phase

EXAMPLE: Converting a standard caseload to an SCE caseload

PER CASELOAD	Pre-CTI	Phase 1	Phase 2	Phase 3	TOTAL
Number of clients in standard CW caseload	4	4	4	4	16
	x 1.5	*x 2*	*x 1*	*x 0.5*	
Number of Standard Caseload Equivalent cases	**6**	**8**	**4**	**2**	**20**

30

What happens if the cases are not scattered across the phases?

It is very important to stagger enrollment into CTI program

16 clients - all in Phase 1

	Pre	1	2	3	
# clients	0	**16**	0	0	16
Adjusted	0	**32**	0	0	32

Too large

16 clients - all in Phase 3

	Pre	1	2	3	
# clients	0	0	0	**16**	16
Adjusted	0	0	0	**8**	8

Too Small

31

TIME FOR A QUIZ!

QUIZ on phases and team

32

Phase two of CTI can be extended beyond the 3 months if necessary?

True

False

33

Which person is an appropriate referral for CTI?

a.) John lost his job last week and is starting a new one on Monday and is very nervous about the transition to the new position.

b.) Betty is being discharged from an Adult Care Facility to go and live with her sister. She has met her new ACT team, however wants as much community support as possible.

c.) Lou is homeless and has been hospitalized 3 times for his Bipolar symptoms over the past 2 months. He says that he wants to apply for housing but every time he is discharged from the hospital he doesn't know where to begin and ends up back in the hospital.

d.) Suzy is homeless, living in the shelter. She has been going to AA for her Alcohol Use Disorder and now states that she is ready to get a job and her own apartment.

34

Which person, based on the diagnostic information, meets the criteria for CTI?

a.) 17 year old high school student with Bipolar Disorder

b.) 34 year old female with Schizoaffective Disorder and a history of Alcohol Use

c.) 57 year old male with a primary diagnosis of Cocaine Use and a secondary diagnosis of Anxiety.

d.) 22 year old female with Borderline Personality Disorder

e.) all of the above

35

On December 4 John had his intake with CTI. The team saw him 3 times a week until he was no longer at the normal meeting place on January 15. The team continued to look for him and located him at a shelter on March 30. What Phase is John in?

a.) John is in Phase 1

b.) John is in Phase 2

c.) John is in Phase 3

d.) John's case was closed 30 days after no contact and needs to have another intake.

36

Phase 3 is when CTI Workers have the most face-to-face contact with the individual receiving services?

True

False

37

Of the following, who would be appropriate for CTI?

1. Mark, a 47 year old man, who has a diagnosis of Schizophrenia, has been in jail for the past 6 months. Prior to being in jail, he was connected to an ACT team that was meeting his clinical needs. He has no benefits, no independent housing and once released from jail, he will be staying with a friend.
2. Karen, a 28 year old, single mother of two who has recently lost her job, is interested in finding employment. She has no child care available. She recently dropped out of counseling due to financial hardships.
3. John, a 26 year old man currently living in an Adult Care Home in Yanceyville, has been sober for 16 months and would like to move into his own apartment. He has been diagnosed with Schizoaffective Disorder but is not currently under any medical/psychiatric care.
4. Sally, a 49 year old female, is being discharged from her second inpatient psychiatric hospitalization stay. She would like to be linked to treatment services.

38

Engaging Skillfully with the Individual

ACTIVITY

39

Engaging Skillfully with the Individual

Demo

May I tell you a bit about myself and my role in CTI?

What would you like me to know about you?

How are you feeling about moving into your own place?

What concerns, if any, do you have about making this transition?

What are you looking forward to?

What strengths can you bring to this transition?

40

Engaging Skillfully with Person

ACTIVITY: Initial Meeting

Pairs:

- CTI worker
- Person being engaged

Instructions:

- Worker engages with person for ~5-7 min
- Uses sample questions as a guide
- Debrief as large group

41

QUESTIONS

42

DAY TWO: CTI SELF-ASSESSMENT, FIDELITY MONITORING REQUIREMENTS, DOCUMENTATION AND OUTCOMES

43

Documentation Requirements

- CTI Assessment
- Service Order
- Authorization
- CTI Phase Plan
- Progress Note
- CTI Team Supervision Form
- CTI Self-Assessment
- CTI Closing Note
- CTI Caseload Review Form
- CTI Phase-Date Form
- State Enhanced Crisis Plan

44

Components of Brief Assessment

The assessment must be completed by a licensed professional and must include the following elements:

A. the individual's presenting problem;

B. the individual's needs and strengths;

C. a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission;

D. a pertinent social, family, and medical history; and

E. evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the individual's needs.

45

Self Assessment & Fidelity Monitoring

The Self-Assessment is a quality improvement tool that is used to measure adherence to the model

- the assessment is completed by the team every 6 months from the date that the team starts
- the assessment is to be kept by the team but be available upon request from NC DMH/DD/SAS and DMA
- the assessment is used to provide a mechanism for quality improvement feedback and guided consultation
- Ideally completed during supervision meeting

46

CTI Implementation Self-Assessment

Three	Sometimes	About half the time	Most of the time	Always
1	2	3	4	5

MAIN COMPONENTS	Score
Time-Limited 1. CTI workers provide no more than nine months of CTI after the date a client starts Phase 1. *For a 6-month CTI program, they provide no more than six months.*	
Three Phases 2. The intervention takes place in three phases, each phase having the same duration. *(e.g., for a 9-month CTI program, each phase lasts 3 months)*	
Focused 3. One to three areas of focus for each phase are selected from your program's list of CTI areas.	

47

Fidelity Monitoring and Site Visits

- Fidelity Monitoring will not begin until teams has been serving consumers for one year after the service definition went into effect
- Conducted Annually
- Track adherence to the model
- Determine annual CTI Performance outcome
- Site visits will be conducted annually for existing teams and every 6 months for new teams

Completed assessment will be shared with the CTI Team as well as the LME-MCO.

48

OUTCOMES

49

Expected Outcomes

The outcomes are based on the individual phase plan, however some outcomes may include:

- The individual will identify and engage in a stable housing plan
- The individual will re-engage with providers and other support systems
- The individuals' utilization of community-based services will increase
- The individuals' state hospital admissions will be reduced
- The individuals' state hospital bed utilization will be reduced
- The individuals' admissions to emergency departments and other crisis care will be reduced
- The individuals' rate of incarceration will be reduced

50

Tracking of outcomes

- Teams will track their outcomes on a provided tracking tool
- This information will be provided to NC DMH/DD/SAS and DMA quarterly

51

QUESTIONS

52

DHHS CONTACTS

Margaret Herring, M.Ed, LPC, LCAS, CCS – DMH/DD/SAS
Margaret.herring@dhhs.nc.gov
(919) 715-2338

Justin Turner, MSW, LCSW – DMH/DD/SAS
Justin.turner@dhhs.nc.gov
(919) 715-2142

Lisa DeCiantis, MA, LPC – DMH/DD/SAS
Lisa.deciantis@dhhs.nc.gov
(919) 715-2308

Kelsi Knick, MSW, LCSW – DMA
Kelsi.knick@dhhs.nc.gov
(919) 855-4288

53

Resources

North Carolina DMHDDSAS
http://www.ncdhhs.gov/divisions/mhddsas/AdultMentalHealth

Center for the Advancement of Critical Time Intervention
https://www.criticaltime.org/cti-model/

North Carolina CTI State Service Definition
https://ncdhhs.s3.amazonaws.com/s3fs-public/State-Funded%20Critical%20Time%20Intervention-CTI-Final%20for%20Posting%207-1-16.pdf

54

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

Based upon the recommendations of the Clinical Governance Committee, the Executive Steering Committee selected *D3: Expansion in Intensive SUD Treatment Options* as the second of its three community-driven projects, which was validated by the results of the fall 2016 Community Needs Assessment surveys.

The Nashua region is in need of additional treatment options to alleviate the sudden and dramatic rise in the number of residents suffering from substance use disorders (SUDs). IDN members determined that through adding additional resources to the community, including additional staffing in the two hospital Emergency Departments and partial intensive outpatient, partial hospital or residential treatment, we could ensure that patients with SUDs are moving from the ED to proper treatment locations with appropriate clinical support.

We also determined that there was a need for additional support in the middle schools and determined piloting having a Student Assistance Counselor in the Elm Street Middle School to provide screening and intervention as well as supportive counseling for those not needing more intensive treatment and for those needing more intensive treatment options, making referrals to clinicians and providers to provide those services. Finally, we determined that more community-based groups were needed to go to where individuals struggling with SUD were, such as soup kitchens, homeless shelters, and peer support centers would expand reach and offer additional support to this population, so we will implement weekly Spirituality groups as well as weekly Pre-Treatment groups, which will use motivational interviewing techniques.

The increase of all of these SUD supports and options for expanding treatment opportunities will hopefully lead to a/an:

- Increase stable remission of substance misuse
- Reduction in hospitalization
- Reduction in arrests
- Decrease in psychiatric symptoms for individuals with co-occurring mental health conditions
- Increase in adolescents receiving annual well-care visits

D3 Project Strategies

<u>Youth SUD Services in Schools</u>

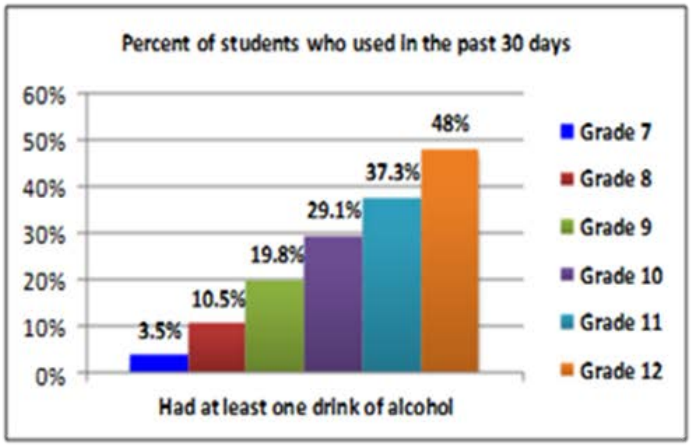
Adolescents in greater Nashua rarely enroll in services for substance misuse on their own; instead, they become connected with care after having been arrested by police, suspended from school or engaged in other high risk behavior. Given The Youth Council's role in offering a Juvenile Court Diversion Program for first time offenders, a School Suspension Center for 5th to 8th graders and Student Assistance Program services at Nashua's two high schools, they are often the first provider to identify substance misuse as a problem and coordinate outpatient treatment and follow-up care with the teen's primary care provider, as warranted.

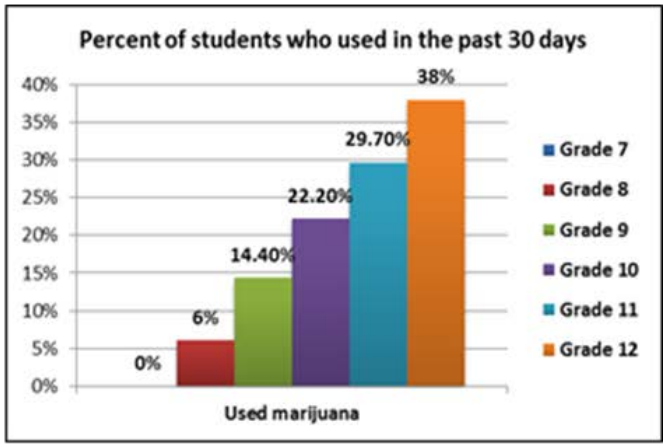
Extent of the Issue in Nashua Youth

Nashua utilizes the CDC's Youth Risk Behavior Survey, administered every other year, to identify risky behaviors among 9th to 12th graders in Nashua. In addition, Nashua Prevention Coalition sponsored the YRBS for 7th and 8th graders for the first time in 2015. In 2015, our high school youth report higher levels of use than those around the state for many substances, including the following:

- 8% of high school students used prescription drugs without a prescription (State 6.8%),
- 16.8% came to school high on marijuana (State 15.3%),
- 25.5% currently use marijuana (State 22.2%),
- 18.1% were offered drugs on school property (State 16.5%),
- 55.6% did not talk with parents about the dangers of substance misuse (State 50%),
- 8.8% drove when drinking alcohol (State 6.3%) and
- 32.8% currently drink alcohol (State 29.9%).

With the School Board's approval of collecting Youth Risk Behavior Survey Data from 7th and 8th grade students in 2015, we can now chart the trajectory of student alcohol and marijuana use (below) as they transition from Middle to High School.





We believe that adding Student Assistance Counselors to identify, support and refer Middle and High School youth will lead to a decrease in substance misuse among students and reduced reports of suicidal thoughts and depression by using the already established YRBS results. The next administration of the survey was this past spring 2017 with the report available by fall 2017/winter 2018.

Referrals

Referrals will be received from current school employees, including guidance counselors, school administrators, School Resource Officers and school nurses. The Student Assistance Counselor will also build referral pathways with primary care physicians for youth needing brief intervention as a result of in-office SBIRT protocols being implemented as a result of the B1 project.

Students that need more significant services than those provided on-site at school (outpatient treatment, intensive services), will be referred to The Youth Council's LCMHC/MLADC and/or Greater Nashua Mental Health Center, and based upon the needs of the youth. Older teens (18+) will be referred to Keystone Hall for services. As youth also often report parents using substances, IDN partners that work with adults will be tapped for resources and support for reaching out to parents to provide them with services.

SAP Strategies

Given that services will be provided on site at school (and include referrals from primary care) this level of support will be "normalized" within the student population. Student Assistance Program (SAP) services will not be advertised specific for alcohol and drug use. Rather, the services will be promoted as stress reduction, improved relationships, building communication skills, reduced anxiety, and the like, which will address the lack of these that often lead to students using substances to self-medicate. Hence, services provided by SAP include "supportive counseling" but NOT treatment. Those services will be provided by Greater Nashua Mental Health Center and/or The Youth Council under existing services.

The strategy involves the Student Assistance Counselor providing assessments on students referred to the program and working with guidance staff to build a collaborative plan to link the student to appropriate services for their unique needs. Additional time will be used to provide interim services to the students until they are able to connect with the recommended services. The Student Assistance Counselor will use that time to communicate with primary care, school-based partners and parents, including building relationships with IDN primary care providers to educate them about the SAP and the use of SBIRT.

Supervision of Student Assistance Counselor will be provided by existing staff person who is a LCMHC and MLADC and is a Certified Recovery Support Worker (CRSW).

Anticipated Targeted Impact

SAPs are anticipated to serve approximately 150 youth in an academic year, with the ideal ratio of 1 SAP Counselor for each 1,000 students in a school. While all students will derive some benefit from the SAP through universal prevention strategies, s/he will be able to provide brief intervention/education and assessment services to ramp up in 2017 from 25 students per year to upwards of 75 students in the 1 Nashua Middle School he/she is located in.

The Counselor will also build relationships with primary care physicians (PCPs), increasing their awareness of the Student Assistance Program, the resources available to youth who positively screen for substance use to refer to for supports/treatment through the PCPs use of SBIRT, and to ensure that youth participating in the SAP who have not received annual well-care visits will get referrals back to their PCP or primary care practice to receive one. It is expected that the Counselor will ramp up their relationship building with PCPs in 2017, eventually reaching approximately 10 by December 31, 2018.

Given that Nashua School District reported a total enrollment of 5,970 students in Middle and High School in 2016, a total of six (6) SAP counselors are needed to meet the 1:1,000 ratio. With two SAPs targeted for funding in the B1 project, we expect the impact will be expanded upon for this project, with the 3 SAPs working closely together with other IDN Member Entities.

<u>Adult Medical Detox Expansion Support</u>

Currently, there exists a significant lack of medical detox/ Medication Assisted Treatment (MAT) opportunities in the greater Nashua region. Through the added programs (non-IDN funded) and added IDN-funded staffing in both the Harbor Care Health and Wellness Center (HCHWC) and its Medical Respite Care (MRC) program, this need will be addressed.

Transportation is provided by staff of these agencies, including Certified Recovery Social Workers (CRSWs) for those individuals who have access issues. HCHWC has a mobile van will be available to the Greater Nashua community bringing primary care, dental care and behavioral health care to those individuals who

cannot access services due to lack of transportation. It is assumed that this process will further identify individuals who are in need of these services, along with the newly funded Mobile Crisis Unit.

The Partial Hospitalization Program (PHP) for adults is conducted in partnership with Harbor Care Health and Wellness Center (Harbor Homes), an FQHC. This program is offered 20 hours a week over a five-day period within the outpatient department at the Center. Time spent in PH varies, but usually is between 4 and 6 weeks for at least six hours per scheduled day. Services include:

- therapeutic milieu
- nursing
- psychiatric/medical evaluation and medication management (including detoxification as appropriate)
- group and individual/family therapy
- psychological testing
- vocational counseling
- rehabilitation recovery counseling
- substance use evaluation and counseling
- development of behavioral plans

Ongoing consultation for medical and psychiatric issues will be available within 8 hours by phone and no more than 48 hours face-to-face, with Cognitive Behavioral Therapy and Motivational Interviewing evidence-based practices used.

Residential Detoxification Program and/or Intensive Outpatient Program (IOP) for adults is conducted in partnership with Harbor Care Health and Wellness (Harbor Homes) and Keystone Hall, a medical respite and SUD treatment center. Keystone Hall will develop the capacity to provide 24/7 medically monitored residential detoxification and stabilization services to adults, as well as outpatient withdrawal management. Through this modality, patients will be evaluated, stabilized (medical and non-medical) and fostered entry into treatment, including access to buprenorphine, methadone, naloxone, and/or naltrexone through MAT providers at Harbor Homes and other IDN MAT providers.

Referrals

The expanded Nurse Care Manager model will deliver an Office-Based Opioid Treatment (OBOT) program at Keystone Hall adding to the program that has existed at Harbor Homes for the last two years. A .6 FTE detox nurse care manager and a .6 FTE non-detox care manager will work closely with local hospitals (Southern NH Medical Center and St. Joseph Hospital) and other community-based organizations to accept referrals once case coordination and communication has occurred – insuring appropriateness of care. Care transition will be closely monitored to insure that all clinical information is received, with a closed loop referral process resulting in treatment plans being shared back with the referring organization (with patient consent).

The targeted annual attributed population will ramp up in 2017 from approximately 25 patients to approximately 600 patients per year by the end of the demonstration.

<u>Adult Community-Based Groups (SUD and Spirituality)</u>

Two initial non-treatment community-based groups will be held weekly in the Greater Nashua area to support community members struggling with substance use disorder, as well as their family members and caregivers. These groups are currently non-billable to insurance and are estimated to serve between 2 and 10 participants weekly for each group.

Spirituality support groups (led by a licensed Pastoral Psychotherapist from the Emmaus Institute) will be held weekly for community members, as well as their family members/caregivers. The groups will engage members in commitment and motivation for participation in activities that support treatment for substance use disorder (SUD). These groups will support its members through activities and motivational interviewing that instill self-efficacy and hope to promote a meaningful life scheme and personal agency as part of their overall health.

Pre-treatment community-based groups (led by a Certified Recovery Coach from H.E.A.R.T.S. Peer Recovery Center and supported by a LADC or Master's prepared therapist from Greater Nashua Mental Health Center) will be conducted weekly in locations around the community, such as the Rescue Mission or Soup Kitchen. They will be geared toward those experiencing homelessness and will utilize motivational interviewing (ASAM Level 1) a foundation for the groups, with some care management and/or coordination to referrals for other levels of care, as needed or requested by group members. It is expected that an average of 2- 10 participants each week will participate in the groups.

Emergency Department SUD Transition (Recovery/Transitional Care Case Managers)

Individuals entering the two hospital Emergency Departments will be screened and referred to one of the IDN-funded Recovery/Transitional Care Case Managers if screened positively for substance use disorder (SUD). The Case Managers will determine if medical care is required and if not, will conduct further assessments to determine which level of treatment is needed.

First, the Case Manager will determine if the patient is in need of emergency detox treatment and if so, will refer to Harbor Homes/Keystone Hall's Nurse Care Manager for their Residential Detoxification Program. The Nurse Care Manager will take the referral and ensure the patient also has an assigned primary care physician (PCP) if one has not already been secured by the patient.

If the patient is not in need of emergency detox treatment, the Case Manager will refer to the list of SUD providers in the region that is kept by the City of Nashua, Division of Public Health & Community Services Substance Misuse Prevention Coordinator to determine the treatment for the patient.

If the patient is not in need of emergency detox treatment and has a severe mental illness, the Case Manager will refer the patient to the IDN's Integrated Dual Diagnosis Treatment (IDDT) program at Greater Nashua Mental Health Center, through their IDDT Clinical Supervisor, who will then assign an IDDT Case Manager who will take the referral and ensure the patient also has an assigned primary care physician (PCP) if one has not already been secured by the patient.

It is expected that an annual target of patients screened and referred through the two Recovery/Transitional Care Case Managers will be ramped up in 2017, with approximately 25 patients and reach approximately 150 by the end of the demonstration period.

Expected Challenges and Solutions

We expect to work very quickly over the next several months to address some of the challenges to ensuring success for care transition teams. These include:

- Investing funding and time into the behavioral health workforce, including recruiting and hiring, as well as training and retaining individuals who understand the value of integrated care and are working in a workplace that supports this coordinated approach
- Developing and implementing intake procedures, treatment planning, and referral protocols that systematically solicit patient consent to confidentially share information among providers through educating the patient as well as the providers and social service support organizations serving the patient
- Integrating electronic health records (or at least shared care plans) across service providers who touch the attributed patients in our IDN
- Investing in enhanced technology and shared record-keeping to ensure systematic information sharing and communication for care coordination across the multi-disciplinary teams being formed in practices across the IDN as part of the B1 Integrated Health project
- Participating in monthly case management meetings for those patients with significant behavioral health or chronic conditions that include all of their providers and social service support team members.

Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

Tracking and monitoring of individuals served by the strategies implemented in D3 will initially be achieved through the use of case management/coordination planning and progress notes through individual patient care plans. Once up and running, the Shared Care Plan platform hosted by will provide for timely information sharing among providers through (or a similar vendor) will allow for case management workflows and triggers.

Adherence to impact measures will be monitored and tracked timely use of the Shared Care Plan (and /a similar vendor), Event Notification Service (and data aggregation provided by

Fidelity to evidence-supported project elements will be accomplished by monitoring outcome indicators for each of the strategies, using the prescribed protocols for patient intake assessment, treatment, management, and referral, and tracking improved patient health outcomes achieved.

D3 Expansion in SUD Treatment Options Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Develop Implementation Plan	456d	04/03/17	12/31/18
DONE	Develop Implementation Plan Timeline	197d	04/03/17	01/02/18
	Develop Project Budget	54d	05/15/17	07/27/17
DONE	Develop budget based on selected project strategies	16d	05/15/17	06/05/17
DONE	Review with Clinical Committee	1d	06/05/17	06/05/17
DONE	Present to Finance Committee for approval	11d	07/10/17	07/24/17
DONE	Present to Executive Committee for approval	1d	07/27/17	07/27/17
DONE	Budget approved	1d	07/27/17	07/27/17
	Develop Workforce Plan	120d	04/17/17	09/29/17
	Develop Staffing Plan (includes all partner strategies)	120d	04/17/17	09/29/17
DONE	Identify positions and number of FTEs	22d	05/04/17	06/02/17
DONE	Determine if they will be employees or shared sub-contractors	22d	05/04/17	06/02/17
DONE	Identify the timeframe for filling the positions	32d	05/04/17	06/16/17
DONE	Secure Staff	120d	04/17/17	09/29/17
DONE	Youth SUD Counselor	77d	04/17/17	08/01/17
DONE	Medical Detox and Non-Detox Nurses	77d	04/17/17	08/01/17
	Recovery/Transitional Care Case Managers .5 FTE x 2	65d	07/03/17	09/29/17
	Community-based Spirituality Group Facilitator	58d	07/03/17	09/20/17
	Community-based Pre-Treatment Group Facilitator	58d	07/03/17	09/20/17
	Community-based Pre-Treatment Group Co-Facilitator	58d	07/03/17	09/20/17
	Develop Recruitment Strategies with Project Partners	392d	07/01/17	12/31/18
	IDN 3 Website development with Career Board	51d	07/01/17	09/08/17
	Contract with	51d	07/01/17	09/08/17
	Conduct IDN Job Fair	63d	07/01/17	09/26/17
	Contract with	51d	07/01/17	09/08/17
	Contract with Crowne Plaza	21d	08/18/17	09/15/17
	Compile job descriptions to populate Career Board on IDN website	41d	08/01/17	09/26/17
	Mass media marketing with radio ads, social media ad sponsorship, flyers shared electronically	41d	08/01/17	09/26/17
	Secure table confirmations from IDN Member Entities and education institutions for event at Crowne Plaza	41d	08/01/17	09/26/17
	Secure RSVPs from potential participants for event land page on website	41d	08/01/17	09/26/17
	Hold event Crowne Plaza	1d	09/26/17	09/26/17
	IDN-funded Recruitment/Hiring Strategies	373d	07/27/17	12/31/18
	Sign-on bonuses and relocation reimbursement	373d	07/27/17	12/31/18
	Project Annual Client Engagement Volumes	36d	05/12/17	06/30/17
DONE	Solicit input from IDN project partners	36d	05/12/17	06/30/17
DONE	Develop projections	15d	06/12/17	06/30/17
	Identify Key organizational/provider participants	151d	04/03/17	10/30/17
DONE	Key participants identified	26d	04/03/17	05/08/17
DONE	Letters of Agreements signed	151d	04/03/17	10/30/17
	Clinical Services Infrastructure	436d	05/01/17	12/31/18
	Develop/Identify Standardized Assessment Tools	45d	05/01/17	06/30/17
DONE	Work with project strategy partners to document the assessments currently being used	45d	05/01/17	06/30/17
	Work with project strategy partners to identify potential assessments to be used	360d	08/07/17	11/31/17
	Develop/Identify Patient Assessment, Treatment, Management and Referral Protocols	45d	05/01/17	06/30/17

DONE	Work with project strategy partners to document protocols currently in place	45d	05/01/17	06/30/17
	Work with project strategy partners to identify potential assessments to be used	345d	08/07/17	11/31/17
DONE	Identify/Develop Roles and Responsibilities of Team Members	44d	05/02/17	06/30/17
DONE	Work with program strategy leads to establish roles and responsibilities of team members	44d	05/02/17	06/30/17
DONE	Youth SUD Services in Schools	22d	05/04/17	06/02/17
DONE	Document role/responsibilities of the Student Assistance Program Counselor	22d	05/04/17	06/02/17
DONE	Adult Medical Detox	22d	05/04/17	06/02/17
DONE	Document role/responsibilities of the Detox and Non-detox RNs	22d	05/04/17	06/02/17
DONE	Adult Community-Based Groups	44d	05/02/17	06/30/17
DONE	Document role/responsibilities of spirituality group facilitator	20d	06/05/17	06/30/17
DONE	Document role/responsibilities of pre-treatment group facilitator	7d	05/05/17	05/15/17
DONE	Document role/responsibilities of pre-treatment group co-facilitator	9d	05/02/17	05/12/17
DONE	RecoveryTransitional Care Case Manager	41d	05/05/17	06/30/17
DONE	Document role/responsibilities of the Recovery/Transitional Care Case Managers	41d	05/05/17	06/30/17
DONE	Identify/Develop Training Plan	162d	05/05/17	12/18/17
DONE	Assess staff training needs of each project strategy	162d	05/05/17	12/18/17
DONE	Solicit training needs from each project strategy partner	41d	05/05/17	06/30/17
	Work with each project strategy partner and IDN 3 work teams to identify training needs for staff	141d	06/05/17	12/18/17
	Create logistics plan for trainings	65d	09/01/17	11/30/17
	Contract with vendors/purchase trainings	261d	10/01/17	09/28/18
	Schedule trainings	109d	10/01/17	02/28/18
	Provide mechanisms for participants to engage in trainings	327d	10/01/17	12/31/18
	Develop/Identify Training Curricula	281d	09/01/17	09/28/18
	Work with vendors to develop curriculum	281d	09/01/17	09/28/18
	Work with vendors to determine training format (webinar, on site, coaching, other)	261d	10/01/17	09/28/18
	Work with vendors to develop evaluation mechanisms	261d	10/01/17	09/28/18
	Collect Signed Agreements with Collaborating Organizations	88d	07/01/17	10/31/17
	Reach out to collaborating organizations to identify roles and responsibilities	88d	07/01/17	10/31/17
	Collect signed Letters of Agreement	88d	07/01/17	10/31/17
	Develop evaluation plan, including metrics that will be used to measure program impact	131d	06/30/17	12/29/17
	Work with Performance Metrics and Quality Monitoring workgroup to establish mechanisms to track and monitor required elements	131d	06/30/17	12/29/17
	Identify mechanisms (registeries) to track and monitor individuals served by the program, adherence, and impact measures.	305d	05/01/17	06/29/18
	HIT platforms (including -data aggregator; ENS/SCP; -DSM; or similar vendor--data query, e-referrals, etc.)	305d	05/01/17	06/29/18
	Individuals served by the program	305d	05/01/17	06/29/18
	Adherence	305d	05/01/17	06/29/18
	Impact measures	305d	05/01/17	06/29/18
	Fidelity to evidence-supported project elements (re-hospitalization data)	305d	05/01/17	06/29/18

	Operationalization of Program	131d	07/01/17	12/29/17
	Implementation of workforce plan	131d	07/01/17	12/29/17
	Deployment of training plan	131d	07/01/17	12/29/17
	Implementation of any required updates to clinical protocols, or other operating policies and procedures	131d	07/01/17	12/29/17
	Use of assessment, treatment, management and referral protocols	131d	07/01/17	12/29/17
	Initiation of Data Reporting	131d	07/01/17	12/29/17
	Number of individuals served (during reporting period and cumulative), vs. projected	131d	07/01/17	12/29/17
	Number of staff recruited and trained (during reporting period and cumulative) vs. projected	131d	07/01/17	12/29/17
	Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	131d	07/01/17	12/29/17
	Ongoing Data Reporting	129d	01/02/18	06/29/18
	Number of individuals served (during reporting period and cumulative), vs. projected	129d	01/02/18	06/29/18
	Number of staff recruited and trained (during reporting period and cumulative) vs. projected	129d	01/02/18	06/29/18
	Staff vacancy and turnover rate for period and cumulative vs. projected	129d	01/02/18	06/29/18
	Impact measures as defined in evaluation plan	129d	01/02/18	06/29/18
	Ongoing Data Reporting	132d	07/01/18	12/31/18
	Number of individuals served (during reporting period and cumulative), vs. projected	132d	07/01/18	12/31/18
	Number of staff recruited and trained (during reporting period and cumulative) vs. projected	132d	07/01/18	12/31/18
	Staff vacancy and turnover rate for period and cumulative vs. projected	132d	07/01/18	12/31/18
	Impact measures as defined in evaluation plan	132d	07/01/18	12/31/18

D3-2. IDN Community Project: Evaluation Project Targets

The table below identifies projected annual client engagement volumes for each of the strategies. See attachment_D3.1 (D3 Implementation Plan) for additional detail.

We expect as we finalize the operations and complete agreements with provider partners by early 2018. Below are some initial targets for potential outcomes from the strategies outlined for D3.

Project Strategy	Client Engagement 2017	Client Engagement 2018
Youth SUD Services (1 Nashua Middle School)	Up to 10	Up to 50
Adult Medical Detox (Detox and Non-Detox)	Up to 25	Up to 100
Adult Community- Based Groups (Spirituality and Pre- Treatment)	Up to 20	Up to 60
Recovery/Transitional Care Case Managers (SNMHC and St. Joseph Hospital)	Up to 25	Up to 100

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased knowledge of universal screening/assessment process (Comprehensive Core Standardized Assessment), across 10 domains to guide the treatment and management of the target sub-population.	Up to 9 IDN-funded positions in the D3 strategies will participate in universal screening training by December 31, 2018.			
Increased knowledge of patient consent requirements, especially related to 42 CFR Part 2 to guide the treatment and management of the target sub-population.	Up to 9 IDN-funded positions in the D3 strategies will participate in training on patient consent, especially related to 42 CFR Part 2 by December 31, 2018.			
Increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub-population.	Up to 9 IDN-funded positions in the D3 strategies will participate in training on communication protocols and workflows (through HIT vendor technologies) by December 31, 2018.			
Increased knowledge of American Society of Addiction Medicine (ASAM) guidelines to ensure proper placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.	Up to 4 of the IDN-funded positions in the D3 strategies will participate in the ASAM training by December 31, 2018.			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased knowledge of the goals of Screening, Brief Intervention and Referral to Treatment (SBIRT) and other treatment and support resources available for referring youth who positively screen for substance use to guide the treatment and management of the target sub-population.	Up to 10 Primary Care Physicians (PCPs) across the IDN Member provider practices will have met with the IDN-funded Student Assistance Program Counselors to receive information about SBIRT and referral resources by December 31, 2018.			
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub-population.	Up to 300 members of the target sub- population will be touched by the programs/activities associated with the D3 strategies.			

D3-3. IDN Community Project: Workforce Staffing

Below represents the workforce associated with the strategies to accomplish the goals of the D3 project.

Project Strategy/Staff Position(s)	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
Mental Health Counselor (Master's Level LMHC)	2	85			
Case Manager (RN Bachelor's Level)	1.2	70.6			
Master's Level Team Leader for IDDT and CTI (LICSW or LMHC)	2	98			
Master's Level Substance Use Disorder Therapist	1	16			
Bachelor's Level Case Manager for IDDT and Co-Located Pilot with GNMHC/Lamprey)	3	56			
Licensed Pastoral Psychotherapist	.5	2			
Peer Support Specialist	.5	30			
Recovery/Transitional Care Case Manager	1	.5			
Community Health Worker	8	40			

D3-4a. IDN Community Project: Budget

The majority of the funding associated with this budget are related to staffing, with associated costs for cell phones, computers, travel reimbursement and supplies. For more details, please see attachment_D3.4b (D3 Budget Spreadsheet).

Category of Funding	Entity Funded	Amount of Funding 2017 - 2020
Student Assistance Program	The Youth Council	$204,800
Adult Medical Detox (2 RNs)	Harbor Homes	$307,200
Spirituality Community-Based Groups	The Emmaus Institute	$31,200
Community-Based Pre-Treatment Groups with group facilitator (Master's Level Counselor) and co-facilitator (Peer Support Specialist)	Greater Nashua Mental Health Center/H.E.A.R.T.S.	$31,236
Emergency Department SUD Transition through Recovery/Transitional Care Case Manager	Southern NH Medical Center	$109,333.33
Emergency Department SUD Transition through Recovery/Transitional Care Case Manager	St. Joseph Hospital	$109,333.33
Total		**$793,102.66**

D3 Expanding Substance Use Disorder Treatment Options
2017 - 2020

Category and Item	Item Notes	2017-2018 Budget Available	2019 - 2020 Budget Available	August 2017 - June 2018 (11 months)	July 2018 - June 2019	July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	Total Requested 2017 - 2020	Total Available 2017 - 2020
Totals		**$379,969.00**	**$567,237**	$213,050.25	$232,418.45	$232,418.45	$116,209.23	$794,096.38	**$947,206.00**
Student Assistance Counselor	1 FTE Student Assistance Counselor			$56,320.00	$61,440.00	$61,440.00	$30,720.00	$209,920.00	
The Youth Council									
Detox and Non-Detox Nurses	2 (.60 FTE) Detox and Non-Detox			$84,480.00	$92,160.00	$92,160.00	$46,080.00	$314,880.00	
Harbor Homes									
Spirituality Community Groups	up to 52 groups per year			$7,150.00	$7,800.00	$7,800.00	$3,900.00	$26,650.00	
The Emmaus Institute									
Community-Based Pre-Treatment Groups	up to 52 groups per year			$6,433.58	$7,018.45	$7,018.45	$3,509.23	$23,979.71	
Greater Nashua Mental Health Center	Co-facilitated in partnership with H.E.A.R.T.S. Peer Support Center								
Recovery/Transitional Care Case Manager in Emergency Department	2 (.5 FTE) Transitional Care Coordinators in Emergency Departments at SNMHC and St. Joseph Hospital			$58,666.67	$64,000.00	$64,000.00	$32,000.00	$218,666.67	

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

Below are the key organizational/provider participants engaging in the D3 strategies.

Project Strategy	Organizational/Provider Participants	Agreements Signed?
Youth SUD Services in Schools	The Youth Council	No (in process)
	Nashua School District, guidance staff at each of the three middle schools	No (in process)
	Greater Nashua Mental Health Center	No (in process)
	Lamprey Health Care	No (in process)
Adult Medical Detox	Harbor Homes	No (in process)
	Keystone Hall	No (in process)
	Southern NH Medical Center	No (in process)
	St. Joseph Hospital	No (in process)
	Greater Nashua Mental Health Center	No (in process)
Adult Community-Based Non-Treatment Groups	The Emmaus Institute	No (in process)
	Greater Nashua Mental Health Center	No (in process)
	H.E.A.R.T.S Peer Recovery Center	No (in process)
ED SUD Care Transitions through Recovery/Transitional Care Case Managers	St. Joseph Hospital	No (in process)
	Southern NH Medical Center	No (in process)

D3-6. IDN Community Project: Standard Assessment Tools

The table below identifies assessment/screening tools used by providers for each project strategy.

Project Strategy	Assessment/Screening tool(s) used
Youth SUD Services in Schools	Screening to Brief Intervention (S2BI)
	PHQ-2
Adult Medical Detox	Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar. Scale
	Riker Sedation – Agitation Scale (SAS)
	Clinical Opiate Withdrawal Scale (COWS) - rates eleven common opiate withdrawal symptoms
	Alcohol Use Disorders Identification Test (AUDIT) - screens for harmful alcohol consumption
	Drug Use Screening Tool (DAST) – provides a quantitative index of problems related to drug misuse.
Adult Non-Treatment Groups	N/A as they are non-treatment interventions
ED Recovery/Transitional Coordinators	ASAM Criteria, S2BI, PHQ-2, Mental Health Screening Form III (MHSF-III)

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

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

Protocol Name	Brief Description	Use (Current/Under Development)
Student Assistance Program (SAP) Assessment	This protocol will include the use of the Screening to Brief Intervention (S2BI) and PHQ tools.	Under Development
Student Assistance Program (SAP) Treatment	N/A for this strategy, as it is not a treatment strategy. Treatment will be made through referrals to other appropriate IDN providers, using patient consent (see attachment_D3.7b).	N/A
Student Assistance Program (SAP) Management	This protocol will incorporate supportive counseling (not treatment).	Under Development
Student Assistance Program (SAP) Referral	This protocol will include the use of a formal consent process with the youth (and parent, if applicable) and will be provided upon positive screen through use as standard assessment tools for external (outside of school) referrals. As the HIT platforms become available for e-referrals and SCP, this will become an electronic process. In-school referrals will be made through the use of an internal referral form (to be created) and documented in the SCP (once available).	Under Development

Protocol Name	Brief Description	Use (Current/Under Development)
Adult Medical In-Patient Detox Assessment	Primary care and ED physicians or other front-line clinicians/providers completing the Comprehensive Standardized Assessment (CSA) annually will include screening for substance use disorders (via SBIRT). If SUD screen is positive, referrals will be made for a more formal assessment (role/location and tool to be identified/developed) to determine level of care needed. If inpatient detox is indicated, a Nurse Case Manager at Harbor Homes will conduct a more thorough assessment of the patient upon intake.	Under Development
Adult Medical In-Patient Detox Treatment	The expanded Nurse Case Manager model will deliver an Office-Based Opioid Treatment (OBOT) program at Keystone Hall adding to the program that has existed at Harbor Homes for the last two years. The current treatment protocols in use will be the starting point for this strategy.	Under Development
Adult Medical In-Patient Detox Management	The expanded Nurse Case Manager model will deliver an Office-Based Opioid Treatment (OBOT) program at Keystone Hall adding to the program that has existed at Harbor Homes for the last two years. The current management protocols in use will be the starting point for this strategy.	Under Development
Adult Medical In-Patient Detox Referral	Referrals are expected to come from a variety of sources, including physicians in IDN provider practices, the recovery/transitional care case managers in the SNMHC and St. Joseph Hospital emergency departments, the community-based non-treatment groups (spirituality and pre-treatment) and Greater Nashua Mental Health Center (via the IDDT program, as applicable).	Under Development

Protocol Name	Brief Description	Use (Current/Under Development)
Adult Non-Treatment Community Groups Referral to Treatment	Referrals will be made to Greater Nashua Mental Health Center (via the IDDT program) and if treatment if determined needed, to Harbor Homes/Keystone Hall to the Nurse Case Manager for the inpatient medical detox program.	Under Development
Emergency Department SUD Transition (St. Joseph Hospital and SNHMC) Assessment	Emergency Department staff will contact the Recovery/Transitional Care Case Manager, who will conduct an assessment (tool(s) to be determined) and discuss with the patient the need for an appropriate level of care, as determined by ASAM criteria.	Under Development
Emergency Department SUD Transition (St. Joseph Hospital and SNHMC) Referral	As determined the patient assessment and level of care deemed appropriate through the use of ASAM criteria, referrals will be made to Greater Nashua Mental Health Center (via IDDT program) or detox/withdrawal management at Harbor Homes/Keystone Hall (via Adult Medical Detox program).	Under Development

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

Project Team Member	Roles and Responsibilities
Greater Nashua Mental Health Center (GNMHC)	Will provide lead facilitation for pre-treatment groups geared for those experiencing homelessness, to be conducted in homeless shelters and other locations in the community, such as the Rescue Mission or Soup Kitchen using motivational interviewing techniques. Motivational interviewing (ASAM Level 1) will be utilized as a foundation for the groups, with some care management/coordination to referrals for other levels of care as needed/requested by group members for up to 52 groups per year with 2 – 10 participants each.
Certified Peer Recovery Coach through H.E.A.R.T.S. Peer Support Center	Will provide co-facilitation role for pre-treatment groups geared for those experiencing homelessness, to be conducted in homeless shelters and other locations in the community, such as the Rescue Mission or Soup Kitchen using motivational interviewing techniques. Motivational interviewing (ASAM Level 1) will be utilized as a foundation for the groups, with some care management/coordination to referrals for other levels of care as needed/requested by group members for up to 52 groups per year with 2 – 10 participants each.
Licensed Pastoral Psychotherapist (LPP) through The Emmaus Institute	Will provide spirituality support groups for community members and their family members/caregivers to support commitment and motivation for engaging in activities that support treatment for substance use disorder (SUD). Up to 52 groups per year with 2 – 10 participants each.
Master's Level Student Assistance Counselor through The Youth Council	Identifies youth or receives referrals from school guidance counselors, administrators, Resource Officer, or nurse, engaging with the Counselor for brief intervention/education and assessment services
Recovery Care Case Manager through Southern NH Medical Center (SNHMC)	Screens Emergency Department patients for substance use disorder and then refers to appropriate treatment
Recovery Care Case Manager through Southern NH Medical Center (St. Joseph Hospital)	Screens Emergency Department patients for substance use disorder and then refers to appropriate treatment
Nurse Case Managers (Detox and Non-Detox) Harbor Homes/Keystone Hall	Support adult patients who are struggling with substance use disorders (SUDs) within a Partial Hospital Program (PHP), Residential Detoxification Program and/or Intensive Outpatient Program (IOP) providing evaluation, stabilization (medical and non-medical), and fostering of clients' entry into higher level treatment

D3 Expansion of SUD Treatment Options Training Topics/Schedule
July 2017

Project Team Member	Training/Support Target Date	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Student Assistance Counselor (The Youth Council)					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Recovery/Transitional Care Coordinator (St. Joseph Hospital)					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Recovery/Transitional Care Coordinator (Southern NH Medical Center)					

D3 Expansion of SUD Treatment Options Training Topics/Schedule
July 2017

Project Team Member	Training/Support Target Date	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Detox Nurse (Keystone Hall/Harbor Homes)					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Non-Detox Nurse (Harbor Homes/Keystone Hall)					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			

D3 Expansion of SUD Treatment Options Training Topics/Schedule
July 2017

Project Team Member	Training/Support Target Date	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Community-Based Spirituality Group Facilitator					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Community-Based Pre-Treatment Group Facilitator					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			

D3 Expansion of SUD Treatment Options Training Topics/Schedule
July 2017

Project Team Member	Training/Support Target Date	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			
Community-Based Pre-Treatment Group Co-Facilitator					
Training					
Universal Screening/Assessment Tools	Between January 2018 and July 2018	N			
Patient Privacy and Consent related to 42 CFR Part 2	Between December 2017 and April 2018	N			
Communication Protocols and Workflows (through HIT vendor technologies)	Between December 2017 and December 2018	N			
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Between December 2017 and December 2018	N			

E4-1a. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

Based upon the recommendations of the Clinical Governance Committee, the Executive Steering Committee selected *E4: Integrated Treatment of Co-Occurring Disorders* or more specifically, implementation of the Integrated Dual Diagnosis Treatment (IDDT) evidence-based program.

IDDT involves the development of a multi-disciplinary team who provides both substance use disorder (SUD) and mental health (MH) treatment for people with severe mental illness (SMI). The model uses the 'stages of change/treatment' approach along with pharmacological and psychosocial therapies and holistic program supports.

The IDN has the following targeted evaluation goals associated with implementation of this program:

- Establish a patient-centered integration model that moves patients to recovery and beyond illness so they can pursue a personally meaningful life
- Improving the continuum of psychiatric care
- Reducing the lengths of stay in the emergency department and in the inpatient unit, if applicable
- Reduction in duplication of services across providers
- Facilitating smooth and effective transition to the community from inpatient settings, especially for vulnerable populations
- Reductions in use of substances
- Improvement in patient's psychiatric symptoms
- Improvement in the patient's functioning
- Decreases in hospitalization
- Increases in housing stability
- Decreases in arrests

Target Population

- Adults and seniors with physical health conditions co-morbid with behavioral health conditions
- Youth and adults with serious emotional disturbance, serious mental health disorders, and co-occurring mental health and substance use disorders

Integrated Dual Diagnosis Treatment (IDDT) Team and Strategies

IDDT is built upon the following core treatment components:

- Multidisciplinary team
- Stage-Wise Interventions
- Access to Comprehensive Services (e.g., residential, employment, etc.)
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interventions
- Substance Abuse Counseling

- Group Treatment
- Family Psychoeducation
- Participation in Alcohol & Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Treatment of Non-Responders

The stages of change in IDDT include:

Stage 1: Pre-Contemplation

Individuals in this stage are not likely thinking about or intending to change a problem behavior—or initiating a healthy behavior—in the near future. They are usually not armed with the facts about the risks associated with their behavior. The clinical focus of providers should be on building a relationship and working alliance with the client and providing practical support for daily living, requiring providers to do continuous assessment.

Stage 2: Contemplation

An individual enters this stage when he or she becomes aware of a desire to change a particular behavior. They begin to weigh the pros and cons of changing their behavior. The clinical focus of providers should be on understanding the engaged client's personal goals, helping the client find his or her motivation to consider reduction in substance use, and participating in other recovery-oriented activities.

Stage 3: Preparation

By the time individuals enter this stage, the pros in favor of attempting to change a problem behavior outweigh the cons and action is intended in the near future. Many individuals in this stage have made an attempt to change their behavior in the past but have been unsuccessful in maintaining that change. The clinical focus in Stage 3 is the same as Stage 2.

Stage 4: Action

This stage marks the beginning of actual change in the behavior. By this point, an individual has shown continued progress in the process of behavior change. Regression to earlier stages is probable. The clinical focus of providers should be on helping the motivated client reduce substance use by acquiring skills and supports for managing symptoms of both disorders in pursuit of personal goals.

Stage 5: Maintenance

Individuals are thought to be in this stage when they have successfully attained and maintained behavior change for at least six months. While the risk for relapse is still present in this stage, it is less so. Individuals need to exert less effort in engaging in change processes after 12 months of sustained change. The clinical focus of providers should be on helping clients in stable remission develop and use strategies for maintaining abstinence and recovery.

The stages of treatment are closely related to the stages of change, yet they are different. The stages of change are based upon the Transtheoretical Model of Change (TTM) and describe a process of personal change. The stages of treatment are based upon the Substance Abuse Treatment Scale (SATS). They focus upon the helping relationship and the client's behavior as it relates to the use of alcohol and other drugs. Medications are combined with different psychosocial treatments during the four stages of integrated treatment to help clients decrease and eventually eliminate their substance use and to help them manage symptoms of both disorders.

The stages of treatment for IDDT include:

Stage 1 (Engagement): This stage involves providing outreach in community-based settings, as well as building a trusting relationship with the client. The provider gains permission from clients to share their process of change, asking what is important to them, listen to and respecting their priorities and getting to know the person for who they are. During this stage, practical support is provided for daily living with continuous assessment for the client's personal history, goals and readiness for change.

Stage 2 (Persuasion): Motivational interventions are part of this stage, committing to understanding the client's goals, understanding the pros and cons of personal change as well as the discrepancy between their goals, their substance use and their lifestyle. The provider helps the client begin to reduce their substance use and supports them in taking their medications regularly, helping them recognize and take pride in their own strengths and successes.

At this stage, ambivalence is normal, so providers must assure clients that change is a normal human response, helping them utilize the pay-off matrix to help them tip decisions away from ambivalence and toward positive action. Clients are educated about alcohol, drugs, mental illness and activities that promote health and wellness and support is provided to the client's families.

Stage 3 (Active Treatment): Stage three includes skill building, where the client learns illness management skills with cognitive behavioral interventions that assist clients with transforming negative thoughts and behaviors into coping skills for both disorders. Social supports are also part of this treatment stage, with encouragement of positive peer supports.

Stage 4 (Relapse Prevention): The final stage of treatment includes the development of a relapse-prevention plan with clients receiving support as they maintain lifestyle changes learned in active treatment. Client's set new goals for enhancing their quality of life and maintain positive peer relationships and supportive clinical relationships to reduce the frequency intensity and duration of relapses.

The IDDT team systematically evaluates each client's stage of treatment at regular intervals. The process of staging clients has the following components:

- Staging happens at least every 6 months
- Include all members of the disciplinary team in discussions about the client
- Use a staging tool like the SATS or other stages-of-treatment tool
- Document the client's stage of treatment and rationale in each of their clinical records

The IDDT model views all activities of life as part of the recovery process. Therefore, a variety of service providers help each client in all aspects of life. The multidisciplinary treatment team meets regularly to discuss each client's progress in all areas of his or her life and to provide insights and advice to one

another. Team members also meet individually and as a group with each client and their caregivers (family, friends, and other supporters) to discuss the client's progress and goals.

Expected Challenges and Solutions

We expect to work very quickly over the next several months to address some of the challenges to ensuring success for care transition teams. These include:

- Investing funding and time into the behavioral health workforce, including recruiting and hiring, as well as training and retaining individuals who understand the value of integrated care and are working in a workplace that supports this coordinated approach
- Developing and implementing intake procedures, treatment planning, and referral protocols that systematically solicit patient consent to confidentially share information among providers through educating the patient as well as the providers and social service support organizations serving the patient
- Integrating electronic health records (or at least shared care plans) across service providers who touch the attributed patients in our IDN
- Investing in enhanced technology and shared record-keeping to ensure systematic information sharing and communication for care coordination across the multi-disciplinary teams being formed in practices across the IDN as part of the B1 Integrated Health project
- Participating in monthly case management meetings for those patients with significant behavioral health or chronic conditions that include all of their providers and social service support team members.

Implementation Plan

a. Project Budget

The majority of the IDDT budget will be allocated for staffing and associated costs, including mileage reimbursement, cell phones, computers and indirect costs. A sub-contract will be executed with H.E.A.R.T.S. Peer Support Center for a Peer Support Specialist to support the multi-disciplinary team.

Note there are significant projected program revenues associated with this budget to help offset the costs.

b. Workforce Plan: staffing plan; recruitment and retention strategies

The IDDT team will be employed by the Greater Nashua Mental Health Center with IDN Clinical Governance Committee overseeing implementation, troubleshooting issues, providing education, and evaluating areas of improvement. All of the positions except for the Peer Support Specialist will be employed by the Greater Nashua Mental Health Center. The Peer Support Specialist position will be a sub contract between Greater Nashua Mental Health Center and H.E.A.R.T.S. Peer Support Center.

IDN 3 plans to hold a job fair in early fall 2017 to provide an opportunity for all IDN Member Entities to reach potential employees for their IDN-funded positions. We expect that with so many open positions in the region that support the goals of the IDN, there may be an opportunity to also fill those, as well.

The IDN will be contracting with to complete the development of its website, which will include a job board where IDN Member Entities can complete forms to submit positions to post on the site throughout the demonstration. will also be providing support for broadening our reach to professional organizations and other potential marketing opportunities to advertise the available IDN positions, especially for those potential members of the workforce who are not local and won't be attending the job fair.

c. Project annual client engagement volumes

- 2017: 24 (6 clients per month September-December)
- 2018: 72
- 2019: 72
- 2020: 72

d. Evaluation plan, including metrics that will be used to measure program impact and Integrated Dual Disorder Treatment Fidelity Scale

As the IDDT team participates in technical assistance and consulting from and engages in the training and support, evaluation outcomes specific to the IDN's target attributed population will be more concretely outlined. This work will include the development of tools and indicators to assess the success in meeting the targeted goals of the interventions. This will likely be developed in the Fall of 2017, with implementation starting in early 2018.

Initial target outcomes might include:

- Short-term (knowledge, skills, resources change)
    - % in independent living situations
    - % competitively employed
    - % with regular social contacts with non-substance misusers
    - Improvement in the continuum of psychiatric care
    - Reduction in duplication of services across providers
    - Increases in housing stability
    - Decreases in arrests and incarceration

- Intermediate (behavior change)
    - % controlling symptoms of schizophrenia
    - % actively attaining remission from substance use
    - Reduction in ED visits and hospitalizations for Behavioral Health and addiction conditions during the reporting period
    - Reduction in the lengths of stay in the emergency department and in the inpatient unit, if applicable
    - Facilitation of smooth and effective transition to the community from inpatient settings, especially for vulnerable populations
    - Improvement in the patient's functioning

- Long-term (systems change)

- Establishment a patient-centered integration model that moves patients to recovery and beyond illness so they can pursue a personally meaningful life

h. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

Tracking and monitoring of individuals served by IDDT will initially be achieved through the use of case management/coordination planning and progress notes through individual patient care plans. Once up and running, the Shared Care Plan platform hosted by will provide for timely information sharing among providers and through will allow for case management workflows and triggers.

Adherence to impact measures will be monitored and tracked timely use of the Shared Care Plan, Event Notification Service and data aggregation provided by

Fidelity to evidence-supported project elements will be accomplished by monitoring and training support initially through , then through oversight by the IDDT Clinical Supervisor.

E4 Integrated Treatment of Co-Occurring Disorders Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
DONE	Develop Implementation Plan	465d	03/21/17	12/31/18
	Develop Implementation timeline	465d	03/21/17	12/31/18
DONE	Complete Project Budget	46d	06/05/17	08/07/17
DONE	Review with Clinical Committee	1d	06/05/17	06/05/17
DONE	Present to Finance Committee for approval	11d	07/24/17	08/07/17
DONE	Present to Executive Committee for approval	1d	07/27/17	07/27/17
DONE	Budget approved	1d	07/27/17	07/27/17
	Develop Workforce Plan	465d	03/21/17	12/31/18
DONE	Develop Staffing Plan	85d	03/21/17	07/17/17
DONE	Identify positions and FTE requirements	85d	03/21/17	07/17/17
DONE	Develop job descriptions	85d	03/21/17	07/17/17
DONE	Determine timeline for filling positions	34d	03/21/17	05/05/17
DONE	Determine if they will be contracted or employees of GNCMHC	34d	03/21/17	05/05/17
DONE	Develop recruitment/retention strategies	392d	07/01/17	12/31/18
	IDN website development with Career Board	51d	07/01/17	09/08/17
	Contract with	51d	07/01/17	09/08/17
	Conduct IDN Job Fair	41d	08/01/17	09/26/17
	Contract with	29d	08/01/17	09/08/17
	Contract with Crowne Plaza	21d	08/18/17	09/15/17
	Compile job descriptions to populate Career Board on IDN website	40d	08/01/17	09/25/17
	Mass media marketing with radio ads, social media ad sponsorship, flyers shared electronically	40d	08/01/17	09/25/17
	Secure table confirmations from IDN Member Entities and education Institutions for event at Crowne Plaza	40d	08/01/17	09/25/17
	Secure RSVPs from potential participants for event landing page on website	40d	08/01/17	09/25/17
	Hold event at Crowne Plaza	1d	09/26/17	09/26/17
	IDN-funded Recruitment/Hiring Strategies	373d	07/27/17	12/31/18
	Sign-on bonuses and relocation reimbursement	373d	07/27/17	12/31/18
DONE	Identify Annual Client Engagement Volumes	41d	05/05/17	06/30/17
DONE	Solicit input from IDN project partners	41d	05/05/17	06/30/17
DONE	Develop projections	35d	05/15/17	06/30/17
DONE	Key organizational/provider participants	183d	03/21/17	11/30/17
DONE	Identify behavioral health partners	74d	03/21/17	06/30/17
DONE	Identify community-based social support service providers	74d	03/21/17	06/30/17
	Draft agreements	66d	08/01/17	10/31/17
	Obtain signatures	74d	08/21/17	11/30/17
	Clinical Services Infrastructure	397d	03/23/17	09/28/18
	Develop consulting and training agreement with Case	137d	03/23/17	09/29/17
	IDN signs Scope of Work and Contract with	76d	07/01/17	10/13/17
	Identify/Develop Standardized assessment Tools	130d	07/03/17	12/29/17
	Consult with to determine appropriate assessment tools to meet program fidelity	130d	07/03/17	12/29/17
	Identify/Develop Patient Assessment, Treatment, Management and Referral protocols	130d	07/03/17	12/29/17
	Consult with to identify protocols	130d	07/03/17	12/29/17
	Patient assessment protocols	130d	07/03/17	12/29/17
	Patient treatment protocols	130d	07/03/17	12/29/17
	Patient management protocols	130d	07/03/17	12/29/17
	Patient referral protocols	130d	07/03/17	12/29/17
	Identify/Develop Roles and Responsibilities for Multi-disciplinary Team Members	171d	05/05/17	12/29/17
DONE	Consult with to outline team member roles conforming to IDDT fidelity model	171d	05/05/17	12/29/17
DONE	Team Leader/Clinical Director	171d	05/05/17	12/29/17

E4 Integrated Treatment of Co-Occurring Disorders Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
DONE	Mental Health Therapist	171d	05/05/17	12/29/17
DONE	Substance Use Counselor	171d	05/05/17	12/29/17
DONE	Case Managers	171d	05/05/17	12/29/17
DONE	Nurse	171d	05/05/17	12/29/17
DONE	Psychiatrist	171d	05/05/17	12/29/17
DONE	Peer Support Specialist	171d	05/05/17	12/29/17
DONE	Supported Employment Specialist	171d	05/05/17	12/29/17
DONE	Criminal Justice Specialist/Liaison	171d	05/05/17	12/29/17
DONE	Housing Specialist	171d	05/05/17	12/29/17
DONE	Family Specialist	171d	05/05/17	12/29/17
	Identify/Develop Training and Supervision Plan, Conforming to SAMSA "Training Frontline Staff" in Integrated Treatment for Co-Occurring Disorders	281d	09/01/17	09/28/18
DONE	Consult with to determine plan for training and understand supervision requirements	281d	09/01/17	09/28/18
	Programmatic and Clinical Consultation	281d	09/01/17	09/28/18
	Pilot site screening and readiness consultation	76d	09/01/17	12/15/17
	Administrative and clinical consultation	281d	09/01/17	09/28/18
	Outcomes development and monitoring	281d	09/01/17	09/28/18
	IDDT Team Clinical Training	130d	12/01/17	05/31/18
	Stage-wise Treatment: Engagement and Persuasion	43d	12/01/17	01/30/18
	Stage-wise Treatment: Action and Relapse Prevention	108d	01/02/18	05/31/18
	Identify/Develop Agreements with Collaborating Organizations, Including Social Service Support Providers	181d	03/23/17	11/30/17
	Identify collaborating organizations	93d	03/23/17	07/31/17
	Obtain signed agreements	110d	07/01/17	11/30/17
	Identify/Develop Evaluation Plan	196d	10/01/17	06/29/18
	Consult with to identify and target outcomes	196d	10/01/17	06/29/18
	Program impact	90d	10/01/17	02/01/18
	IDDT fidelity scale	131d	12/29/17	06/29/18
	Baseline Fidelity Assessment conducted	131d	12/29/17	06/29/18
	Identify/Develop Mechanisms (registries) to Track and Monitor Patients Served by Program	130d	09/01/17	03/01/18
	Utilize HIT platforms (including (-data aggregator; ENS/SCP; -DSM; or similar vendor--data query, e-referrals, etc.) to monitor	130d	09/01/17	03/01/18
	Individuals served by the program	130d	09/01/17	03/01/18
	Adherence	130d	09/01/17	03/01/18
	Impact measures	130d	09/01/17	03/01/18
	Fidelity to the program and to the SAMSA model	130d	09/01/17	03/01/18
	Operationalization of Program	131d	07/01/17	12/29/17
	Implementation of workforce plan	131d	07/01/17	12/29/17
	Deployment of training plan	131d	07/01/17	12/29/17
	Implementation of any required updates to clinical protocols, or other operating policies and procedures	131d	07/01/17	12/29/17
	Use of assessment, treatment, management and referral protocols	131d	07/01/17	12/29/17
	Initiation of Data Reporting	131d	07/01/17	12/29/17
	Number of individuals enrolled (during reporting period and cumulative), vs. projected	131d	07/01/17	12/29/17
	Number of staff recruited and trained (during reporting period and cumulative) vs. projected	131d	07/01/17	12/29/17
	Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	131d	07/01/17	12/29/17
	Ongoing Data Reporting	130d	01/01/18	06/29/18
	Number of individuals served (during reporting period and cumulative), vs. projected	130d	01/01/18	06/29/18

E4 Integrated Treatment of Co-Occurring Disorders Implementation Plan
July 2017

Status	Task Name	Duration	Start Date	End Date
	Number of staff recruited and trained (during reporting period and cumulative) vs. projected	130d	01/01/18	06/29/18
	Staff vacancy and turnover rate for period and cumulative vs. projected	130d	01/01/18	06/29/18
	Impact measures as defined in evaluation plan	130d	01/01/18	06/29/18
	Ongoing Data Reporting	132d	07/01/18	12/31/18
	Number of individuals served (during reporting period and cumulative), vs. projected	132d	07/01/18	12/31/18
	Number of staff recruited and trained (during reporting period and cumulative) vs. projected	132d	07/01/18	12/31/18
	Staff vacancy and turnover rate for period and cumulative vs. projected	132d	07/01/18	12/31/18
	Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	132d	07/01/18	12/31/18

E4-2a. IDN Community Project: Evaluation Project Targets

The IDN will contract with to provide programmatic and clinical consultation both on-site and via phone, as well as clinical training and evaluation services, including a baseline IDDT team-based fidelity review.

The Integrated Dual Diagnosis Treatment (IDDT) program is an evidence-based program recognized by SAMHSA and therefore, has fidelity built into the model (see Fidelity Scale: attachment_E4.2c). Greater Nashua Mental Health Center (GNMHC) will employ and supervise the IDDT team, working closely with , IDN Member Entities, as well as the IDN Clinical and IT/Data Governance Committees to implement the program.

IDDT's fidelity is based upon the IDDT multi-disciplinary team following the 'stages of treatment' including:

Stage 1 (Engagement): This stage involves providing outreach in community-based settings, as well as building a trusting relationship with the client. The provider gains permission from clients to share their process of change, asking what is important to them, listen to and respecting their priorities and getting to know the person for who they are. During this stage, practical support is provided for daily living with continuous assessment for the client's personal history, goals and readiness for change.

Stage 2 (Persuasion): Motivational interventions are part of this stage, committing to understanding the client's goals, understanding the pros and cons of personal change as well as the discrepancy between their goals, their substance use and their lifestyle. The provider helps the client begin to reduce their substance use and supports them in taking their medications regularly, helping them recognize and take pride in their own strengths and successes.

At this stage, ambivalence is normal, so providers must assure clients that change is a normal human response, helping them utilize the pay-off matrix to help them tip decisions away from ambivalence and toward positive action. Clients are educated about alcohol, drugs, mental illness and activities that promote health and wellness and support is provided to the client's families.

Stage 3 (Active Treatment): Stage three includes skill building, where the client learns illness management skills with cognitive behavioral interventions that assist clients with transforming negative thoughts and behaviors into coping skills for both disorders. Social supports are also part of this treatment stage, with encouragement of positive peer supports.

Stage 4 (Relapse Prevention): The final stage of treatment includes the development of a relapse-prevention plan with clients receiving support as they maintain lifestyle changes learned in active treatment. Client's set new goals for enhancing their quality of life and maintain positive peer relationships and supportive clinical relationships to reduce the frequency intensity and duration of relapses.

The IDDT team will systematically evaluate each client's stage of treatment at regular intervals. The process of staging clients has the following components:

- Staging happens at least every 6 months
    - Includes all members of the disciplinary team in discussions about the client

- Using a staging tool like the SATS or other stages-of-treatment tool
- Documenting the client's stage of treatment and rationale in each of their clinical records.

The IDDT model views all activities of life as part of the recovery process. Therefore, a variety of service providers within the IDN will help support each client in all aspects of their life. The multi-disciplinary treatment team will meet regularly to discuss each client's progress in all areas of his or her life and to provide insights and advice to one another. Team members also meet individually and as a group with each client and their caregivers (family, friends, and other supporters) to discuss the client's progress and goals.

The IDDT fidelity model outlines the caseload for the team as an average of approximately 6 clients per month. Since the team will be working closely with in 2017 with staff training to occur in early December, no clients are expected to be served in 2017. Below are the targets for the remaining years of the demonstration:

- 2018: 72
- 2019: 72
- 2020: 72

E4-2b. IDN Community Project: Evaluation Project Targets

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

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

Project Strategy	Client Engagement 2017	Client Engagement 2018	Client Engagement 2019	Client Engagement 2020
IDDT	0	72	72	72

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased knowledge of patient consent requirements, especially related to 42 CFR Part 2 to guide the treatment and management of the target sub-population.	All of the IDDT team members will participate in training on patient consent, especially related to 42 CFR Part 2 by December 31, 2018.			
Increased knowledge of the fidelity model of treatment for the IDDT evidence-based program.	All of the IDDT team members will participate in training provided by provide over 4 full days to learn the protocols associated with IDDT by December 31, 2018.			
Increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub-population.	All of the IDDT team will participate in training on communication protocols and workflows (through HIT vendor technologies) by December 31, 2018.			
Increased knowledge of the IDN's resources to support the physical health and mental health, as well as those that support the social determinants of health, including economic, legal, educational and social, as well as housing and transportation.	A minimum of monthly case management meetings will be held in the IDN to support the knowledge-building and resource-building skills of behavioral health case management and care coordinators.			
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub-population.	A minimum of 60 members of the target sub-population will be served by the IDDT program by December 31, 2018.			

E4-3a. IDN Community Project: Workforce Staffing

The table below identifies the staffing plan to achieve the goals of the Integrated Dual Diagnosis Treatment (IDDT) evidence-based program.

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's Level Team Leader (LICSW or LMHC)	1	98			
Master's Level Mental Health Therapist	1	85			
Master's Level SUD Counselor	1	16			
Licensed Pastoral Psychotherapist	.5	2			
Case Manager (Bachelor's Level)	3	56			
Case Manager (RN Bachelor's Level)	1.2	70.6			
Recovery/Transitional Care Case Manager	1	.5			
Nurse (Associate's Level)	.5	73			
Psychiatrist	.5	3			
Peer Support Specialist (sub contract with H.E.A.R.T.S. Peer Support Center)	1	30			
Supported employment specialist	.5	11			
Criminal Justice Specialist/Liaison	.1	6			
Housing Specialist	.1	Unsure			
Family Specialist	.1	Unsure			
Community Health Worker	8	40			

E4-3b. IDN Community Project: Evaluation Project Targets

Below are the targeted engagement numbers for participants in the Integrated Dual Diagnosis Treatment (IDDT) program as well as the target evaluation goals through December 31, 2018.

Project Strategy	Client Engagement 2017	Client Engagement 2018
Integrated Dual Diagnosis Treatment (IDDT)	Up to 5, depending upon training timing and referral protocols being in place	72

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased knowledge of patient consent requirements, especially related to 42 CFR Part 2 to guide the treatment and management of the target sub-population.	Up to 6 of the IDDT team members will participate in training on patient consent, especially related to 42 CFR Part 2 by December 31, 2018.			
Increased knowledge of the fidelity model of treatment for the IDDT evidence-based program.	Up to 6 of the IDDT team members will participate in training provided by provided over 4 full days to learn the protocols associated with IDDT by December 31, 2018.			
Increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub-population.	Up to 8 members of the IDDT team will participate in training on communication protocols and workflows (through HIT vendor technologies) by December 31, 2018.			
Increased knowledge of the IDN's resources to support the physical health and mental health, as well as those that support the social determinants of health, including economic, legal, educational and social, as well as housing and transportation.	Up to 6 case management meetings will be held in the IDN to support the knowledge-building and resource-building skills of behavioral health case management and care coordinators.			
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub-population.	Up to 77 members of the target sub-population will be served by the IDDT program by December 31, 2018.			

E4-4a. IDN Community Project: Budget

The majority of the IDDT budget will be allocated for staffing and associated costs, including mileage reimbursement, cell phones, computers and indirect costs. A sub-contract will be executed with H.E.A.R.T.S. Peer Support Center for a Peer Support Specialist to support the multi-disciplinary team.

Note there are significant projected program revenues associated with this budget to help offset the costs. Please see attachment_E4.4b (E4 Budget) for more details.

Category of Funding	Entity Funded	Amount of Funding 2017 - 2020
Salary/Benefits	Greater Nashua Mental Health Center	$1,571,840
Sub-contract (Peer Support)	H.E.A.R.T.S. Peer Support Center	$57,000
Mileage Reimbursement	Greater Nashua Mental Health Center	$41,176
Supplies (cell phone, computers)	Greater Nashua Mental Health Center	$12,600
Indirect Costs	Greater Nashua Mental Health Center	$254,641
Projected Program Revenues	GNMHC	$1,320,000
Total Budget Funded		**$617,257**

E4 Integrated Treatment of Co-Occurring Disorders
2017 - 2020

Category and Item	Comments	2017 - 2018 Total Available	2019 - 2020 Total Available	Oct 2017 - June 2018 (9 months)	July 2018 - June 2019		July 2019 - June 2020	July 2020 - Dec 2020 (6 months)	2019 - 2020 IDN Request (after revenue)	Total Requested 2017 - 2020	Total Available 2017 - 2020
Totals		**$379,969**	**$567,237**	$445,113.54	$644,283.00	$649,396.54	$644,283.00	$322,159.48	$86,442.56	$735,839	**$947,206**
Projected Program Revenues FY 2018: $440,000 from Medicaid Program Service Fees				$0		$440,000 expected Medicaid revenues (2018) Total requested 2017 - 2018 = $1,089,396.54 - $440,000 expected revenues = $649,396.54			$880,000 expected Medicaid revenues (2019 - 2020) Total requested 2019 - 2020 = $966,442.48 - $880,000 expected revenues = $86,442.56		
Staffing	Assumed training would start by November 2017 with some potential cases. The Clinical Supervisor starts working with October 2017			$359,786.58	$531,200.00		$531,200.00	$265,617.98		$1,687,804.56	
Sub-contracts	H.E.A.R.T.S. Peer Support Center			$12,000.00	$18,000.00		$18,000.00	$9,000.00		$57,000	
Travel	$1,182.09/year per staff person			$8,668.67	$13,003.00		$13,003.00	$6,501.50		$41,176	
Supplies	cell phone and computers			$6,600.00	$2,400.00		$2,400.00	$1,200.00		$12,600	
Overhead				$58,058.29	$79,680.00		$79,680.00	$39,840.00		$257,258	

E4-5. IDN Community Project: Key Organizational and Provider Participants

All of the organizations/providers have been engaged in the planning for the IDDT program, but agreements are still in the process of being completed. We expect that all agreements will be completed no later than November 30, 2017.

Organization/Provider	Agreement Executed (Y/N)
HEARTS for Peer Specialist	N (in progress)
NAMI for Family Support Services	N (in progress)
Lamprey for Health Promotion (if no identified PCP)	N (in progress)
Keystone Hall for Residential Level of Care for SUD	N (in progress)
Harbor Homes for Housing (e.g., Bridge grant)	N (in progress)
SMART Recovery, AA, NA, HA for mutual/self-help support	N (in progress)

E4-6. IDN Community Project: Standard Assessment Tools

The tools below are being considered for use in the IDDT program, but are subject to change, depending upon the consultation and advice of the .

Standard Assessment Tool Name	
Addiction Severity Index (ASI)	Designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status.
PHQ 2 & 9	Completion of the PHQ provides the frequency of depressed mood and anhedonia over the past two weeks
SBIRT	Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
DAST	The Drug Abuse Screen Test designed to provide a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research
AUDIT (Alcohol Use Disorders Identification Test)	Questionnaire method of screening for excessive drinking and alcohol use disorders.

E4-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals

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

Protocol Name	Brief Description	Use (Current/Under Development)
IDDT Patient Assessment	There are 12 steps to the assessment of patients who are entering IDDT, as outlined in the fidelity model.	Under Development
IDDT Patient Treatment and Management	During the initial phase of treatment clients will be admitted to 1:1 therapy once a week, group therapy twice a week, community based services once a week, and receive Case Management and Med Services on an on-going basis. Treatment is non-linear and follows patient's needs, which are reviewed at least every 3 months.	Under Development
IDDT Patient Management	If client cannot be maintained in outpatient level of care, will refer to other IDN members for residential or PHP services (Keystone Hall). MAT will be provided at either GNMHC or another IDN member organization after assessment of clinical needs and contraindications.	Under Development
IDDT Patient Referral	For patients who have needs that cannot be served through the IDDT team, referrals will be made to IDN partners.	Under Development

E4-8. IDN Community Project Member Roles and Responsibilities

The table below outlines the project member roles and responsibilities.

Project Team Member	Roles and Responsibilities
Team Leader/Clinical Director	Provides clinical supervision to IDDT service team members
Mental Health Therapist	Provides direct services to support recovery from mental health symptoms including individual psychotherapy or Illness Management and Recovery (IMR).
Substance Abuse Counselor	Provides relapse prevention approaches for clients who achieve abstinence
Case Manager	Assesses, monitors and links clients to other services to address needs including dental, legal, housing, etc. Also provides services in the community to support recovery as needed.
Nurse	Supports medication compliance though administration, monitoring, and educating about medication.
Psychiatrist	Provides direct clinical supervision to medical residents and fellows, nurses, advanced practice nurses, physician assistants, and other medical professionals and is ultimately accountable for all medical decisions and, therefore, any legal consequences related to treatment
Peer Support Specialist	To be determined
Supported employment Specialist	Assist individual to find and maintain employment
Criminal Justice Specialist/Liaison	Support client through legal process.
Housing Specialist	Support the individual through the process of locating, securing, and maintaining safe and stable housing
Family Specialist	Ensures the family has access to treatment formats targeted at families/supports of clients including education, family therapy, and support groups

IDDT Consultation, Training and Fidelity Monitoring Plan
July 2017

Project Team Member	Training/Support Target Timeframe	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
IDDT Team Leader (Supervisor)					
Programmatic and Clinical Consultation					
Pilot Site Screening and Consultation	October-November 2017	N			
Administrative/Clinical Consult	October 2017 - September 2018	N			
Outcomes Development and Monitoring	January 2018 - September 2018	N			
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Mental Health Therapist					
Programmatic and Clinical Consultation					
Pilot Site Screening and Consultation	October-November 2017	N			
Administrative/Clinical Consult	October 2017 - September 2018	N			
Outcomes Development and Monitoring	January 2018 - September 2018	N			
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Substance Use Counselor					
Programmatic and Clinical Consultation					

IDDT Consultation, Training and Fidelity Monitoring Plan
July 2017

Project Team Member	Training/Support Target Timeframe	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Pilot Site Screening and Consultation	October-November 2017	N			
Administrative/Clinical Consult	October 2017 - September 2018	N			
Outcomes Development and Monitoring	January 2018 - September 2018	N			
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Psychiatrist					
Programmatic and Clinical Consultation					
Pilot Site Screening and Consultation	October-November 2017	N			
Administrative/Clinical Consult	October 2017 - September 2018	N			
Outcomes Development and Monitoring	January 2018 - September 2018	N			
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Nurse					
Programmatic and Clinical Consultation					
Pilot Site Screening and Consultation					
Pilot Site Screening and Consultation	October-November 2017	N			

IDDT Consultation, Training and Fidelity Monitoring Plan
July 2017

Project Team Member	Training/Support Target Timeframe	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Administrative/Clinical Consult	October 2017 - September 2018	N			
Outcomes Development and Monitoring	January 2018 - September 2018	N			
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Case Manager					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Case Manager					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Peer Support Specialist					

IDDT Consultation, Training and Fidelity Monitoring Plan
July 2017

Project Team Member	Training/Support Target Timeframe	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Supported Employment Specialist					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Supported Employment Specialist					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Criminal Justice Specialist/Liaison					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			

IDDT Consultation, Training and Fidelity Monitoring Plan
July 2017

Project Team Member	Training/Support Target Timeframe	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Housing Specialist					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			
Family Specialist					
Training					
IDDT Stage-wise Treatment Training					
Overview of Model and Engagement & Persuasion Stages of Treatment	December 2017	N			
IDDT Stage-wise Treatment Training					
Action and Relapse Prevention Stages of Treatment	March 2018	N			
Fidelity Review					
Interviews with staff	August/September 2018	N			

CASE

CASE WESTERN RESERVE UNIVERSITY

Ohio Substance Abuse and Mental Illness
Coordinating Center of Excellence
OHIO SAMI CCOE

IMPLEMENTING IDDT

A step-by-step guide to stages of organizational change

www.ohiosamiccoe.case.edu

INTRODUCTION

The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring mental and substance use disorders.

Systems change

Organizational change

Clinical change

This booklet outlines the stages-of-change technology that the Ohio SAMI CCOE utilizes with policy makers, administrators, team leaders, service providers, community stakeholders, and steering committees to guide them through the process of implementing the Integrated Dual Disorder Treatment (IDDT) model. IDDT is an evidence-based practice (EBP) for people with co-occurring mental and substance use disorders (see Drake 1998, 2001 in Sources on page 38).

Each stage of change in this booklet contains expectations, strategies, and action steps that will help you fulfill incremental goals during the implementation process. The stage-wise approach is important because it sets a realistic, manageable pace for achieving high fidelity to IDDT and improved outcomes.

This booklet serves three specific purposes:

- It provides a brief overview of all the stages of change and, thus, helps develop realistic expectations for the implementation process.
- It provides a benchmark for your current activities.
- It serves as a record (or checklist) of the incremental progress that you make over time.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

The stages of change are adapted from James O. Prochaska, et al., and the stages of implementation are adapted from Pamela S. Hyde, et al. (see Sources on page 38).

STAGES OF CHANGE

You are about to discover that the process of organizational change and service systems change is not much different than the process of personal change that your clients utilize on the road to recovery. The explanation is simple. Change is change, no matter what the setting or purpose. Individuals must be ready, willing, and able to do the work. They must also have support from people who will respect, evaluate, and encourage their efforts along the way. Consumers in mental health and substance abuse treatment find assistance from service providers who help them navigate their personal recovery journeys. Organizations and systems that implement service innovations find guidance from technical-assistance organizations (or other sources of technical support), which help them navigate a complex web of relationships and change processes.

There is a relationship-based clinical technology called *stages of change* that research has validated as effective for people who want and need to enhance the quality of their lives. The technology is based on the premise that change occurs incrementally over time through five stages—pre-contemplation, contemplation, preparation, action, and maintenance (see Prochaska and Connors in Sources on page 38). Thus, for people with co-occurring mental and substance use disorders, *big* changes like sobriety, symptom management, and an increase in independent living are built upon a series of *small, incremental* changes in their thinking and behavior. Likewise, for organizations and systems that are implementing IDDT, *big* changes like high fidelity and improved outcomes are built upon a series of *small, incremental* changes in philosophies, policies, and individual practices.

SUPPORTING RECOVERY

The IDDT model is not a conventional service that is implemented within organizations simply to respond to specific client needs, such as improving social skills, anger management, or personal health. IDDT is implemented to reinvent service systems, organizations, and individual clinical practices to support positive personal change and recovery among people with co-occurring mental and substance use disorders and their social support networks. IDDT is designed to enhance consumer outcomes, program outcomes, and system outcomes simultaneously. When you implement this service model, you begin with the desired outcomes in mind.

Core components

There are 12 organizational characteristics and 14 treatment characteristics of the IDDT model that are called *fidelity domains* (see page 5). These domains encourage systems and organizations to develop holistic integrated system structures and treatments that promote the physical, emotional, social, and economic well-being of people with co-occurring disorders. These core components also provide a structure for a continuous quality-improvement process that addresses both organizational and clinical outcomes. Research demonstrates that organizations generate improved outcomes when they maintain fidelity to the components of IDDT (see McHugo in Sources on page 38). In other words, successful implementation requires your personal and organizational commitment to positive change.

A COMMUNITY EFFORT

Successful implementation of IDDT is neither a top-down nor a bottom-up grassroots initiative. It is both. It depends upon involvement from many different people, including the following:

- State and county authorities (e.g., mental health, substance abuse, criminal justice, housing, and health)
- Agency and organization administrators
- Direct service providers
- Community stakeholders
- Clients
- Family members and friends who support clients in their recovery

Collaborating for change

Service systems, consumer groups, and community stakeholders who are typically involved with and/or affected by IDDT implementation include those listed below.

Systems & Groups	Stakeholders
Mental Health Services	■ State mental health authority ■ Community-based mental health centers and providers ■ Crisis services ■ Inpatient state hospitals and community hospitals
Alcohol and Drug Addiction Services	■ State alcohol and drug addiction services authority ■ Chemical dependency treatment programs and providers
Criminal Justice	■ Law enforcement: police & sheriff's departments ■ Judges/Courts ■ Probation ■ Parole ■ Jails and prisons
Health Services	■ Hospital emergency rooms ■ Primary care physicians
Vocational Rehabilitation	■ State vocational rehabilitation (VR) authority ■ Vocational rehabilitation programs and providers ■ Business owners/employers ■ Employment programs within mental health agency or local community ■ Colleges and adult training institutions
Housing	■ Homeless shelters ■ Group homes ■ Landlords/apartment owners ■ Other supported-housing
Education	■ Colleges, universities, and training programs ■ General Education Degree (GED) programs ■ Supportive Education programs
Consumers/Clients	■ Interested individuals
Family Members	■ Client support networks (i.e., individuals who clients identify as close and important, which may include biological family members and others)
Advocacy Groups	■ Representatives from consumer groups ■ Representatives from the National Alliance of the Mentally Ill (NAMI) ■ Other local, regional, and national advocacy groups
Media (The work of local media might assist with public education and consensus building.)	■ Health, human service, and human interest writers, reporters, and editors in print, radio, television, cable television, and web-based media (i.e., commercial, public, and college media)

IDDT AT-A-GLANCE

NEGATIVE CONSEQUENCES

Individuals with co-occurring mental and substance use disorders are more likely to experience the following:

- Psychiatric episodes
- Use, abuse, and relapse to alcohol and other drugs
- Hospitalization and emergency room visits
- Relationship difficulties
- Violence
- Suicide
- Arrest and incarceration
- Unemployment
- Homelessness
- Infectious diseases, such as HIV, hepatitis, and sexually transmitted diseases
- Complications resulting from chronic illnesses such as diabetes and cancer

IDDT FIDELITY DOMAINS

The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring mental and substance use disorders and their families. The fidelity domains listed below are the core components of IDDT.

Organizational Characteristics

1. Program Philosophy
2. Eligibility/Client Identification
3. Penetration
4. Assessment
5. Treatment Plan
6. Treatment
7. Training
8. Supervision
9. Process Monitoring
10. Outcome Monitoring
11. Quality Improvement
12. Client Choice

Treatment Characteristics

1a. Multidisciplinary Team
   1b. Substance Abuse Specialist
2. Stage-Wise Interventions
3. Access to Comprehensive Services
4. Time-Unlimited Services
5. Assertive Outreach
6. Motivational Interventions
7. Substance Abuse Counseling
8. Group Treatment
9. Family Psychoeducation
10. Participation in Alcohol & Drug Self-Help Groups
11. Pharmacological Treatment
12. Interventions to Promote Health
13. Secondary Interventions for Treatment of Non-Responders

DESIRED OUTCOMES

IDDT Decreases

- Duration, frequency, and intensity of mental and substance use disorder symptoms
- Hospitalization
- Arrest and incarceration
- Duplication of services
- Treatment drop-out
- Utilization of high-cost services

IDDT Increases

- Abstinence from use of alcohol and other drugs
- Continuity of care
- Improved relationships
- Consumer quality-of-life
- Stable housing
- Employment
- Independent living

Resources

A description of the treatment characteristics may be found in this free booklet, which may be obtained online:

IDDT Overview
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87

Also consult these free resources:

IDDT Fidelity Scale
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=107

SAMHSA (2003). *Co-occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* (see Sources on page 38; this resource is commonly referred to as "The Toolkit").

STAGE 1
PRE-CONTEMPLATION

Over 50 percent of people in the United States who have been diagnosed with a severe mental illness have also been diagnosed with a co-occurring substance use disorder.

— D. A. Regier, et al. (1990). Comorbidity of Mental Disorders with Alcohol and other Drug Abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, v264, n19, p2511-2518.

Unaware or uninterested

This stage is defined by a business-as-usual atmosphere. Most mental health and substance abuse treatment systems and service organizations provide traditional (parallel or sequential) treatments. Clients must find help for each disorder in different departments or at different agencies, in different parts of town, with different service providers, often on different days. Services are frequently designed to respond to crises or to manage risks rather than to foster a full recovery process, including independent living and employment in the community. Administrators and providers may have an intuitive sense that this treatment structure is not working.

The idea to reinvent systems and service organizations at this stage often arrives as a disruption in current thinking, usually in the form of excessively high staff turnover or questions about unsatisfactory outcomes. The questions may come from any number of sources, including policy makers at state or county mental health and substance use authorities, local foundation representatives, agency administrators, service providers, community stakeholders, clients, or family members. At this time, most people in the organization are unaware of and see no need to change policies and practices.

Traditional services are frequently designed to respond to crises or to manage risks rather than to foster a full recovery process, including independent living and employment.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

1 ASK IMPORTANT QUESTIONS

Historically, people with co-occurring disorders have been excluded from mental health treatment because of their substance use disorder. Likewise, they have been excluded from substance abuse treatment because of their severe mental health symptoms. As a result, they frequently have not gotten the help they need.

It is important for administrators and service providers to ask if people with co-occurring disorders in their communities are currently receiving treatment for both disorders—preferably at the same time—and where. If you cannot answer this question and/or if you think these clients are being served adequately elsewhere, it is time to investigate.

If your organization does have a service program for individuals with co-occurring disorders, inquire about the outcomes of the program and its philosophies and practices. If the program is built upon a model that is not evidence based, it may be the right time for change.

Here are some questions to guide your investigation:

- Have you considered that your clients may have co-occurring disorders?
- How does your organization identify these individuals? Are there assessment instruments available?
- Do you know who these clients are and where they are being served?
- Do you know the daily-living needs and treatment needs of these clients?
- Do you collect, analyze, review, and share outcomes about this population?
- Are the outcomes for this population satisfactory to your organization, to your local community, and to your clients and their families?

2 BEGIN THE CHANGE PROCESS

The contemplation stage outlines nine steps that will help you consider if the IDDT model is right for your organization and community (see page 8).

STAGE 2
CONTEMPLATION

"At some point, someone has to think about making use of an innovation. This requires some degree of awareness that leads to acquisition of information and exploration of options."

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Loius de la Parte Florida Mental Health Institute, p15.

Consensus building

This stage is characterized by thinking about and evaluating the advantages and disadvantages of implementing IDDT, exploring your concerns about the process, and engaging in a relationship with a technical-assistance organization (or another source of support) to access the lessons that have already been learned by other service systems and organizations. All of these activities will help you evaluate your readiness, willingness, and ability to begin the implementation process. The activities will also demonstrate that you are not alone. You do not have to repeat the same mistakes that others have made.

Full implementation of IDDT creates big changes incrementally over time. Managing these changes requires a significant investment of time, energy, and human resources–and sometimes financial resources. Therefore, you need to know what to expect. IDDT programs provide services for both mental and substance use disorders in the same place and with the same treatment staff, who help clients address both issues at the same time. To accomplish this, many administrative and clinical components of service systems and organizations need to be reevaluated, rearranged, reinvented, or refinanced. Use this section of the booklet to engage in some serious administrative introspection about implementation.

Keep in mind that you should not try to rush through the implementation process. Many successful IDDT programs have taken an entire year to complete the contemplation and preparation stages (see chart below). The pace of implementation is different for every organization. It is useful to proceed carefully and deliberately (see Tip on page 13).

From time to time, ask members of your organization an important question about IDDT implementation: "Is this what we want to do?"

Evaluate your readiness, willingness, and ability to begin the implementation process.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

1 CONDUCT A NEEDS ASSESSMENT

2 DEVELOP AWARENESS OF AVAILABLE OPTIONS

3 IDENTIFY CURRENT PRACTICES AND RATIONALES

4 EXAMINE YOUR MISSION, VALUES, GOALS, AND VISION

5 CHECK IT OUT

6 ENGAGE TECHNICAL ASSISTANCE

7 ASSESS THE PROS AND CONS

8 DEVELOP INFORMED CONSENT AND CONSENSUS

9 EXPLORE CONCERNS

STAGE 2: CONTEMPLATION *continued*

1 CONDUCT A NEEDS ASSESSMENT

The motivation to change your policies and practices must ultimately come from inside your system or your organization. Otherwise, there will be a lot of resistance and little change. It is important that you and your community arrive at your own informed conclusion about the service needs and outcomes of people with co-occurring disorders in your region. Be aware that leaders may be reluctant or unable to address the service needs and outcomes. You might not have a mechanism for collecting, evaluating, reporting, and discussing the significance of the data. Conduct your own comprehensive Needs Assessment. It will help get you started.

A comprehensive assessment identifies consumers with severe mental illness and co-occurring substance use disorders who will benefit from IDDT. It then identifies *all* of the service needs of *all* clients in your agency and community. It also identifies which services your clients do and do not utilize. To get this information, system administrators typically involve many stakeholders. Agency administrators involve all departments in their organization and all community stakeholders who might interact with clients (see stakeholder list on page 4). Ask them to report the following about their interactions with your clients:

- Types of service used
- Frequency of service use
- Duration of service use
- Costs for current service utilization

The Needs Assessment also requires you to ask your clients and their family members about service utilization and quality-of-life outcomes.

2 DEVELOP AWARENESS OF AVAILABLE OPTIONS

Evaluate the results of your Needs Assessment. Which client groups experience the greatest need and the most problematic quality-of-life outcomes? Which client groups are the most expensive to serve? Plan to direct your policy and practice innovations toward them. If the outcomes for people with co-occurring mental and substance use disorders are the most negative, conduct your own research of all available service innovations that will benefit them, including EBPs. However, if these clients experience significant rates of recovery with your current practices, there may be little need for change, especially if you are keenly aware of the factors that contribute to the positive outcomes. If this is the case, be sure you have mechanisms in place to maintain these practices.

There are many options available to enhance services for people with mental and substance use disorders. Analyze all options and choose one that fits the needs of your region or community. For instance, there are several EBPs that have been designed and tested for a variety of mental disorders as well as for dual disorders. Some of these EBPs include the following:

- Assertive Community Treatment (ACT)
- Integrated Dual Disorder Treatment (IDDT)
- Supported Employment (SE)
- Illness Management and Recovery (IMR)
- Family Psychoeducation (FPE)
- Medication Management Approaches in Psychiatry (MedMAP)

3 IDENTIFY CURRENT PRACTICES AND RATIONALES

Before you reach the conclusion that you need IDDT, establish a rationale for it. Compare the policies, structures, and outcomes of your current practices with the EBPs that you have researched. Is there potential for improvement with the EBPs? Subject your status quo to your own analysis. Ask yourself and key stakeholders an important question: "Why do we provide services this way?" If your answer is "because we've always done it like this," ask another important question: "Are we making every effort possible to help our clients strive to achieve *their* greatest potential for living independent, satisfying lives in the community?"

4 EXAMINE YOUR MISSION, VALUES, GOALS, AND VISION

- What is the purpose of your system or agency?
- What outcomes do your clients and their family members want to achieve?
- What assumptions do you make about your clients?

5 CHECK IT OUT

Before you spend any money or ask your staff to throw out the old to make room for the new, prepare yourself, your service system, and your organization with information. It will help everyone manage their anxiety about potential failure, and it will help everyone manage practical concerns about providing and funding services. Here are a few things you can do to develop realistic expectations about the challenges and successes ahead.

Common elements of evidence-based programs

- Clear philosophy, beliefs, and values
- Specific treatment components (treatment technologies)
- Treatment decision making (within the program framework)
- Structured service delivery components
- Continuous improvement components that encourage innovation

—Dissemination Working Group, 1999 (see Fixsen, et al., p27 in Sources on page 38).

Review the literature

Consult published literature about EBPs. Some criteria that define the literature are included below as a brief and general overview to inform your search. References to more information about the criteria are also provided. A useful resource for this step of implementation is "How to Read and Understand the Literature" in *Turning Knowledge into Practice* by Pamela S. Hyde, et al. (see Sources on page 38).

- *Relevant and objective outcome measures*
  EBP research examines client outcomes, organizational outcomes, and systems outcomes and, thus, identifies administrative practices and clinical practices that improve quality of life for consumers and their families and improve service success and cost-savings for organizations and service systems.

- *Controlled research*
  This refers to the design of the research studies that have examined the administrative practices and clinical practices that became the evidence-based practice. Controlled research typically includes these key components: clear hypothesis; rigorous methods; controlled conditions; participants who have similar attributes (e.g., diagnosis, income, level of education, etc.); random assignment of research participants to an experimental group (in which the new practice is used) and a control group/non-experimental group (in which the old practice is used); a large number of participants (to eliminate the possibility of "chance" results); internal validity; external validity; reliability; statistically significant results of the comparison of the outcomes from the experimental group and the control group.

- *Replication*
  EBPs have been studied with more than one research group. In other words, improved consumer outcomes, program outcomes, and system outcomes have been replicated in different settings, with different clients, and by different researchers over time (i.e., across differing agencies/organizations, regions).

- *Standardized treatments*
  EBPs have organizational characteristics (administrative components) and treatment characteristics (treatment components) that are called fidelity domains (see page 5). Organizations that maintain fidelity to the EBP produce improved outcomes. Fidelity domains are not prescriptions or step-by-step instructions for how service providers must interact with clients. Rather, fidelity domains create organizational and treatment frameworks in which providers can maximize the benefits of the most effective approaches currently available.

  (For more information, see Figure 2 on page 37. Also, consult the following in Sources on page 38: SAMHSA 2003, p1-7; Pamela S. Hyde, et al., p31, 34-36, 104-107; Robert E. Drake 2004, p361.)

Interview other programs

Talk to people at existing IDDT programs who have already gone through the implementation process. They will give you real-life examples from their experiences. We suggest you talk to the following:

- Mental health and substance abuse authorities
- Agency/program directors
- Clinical directors
- Team leaders
- Direct service staff (service providers)

Here are some questions to ask:

- What have been the most significant benefits of implementing IDDT?
- What were the most challenging barriers you experienced during implementation? How did you overcome these barriers?
- What are your top three barriers to sustaining IDDT? What are your plans for overcoming these barriers? How did you identify and decide upon these strategies?
- If you were going to implement again tomorrow, what would you do the same and what would you do differently?

(To connect with your peers at other IDDT programs, contact the Ohio SAMI CCOE or consult the EBP Program Locator database on our web site: www.ohiosamiccoe.case.edu/ebpprograms)

Attend a training

Attend an introductory training to enhance your knowledge of IDDT and to build a network of peers with whom you may consult in the future.

Visit a high-fidelity program

After you have completed reading about IDDT and have talked to a few peers on the telephone and at training events, take a field trip to a high-fidelity program. Start by interviewing the person at the state or county authority or agency who has a similar position as you. This person will have a collegial (or "street-level") credibility that you will not get from books or presentations. The visit will give you a *feel* for what IDDT is all about. It will add experiential data to your research.

(Participate in a free online implementation network: www.ohiosamiccoe.case.edu/training/messageboard_fr.html)

continued on next page

6 ENGAGE TECHNICAL ASSISTANCE

Technical-assistance organizations and other support services can help you avoid repeating the same mistakes that others have made. They can also evaluate the barriers that are unique to the culture of your system, your community, and your organization and make recommendations for changes that are based on experience. Technical-assistance consultants work closely with your organization to transform your administrative and service environments to support and promote *integrated* mental and substance abuse services. There are typically two types of consultation, which are described below. Use the following tips and questions to prepare for engaging technical-assistance organizations and other forms of support.

Resistance to change can be minimized by listening, sharing ideas, and developing consensus.

- Make a list of your top 10 concerns about IDDT.
- Is there a technical-assistance organization in your state to help you alleviate or address your concerns?
- Does the substance abuse or mental health authority in your county or state provide technical support, or will it provide financial assistance to help you acquire it?
- Do you have funding to send your staff to training?
- Does the technical assistance organization in your state provide onsite training that is customized for the knowledge and skills of your staff?

Organizational consultation

This form of consultation focuses on the entire IDDT Fidelity Scale, including the 12 organizational characteristics and 14 treatment characteristics (see page 5). Consultants provide a number of ongoing services, including the following:

- Encourage a manageable pace for implementation by keeping your focus on the stages and steps outlined in this booklet.
- Help you make informed decisions by providing examples of lessons learned from other IDDT programs.
- Remind you of the importance of pursuing and maintaining collaborations with community stakeholders and other systems that provide essential services, such as housing, employment, criminal justice intervention, and peer supports like 12-step groups, among others.
- Assist your steering committee in its efforts to provide oversight.

Clinical consultation

This usually occurs in the action stage of implementation.

7 ASSESS THE PROS AND CONS

Use the information that you have collected thus far to re-evaluate your Needs Assessment. Do people with co-occurring mental and substance use disorders in your community, in fact, need an innovation in service? How does IDDT address this innovation? Here are some items to consider as you evaluate the pros and cons of IDDT:

- Refer to your Needs Assessment (see page 10) and list each need of your clients, staff members, and community stakeholders; does IDDT address these needs?
- Which people, programs, or organizations in your system, community, or organization could be re-trained, re-organized, or re-financed to move toward IDDT implementation?
- Briefly describe the strengths of your organization that will facilitate the implementation of IDDT.
- What are the barriers in your system, community, or organization that will prohibit the implementation of IDDT?
- How can these barriers be overcome?
- Is there technical assistance available to help enhance current strengths, to develop new strengths, and to help eliminate barriers?
- Briefly describe the source, depth, accessibility, and expertise of the technical assistance that is available.
- What is the estimated cost?
- Are there sources of funds available from the following: your organization, community stakeholders, foundations, or county, state, and the federal government?
- Can you manage this innovation without special funding?
- Have peer organizations overcome these same barriers (e.g., refer to your notes from your telephone conversations and site visits)?
- Who are your peer contacts?

8 DEVELOP INFORMED CONSENT AND CONSENSUS

The assessment you conducted in the previous step helps you clearly understand the benefits and risks of implementing IDDT and, thus, helps you develop informed consent and consensus in your organization about your decision to proceed. Be sure to involve senior management and a cross section of service providers and consumers in your service system and/or organization while you are contemplating change. IDDT will require systems and organizations to change their policies and procedures. The people with authority to make these changes must be informed if they are going to agree to participate. In addition, high-level managers at organizations will have more success talking to community stakeholders like judges, police chiefs, and hospital CEOs, all of whom will be important collaborators who will contribute to the implementation effort.

While developing consent and consensus in your system or organization, pay particular attention to IDDT's fidelity domains (see page 5). On the road to achieving improved outcomes, fidelity drives the bus. The fidelity domains will challenge you to reexamine every aspect of your business. Here are some examples of administrative changes you will face:

- Client eligibility for service (Axis II vs. Axis I diagnoses)
- Billable-time policies (e.g., for assertive outreach, training)
- Relevant outcomes and performance (e.g., client movement through stages of treatment, abstinence from substances, employment, housing, quality of life) might replace unit-of-service productivity as a means to measure performance
- Documentation of policies and procedures
- Clinical documentation format (e.g., screening tools, assessment, treatment plan)
- Organizational structure (e.g., lines of supervision and reporting; types of services offered; providing programs vs. providing team-based services)
- Team constellation and staffing (be careful not to eliminate positions until you understand how they might serve the IDDT team)
- Job descriptions
- Physical space (e.g., for groups, shared offices for teams)
- Transportation issues (e.g., for groups)
- Time commitment (e.g., steering committees, technical-assistance consultation supervision)

9 EXPLORE CONCERNS

For every barrier that you identify in the previous step, continue to be persistent about your research. When in doubt, call upon your technical-assistance organization and compare what they have to say with what your contacts at the high-fidelity programs had to say when you visited them. Also, ask your community stakeholders how they might help you overcome the barriers you have identified. By asking them for help, you may inspire a shared sense of purpose—a true partnership.

Cost and cost-shifting is typically a concern. Know that there are IDDT initiatives in Ohio that started with a variety of funding arrangements. Some Ohio programs acquired seed money from state and federal grants. Some found resources from local foundations. And some found resources of their own by restructuring their organizations. So don't let the perceived cost of IDDT implementation hold you back from moving along. You will explore cost issues in more depth on the following pages (see the "Identify financial resources" section on page 18).

Change is not a linear process. People and organizations move back and forth through the stages, which creates an overlap or spiral effect. As a result, it is often difficult to clearly define the stage of change in which an individual or organization functions.

In addition, individuals who are participating in an organizational change process are often in different stages of personal change. For instance, not everyone will agree at the same time that IDDT is a necessary innovation. The lack of consensus influences progress. Thus, organizational change is more complex than individual change. There are many forces that affect the speed and quality of the implementation process.

Resist the temptation to focus on the barriers to innovation. There will always be risks and barriers, but there is evidence that client outcomes, program outcomes, and service system outcomes will improve as a result of IDDT. Remind yourself of the positive outcomes that can be achieved (see page 5).

✔ ✔ ✔

STAGE 3
PREPARATION

"Broad-based community education and ownership that cuts across service sectors is critical to installing and maintaining an evidence-based program with its unique characteristics, requirements, and benefits."

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Loius de la Parte Florida Mental Health Institute, p15.

Motivating

In this stage, your work will focus on motivating people in your organization, other organizations, other service systems, and the local community to recognize the value of IDDT and to join the implementation effort. You will also provide stakeholders with opportunities to contribute their experience, expertise, and resources to the process. You will use all of the research you conducted in the contemplation stage to communicate the following clearly and concisely to multiple audiences as you invite them to participate and develop a long-term collaboration:

- Importance of including IDDT principles in mission statements (of organizations and service systems)
- Prevalence of co-occurring mental and substance use disorders in your community
- Impact of co-occurring disorders on clients, operations, and systems
- Current outcomes and service needs in the community
- Targeted outcomes of IDDT (i.e., consumer, program, and systems outcomes)
- IDDT principles and implementation process
- Existing barriers to change in the community and in service systems
- Existing facilitators of change in the community and in service systems
- Potential collaborators for the change process

Motivate others to contribute their experience and expertise to the implementation process.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

1 DEFINE YOUR RATIONALE

2 IDENTIFY STAKEHOLDERS

3 BUILD CONSENSUS

4 FIND YOUR IDDT "CHAMPIONS"

5 IDENTIFY FINANCIAL RESOURCES

6 ASSEMBLE A STEERING COMMITTEE

7 CONDUCT A READINESS ASSESSMENT

8 DECIDE TO IMPLEMENT OR NOT

9 RECRUIT A TEAM LEADER

10 PLAN TO START SMALL

11 ASSEMBLE THE MULTIDISCIPLINARY SERVICE TEAM

12 BEGIN AN IMPLEMENTATION PLAN

STAGE 3: PREPARATION *continued*

1 DEFINE YOUR RATIONALE

Before you proceed any further, clearly define why IDDT is necessary for your organization and the service systems in your community and region. Examine your mission statement and make sure it is aligned with the principles of integrated treatment. If it is not, consider changing it and be prepared to explain the changes to people in your organization and community. It will enhance their understanding of the innovation. IDDT principles will have more influence if they are included in the mission and values of your organization.

2 IDENTIFY STAKEHOLDERS

To achieve and sustain high fidelity and improved outcomes, you will need many different people to contribute their passion, talent, and expertise to the project. Therefore, it is important to recruit representatives from your organization, from other organizations and systems, and from the community at-large to participate in a steering committee or advisory group. They will guide the implementation process by giving voice to the ideas, concerns, and experiences of those who make policies, provide services, and receive help.

Before you pick up the phone, though, think strategically about those who will make the most valuable contributions to the implementation process. You will need a balance of people who have knowledge of *and experience* with policy making, service provision, and service utilization. You will also need to include those who have access to financial and political resources. It is an effective strategy to assemble a steering committee or advisory group that is small. Smaller groups can accomplish more in a shorter time frame. You can invite more people to join the group as the implementation process evolves.

Be mindful of politics

Recruiting stakeholders for a steering committee or advisory group is a practical and political process. In every system and community, there are power dynamics and relationships. Be mindful of them and know that there may be potential collaborators who have a troubled history, with failed collaborations. Therefore, engage each individual and group with a positive attitude. One way to stay upbeat and hopeful is to remain focused on the common interests of the group, including improved outcomes that high-fidelity IDDT services generate (see page 5). Put yourself in the shoes of the people you are approaching and ask yourself an important question: "What is in it for them?" Highlight the improved outcomes but refrain from an exclusive use of statistics.

Whenever possible, present statistics with a human face: share a few real-world success stories from the programs that you visited in the contemplation stage. This will remind your collaborators that you are all in the business of helping people with co-occurring disorders and their family members improve the quality of their lives.

Assemble a long list of names

In the brainstorming phases of projects like this one, it is productive to get all of your ideas out "on the table" and in writing, where you and your initial planning group can see them and evaluate them. Assemble a long list of all the stakeholders who might be good for your steering committee or advisory group. Start by including a representative from each stakeholder group that you identified in your Needs Assessment (or consult the list on page 4). Many of these people will be interested in the IDDT service innovation, because they will benefit in some way from improved outcomes.

Evaluate and choose the best candidates

Transform your list of stakeholders into an evaluation tool. Ask the questions below about each person to evaluate if he or she is ready, willing, and able to make a contribution. Rank your candidates. In the end, make sure each stakeholder group is represented.

Ready

- Demonstrates an investment in or expresses a sincere desire to improve care for this client population? (Y/N)
- Accurately and assertively represents his/her constituents? (Y/N)

Willing

- Has a reputation for working cooperatively with others? (Y/N)
- Is willing to refer clients with co-occurring disorders to the IDDT service team? (Y/N)

Able

- Communicates ideas effectively?
- Has a reputation for encouraging ideas and supporting people through change? (Y/N)
- Has access to resources that will benefit the cause (i.e., knowledge, people, money)? (Y/N)
- Has the power to influence policy changes in systems or organizations? (Y/N)

3 BUILD CONSENSUS

The implementation advisory group or steering committee within an agency should eventually consist of community stakeholders, agency managers, consumers, family members, and direct service providers. Make an initial presentation to each group and solicit their ongoing feedback and questions. It is useful to approach each group and every individual from the stages-of-change approach (see page 3). Remember that individuals must be ready, willing, and able to do the work of reinventing service systems, organizations, and clinical practices. Some people may jump directly to the preparation stage with you. Others might need some time for contemplation. Yet, others may be stuck in the business-as-usual mindset that defines pre-contemplation. Note that their unwillingness to change may be one of the biggest barriers to your success. Find a way to work with them or, perhaps, around them at first. Technical assistance from an outside group can provide helpful suggestions.

At some point in the consensus-building process, you might consider using a helpful tool like "The Evidence-Based Practice Attitude Scale (EBPAS)" to assess the openness and willingness of individuals within your organization to commit to IDDT implementation (see Aarons in Sources on page 38).

Administrative consensus

Top or upper-level managers in organizations have the authority to change policies to support IDDT practices. Therefore, they must be included in the process. If an organization places the responsibility of implementation upon a clinical team leader, there will be problems. He or she is likely to run into a number of administrative barriers that only managers can change. For example, an aggressive productivity policy for case management is likely to prohibit a team from conducting effective outreach with clients who are in the *pre-contemplation* stage of personal change and the engagement stage of treatment (see list in "Develop informed consent and consensus" section on page 12 for additional examples). In addition, top or upper-level managers will have more success accessing and convincing community stakeholders like judges, police chiefs, and hospital CEOs to collaborate. Include the following on the implementation steering committee or advisory group:

- Chief executive officer
- Chief financial officer
- Clinical supervisors and managers
- Appropriate clinical team leaders
- Service providers (e.g., case managers)
- Quality improvement/assurance officer
- Information systems officer

Staff consensus

It is more important to assemble a team of IDDT service providers who are committed to the philosophies of integrated treatment than to assemble a team of providers who simply have many years of experience. Staff members who are accustomed to providing services "the old way" may be resistant to change. It is not time yet to recruit team members. However, it is time to identify the best candidates. Let your staff know that the organization is preparing to implement IDDT. Be clear about IDDT's client-centered stage-wise approach and help each staff member assess its pros and cons. Encourage them to do some serious soul-searching and to ask themselves if this is what they really want to do. Potential team members are those who truly embrace client-centered stage-wise integrated treatment. Their enthusiasm and hope will propel them and their clients to success. Be prepared to provide access to extensive training. Know that in some cases, you might have to recruit IDDT team members from other departments within the agency or from outside the organization. The team leader will work with the program administrator to recruit team members (see pages 19-20).

Community consensus

As you engage community stakeholders, provide information about IDDT to them so that they begin to understand IDDT's basic principles, including stage-wise approach to treatment (i.e., engagement, persuasion, active treatment, relapse prevention). Remember that IDDT providers help clients find their own motivation to change gradually over time with social support. Be prepared to answer questions about the principles of IDDT (see list of fidelity domains on page 5).

Community stakeholders may need to rethink how they interact with clients who have co-occurring disorders and how they interact with your organization. For instance, in the past, the local court may have referred clients to your organization with the expectation that they will achieve sobriety in 30 days. IDDT's success is based on a stage-wise approach over longer periods of time. It does not demand that clients meet unrealistic short-term expectations that are imposed upon them. Ask each stakeholder if he or she is open to learning more about IDDT and contributing to this effort. Presuming they may initially be skeptical, provide stakeholders with information in print and in person about the outcomes that can be achieved with a high-fidelity program. Also remind them that high fidelity depends upon cooperation from the community—namely, them.

(Use the *IDDT Overview* booklet to help build consensus: www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87.)

continued on next page

4 FIND YOUR IDDT "CHAMPIONS"

IDDT champions are people within your organization who have an unwavering enthusiasm for and commitment to IDDT treatment principles, fidelity, and outcomes. They are the heart-and-soul of implementation—the leaders whose enthusiasm will inspire others on an interpersonal level. The champions are involved in all aspects of implementation. They attend steering committee meetings and treatment team meetings, read the fidelity reports, and request training for team members. They stay in contact with peers at other programs and often represent your organization at regional and statewide meetings. In short, IDDT champions are part enthusiasts, part overseers, and part advocates. They keep the energy, focus, and motivation alive and vibrant. If your IDDT champions are not administrators, they will need the support of a high-level manager who will ensure that the policies of your organization support the cause.

5 IDENTIFY FINANCIAL RESOURCES

Create a list of all the IDDT services that you will provide in the four stages of treatment (see Figure 1 on page 36) and identify a source of income for each. This will help you evaluate your revenue streams and identify missing sources of income. For instance, some service activities like outreach (in the engagement stage of treatment) and multidisciplinary team meetings might not be billable to some insurance programs or other funding sources. Therefore, you will need to find another source of income to cover these expenses.

Be prepared to make presentations to community stakeholders who will benefit financially from a reduction in service utilization by people with co-occurring disorders. You might convince them to contract with your agency for some of its services. Also make presentations to other potential funding sources, such as the United Way and local foundations and keep an open mind about unorthodox sources that might be available in your community. Ask around. Maybe there is a professional athlete or a successful business owner who is invested in helping people with mental illness or co-occurring mental and substance use disorders: they might be interested in contributing to the IDDT cause.

Contact other IDDT providers in your peer network for advice. Ask them how they have arranged their budgets to ensure income for IDDT services. Here is a list of possible funding sources:

- Insurance reimbursement (e.g., Medicaid, Medicare, private insurance)
- Mental health authority
- Substance abuse authority
- Other public systems that work with the co-occurring population and will benefit from improved outcomes (e.g., criminal justice system, hospitals)
- Grants from government sources (e.g., federal, state, county, local)
- Gifts and grants from private benefactors (e.g., foundations, entrepreneurs, industrialists, athletes, entertainers, estates)

6 ASSEMBLE A STEERING COMMITTEE

By now, you have identified a number of individuals within your organization and community who may be interested in IDDT and working cooperatively with others. It is time to invite them to be a part of your implementation steering committee. The committee will help your organization stay focused on implementing and sustaining a high-fidelity program over time. Steering committees consist of community stakeholders and an internal work team of individuals from your organization.

The *internal work team* consists of the IDDT program manager and team leader, service providers, and key organizational administrators (e.g., chief executive officer, chief financial officer, chief information technology officer, clinical director, quality-improvement staff) who collaborate with *community stakeholders* (see page 4).This team takes most of the responsibility for developing the multidisciplinary service team, reviewing team performance, and reviewing and monitoring fidelity action planning and outcomes. The community stakeholders tend to take a macro approach to their work. They help the organization identify needed support and resources then work within the systems that they represent to provide that support (e.g., housing networks, employers, criminal justice/probation officers). In addition, committee members work to minimize barriers between systems and to build bridges between the IDDT team and consumer groups like NAMI.

Committee activities

The steering committee (and the internal work team) oversees a number of activities, which include the following:

- Review results of the Needs Assessment (see page 10)
- Identify, select, and track desired client outcomes, agency outcomes, and systems outcomes (see page 26)
- Review the fidelity report (see page 24)

- Develop a broad-based implementation plan (see page 21)
- Develop a fidelity action plan with specific action steps for each EBP component (see page 24)
- Identify and minimize organizational barriers and systems barriers to implementation and fidelity (see page 27)
- Plan a "kickoff" event for stakeholders to educate them about and to build enthusiasm for IDDT (see "Begin an implementation plan/Raise awareness" on page 21)
- Review and recommend enhancements to administrative policies and practices (e.g., billing, treatment plans and documentation)
- Review outcome reports at least quarterly (see page 26)
- Monitor quality improvement
- Identify and pursue sources for funding, as needed

7 CONDUCT A READINESS ASSESSMENT

The Readiness Assessment is conducted by your technical-assistance organization. It is a discussion with your internal work team about the key components described on the previous pages that are required for successful implementation. The assessment ensures that you have begun to consider and assess everything you need for your journey. It checks for the following:

- Impressions about the need to change
- Factors that influence interest in adopting the EBP
- Support for implementation within the organization and from local, county, and state authorities
- Recent experiences with adopting service innovations
- Information from the Needs Assessment
- Current treatment philosophy
- Presence of an existing work team/steering committee
- Current and projected outcomes
- Current service array, service team, and program structure
- Staff knowledge and expertise base, attitudes, and openness to change
- Administrative and clinical supervisory structure
- Consumer and family member involvement in service planning and delivery
- Financial health and funding resources for implementation
- Collaborative potential
- Awareness of key IDDT principles and implementation processes
- Overall readiness

8 DECIDE TO IMPLEMENT OR NOT

The Readiness Assessment is designed to provide you and your technical-assistance consultants with enough information to make a collective decision to proceed with implementation or not. Some organizations may need to acquire additional human and financial resources before beginning the process. It is important to be prepared adequately for implementation.

Encourage your implementation team to ask the following questions to decide whether your organization is ready to implement or not:

- Is there consensus to implement?
- Is this the right time to initiate organizational change?
- Do we have the time and energy to dedicate ourselves to the entire implementation process?
- Are we confident that we have the necessary financial support to provide IDDT services?
- Are we prepared to address organizational policy and procedure changes?

9 RECRUIT A TEAM LEADER

Once you decide to proceed, it is time to formally recruit your IDDT team leader—if you have not already done so. This person is responsible for building and maintaining the service team. He or she is somebody who is comfortable working with a variety of professionals and fulfills a multifaceted role that combines interpersonal, administrative, and clinical skills. The team leader is responsible for hiring staff, providing administrative and clinical supervision, fostering communication among team members, and encouraging resolution when disagreements about treatment strategies arise. The team leader is a champion of the practice and, therefore, must be skilled in developing, training, and coaching staff members. The team leader meets one-on-one with team members, leads team meetings, facilitates ongoing clinical training, and represents the team at administrative meetings and steering committee meetings. Some team leaders also maintain a small caseload to keep themselves in touch with clinical and programmatic issues that affect consumers, caregivers, and treatment team members.

For more information about the role of the team leader, consult these resources:

- www.ohiosamiccoe.case.edu/training/teamleader/teamlead.html
- www.ohiosamiccoe.case.edu/news/samimatters2001spring.pdf (see pages 8-10 of this pdf)
- Mercer-McFadden (see Sources on page 38)

continued on next page

10 PLAN TO START SMALL

The Needs Assessment that you conducted in the contemplation stage identified the total number of clients in your local mental health and substance abuse systems who might benefit from IDDT services. You should not try to serve all of them at once. Instead, work with a small subset. For instance, if you identified 1,000 eligible clients, start by serving 50 with one team of providers. There is a practical reason for this approach. If your IDDT program is small, the impact of the barriers that it experiences will tend to be small and, therefore, manageable. On the contrary, if your fledgling program is large and involves many team members and clients, the impact of barriers will be large and possibly disruptive or problematic to the organization. Once the initial service team achieves at least moderately high fidelity and improved outcomes with the initial group of clients, you will make plans for an incremental expansion of the services. This typically occurs in the maintenance stage of implementation (see "Expand IDDT Services" on page 31).

Some organizations in Ohio have implemented IDDT on a large scale (e.g., with multiple teams serving many clients). However, the unintended consequences of implementation—which can and do occur—affected a large number of people within and served by the organization. Thus, the lessons learned during implementation were more painful than they might have been with a small initiative.

11 ASSEMBLE THE MULTIDISCIPLINARY SERVICE TEAM

The IDDT model views all activities of life as part of the recovery process. Therefore, the model provides each client with a variety of service providers to help him or her in all aspects of life. The team consists of the following:

- Team leader
- Case manager(s)
- Mental health counselor
- Substance abuse specialist
- Criminal justice specialist/liaison
- Employment specialist
- Housing specialist
- Nurse
- Psychiatrist/physician
- Family specialist

One of the first tasks of the IDDT team leader is to work with program administrators to recruit members of the multidisciplinary service team. Implementation experiences in Ohio indicate that the most effective (i.e., collaborative) teams are formed when the new IDDT team leader interviews and selects his or her own staff (with input and oversight from upper management). In the staff-consensus section on page 17, you identified potential candidates for the job—that is, service providers who are committed to IDDT's client-centered stage-wise integrated treatment approach. Use the list of names to recruit team members and remember that in some cases, you might have to recruit from other departments within the agency or from outside the organization. Remember that it may be helpful to use "The Evidence-Based Practice Attitude Scale (EBPAS)" to assess the openness and willingness of potential team members to commit themselves to IDDT implementation (see Aarons in Sources on page 38). Team leaders should work with each team member to develop individual professional development plans. They should shadow team members in the community and be prepared to model new practices and coach providers as they work to integrate new knowledge and skills into practice.

The multidisciplinary treatment team meets daily to discuss pressing issues and meets regularly to discuss each consumer's progress in all areas of his or her life. Team members use formal and informal meetings to provide insight and advice to one another. They meet individually and as a group with each client and their caregivers (family, friends, and other supporters) to discuss the client's progress and goals. Successful IDDT programs coordinate all aspects of recovery to ensure that consumers, caregivers, and service providers are working together toward the same goals in a collaborative manner. When necessary and appropriate, team members may "fill in" for each other to provide clients with services they need in a timely manner. For instance, nurses may provide case management services when delivering medication to clients in community locations.

The ongoing cohesiveness and success of the multidisciplinary team depends a lot upon the team leader's and the program manager's ability to utilize effective recruitment strategies, to make smart hiring decisions, to execute retention initiatives (such as ongoing training), and to be prepared for staff turnover. Be on the look-out for potential team members. Invite service providers within your organization who are not members of an IDDT team to training sessions and consultations. If they express an interest and enthusiasm for IDDT, they may be a future candidate for the team.

(For more information about identifying and recruiting potential team members, see the "Build consensus" section on page 17.)

12 BEGIN AN IMPLEMENTATION PLAN

The Implementation Plan is your organization's to-do list of practical needs for the start-up of your IDDT program. The Implementation Plan is not an auditing or accreditation tool. Nor is it specifically related to fidelity. The Plan is utilized by your steering committee and other committees to guide the process until the Fidelity Report and Fidelity Action Plan have been written (see page 24). Your technical-assistance organization (or other source of technical support) will help you develop the Implementation Plan, which is a matrix that consists of four major components:

- Implementation item
- Task required
- Person or group responsible
- Deadline for completion

Raise awareness

Now that you are ready to begin the action stage of implementation, it is time to celebrate this new era of service innovation with all stakeholders in the community (see table on page 4). Invite them all to a "kickoff" event. Take time to describe again the core components of the model, expected outcomes, and the benefits of the outcomes for clients, their families, and the community at-large. Be sure to emphasize that it is not just your organization which is implementing IDDT. *Implementation is a community effort.* Remind stakeholders that the success of IDDT depends upon active participation by and collaboration with all of them. IDDT is about community investment and change.

A kickoff event educates community stakeholders about IDDT and celebrates a new era of service innovation.

Talk to your technical-assistance consultants (or other source of technical support) about your feelings and thoughts regarding the implementation process. They may have insights and advice from colleagues at other programs who have gone through all five stages of implementation. The insights and advice might help you through this transitional period.

✔ ✔ ✔

STAGE 4
ACTION

"Structural supports necessary to initiate the program are put in place. These include ensuring the availability of funding streams, human resource strategies, and policy development as well as creating referral mechanisms, reporting frameworks, and outcome expectations."

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Loius de la Parte Florida Mental Health Institute, p16.

Implementing

In this stage, the service team begins to provide stage-wise interventions to clients with co-occurring disorders. Your steering committee monitors the progress of these activities by reviewing the results of fidelity reviews, fidelity action plans, and outcomes reports. In addition, your administrative team monitors the individual and political reactions to change within your organization and community: it maintains ongoing communication with everyone involved with and affected by implementation, resolves potential conflicts, and strives to remove barriers to change.

In this stage, members of your administrative team, service team, and steering committee attend training events that are designed to help them translate IDDT principles into practice. However, these individuals may already be attending training. If this is the case, then already there is momentum. This demonstrates that the stages of implementation and change often overlap and that progression is more cyclical than linear.

Are you ready? Your clients are waiting. Positive change is in the future!

Provide stage-wise interventions. Monitor fidelity items, outcomes, and reactions to change.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

1 CONDUCT A BASELINE FIDELITY REVIEW

2 DEVELOP A BASELINE FIDELITY ACTION PLAN

3 DEVELOP STAGE-WISE INTERVENTIONS

4 ACQUIRE AND INTEGRATE TRAINING

5 ENGAGE IN CLINICAL CONSULTATION

6 PROVIDE STAGE-WISE INTERVENTIONS

7 DEVELOP AND MONITOR OUTCOMES

8 CONTINUE TO EDUCATE AND TRAIN STAKEHOLDERS

9 ADDRESS BARRIERS

10 ADDRESS UNINTENDED CONSEQUENCES

1 CONDUCT A BASELINE FIDELITY REVIEW

The fidelity review is not an audit or accreditation process. It is strictly a quality-improvement process.

The fidelity review (or assessment) provides a formal mechanism for independent evaluation of your IDDT services. It is not an audit or accreditation process. It is strictly a quality-improvement process that provides you with information to make decisions about your next steps. Research demonstrates that IDDT programs which maintain fidelity to the model achieve the best results. Optimally, organizations engage in an external IDDT fidelity review process at least once per year. The fidelity review and fidelity action plan (see action step 2 in adjacent column) create a continuous quality-improvement process—a cycle of planning, implementation, evaluation, and service enhancement.

In Ohio, fidelity reviews are conducted onsite at the organization by a team that has been trained to conduct the reviews. The team often consists of representatives from the Ohio SAMI CCOE, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, and representatives from peer IDDT initiatives throughout the state. The SAMI CCOE does not recommend that organizations perform their own fidelity reviews. The experiences of Ohio organizations have demonstrated that external fidelity reviewers provide an objective perspective that is more helpful for future service enhancements.

On the road to achieving improved outcomes, fidelity drives the bus.

Fidelity Scale

The fidelity-review team uses the IDDT Fidelity Scale. It is an evaluation instrument that is designed to measure the degree to which programs administer services according to IDDT's organizational index (12 organizational characteristics) and treatment index (14 treatment characteristics). Obtain the IDDT Fidelity Scale online (see sidebar on page 5).

Interviews

The fidelity-review team conducts interviews with agency and service administrators, direct-service staff, family members, and clients. These discussions elicit information about the effectiveness of the IDDT model and provide information about the facilitators and barriers to successful implementation.

Practice observation

If possible, the fidelity-review team observes team meetings, treatment groups, and individual one-on-one practices with clients to observe the team's application of the model's principles.

Documentation reviews

The assessment team reviews randomly drawn consumer case records to ascertain the quality of documentation of integrated assessment, treatment planning, and service provision. It also reviews agency documents to ascertain the presence of policies and procedures that support implementation of the model.

Resources

For an overview of stage-wise interventions, see Figure 1 on page 36.

Fidelity scores

External fidelity reviewers will evaluate all the data that the fidelity-review team collects and will generate fidelity scores for all items outlined in the Fidelity Scale.

Fidelity report

External reviewers or program consultants present recommendations and suggestions for each of the fidelity items and recommendations for next steps in a Fidelity Report then work with your steering committee to create an action plan for improving or maintaining fidelity (see "Assemble a steering committee" on page 18).

2 DEVELOP A BASELINE FIDELITY ACTION PLAN

The Fidelity Action Plan is created by your steering committee in consultation with your technical-assistance organization. The plan addresses all areas of the IDDT scale. It outlines next steps in your journey toward reaching and sustaining high fidelity and improved outcomes. It provides accountability to your internal work team and steering committee, which use the document to compare current activities with stated goals each time it meets. The plan consists of four major components:

- Fidelity scale item
- Action required
- Person or group responsible
- Deadline

3 DEVELOP STAGE-WISE INTERVENTIONS

IDDT emphasizes that recovery occurs incrementally over time through stages of change and treatment. Therefore, for people with co-occurring mental and substance use disorders, big changes like sobriety, symptom management, and an increase in independent living are built upon a series of small, incremental changes in feelings, thoughts, and behavior. IDDT services should be developed and delivered in a culturally appropriate manner. This will further assure the likelihood of successful outcomes.

It is time for your service team members to concentrate on utilizing the stage-wise philosophy in their practices. Keep in mind that this practice transformation will also occur in stages over time. First, your team members will develop the capacity to "stage" clients—that is, to assess accurately their experiences and mental and substance abuse symptoms and to utilize the most appropriate interventions for those symptoms and experiences (see Figure 1 on page 36). Then your team members will develop proficiency with the techniques. Be patient yet persistent. Remember that each person on the team will have a different level of readiness to change (see Tip on page 13). Consistently remind them that research suggests that individuals with co-occurring disorders gain the most confidence with personal change when they are encouraged to experience incremental successes over time. It is also important for the service team to acknowledge clients as they experience those successes.

Interventions

High-fidelity IDDT programs offer comprehensive services because the recovery process occurs in the context of daily living. The list of services and interventions below emerges from the treatment characteristics of the IDDT Fidelity Scale (see page 5):

- Assertive community treatment
  - Case management
  - Outreach
  - Secondary interventions for non-responders
- Housing/Residential services
- Medical services (to promote health)
  - Pharmacological treatments
  - Primary health services
- Illness management and recovery
  - Psychoeducation
  - Cognitive behavioral methods for using medication
  - Relapse-prevention services
  - Coping-skills interventions
- Supported employment
- Motivational Interviewing (MI)
- Integrated substance abuse and mental health counseling
- Cognitive Behavioral Therapy (CBT)
- Group interventions
  - Persuasion groups or motivational groups
  - Social-skills training
  - Recreational group activity
  - Active-treatment groups
  - Relapse-prevention groups
  - Family therapy (see family services)
- Family Services
  - Outreach, psychoeducation, consultations
  - Collaborations with NAMI
  - Multiple family groups
  - Behavioral Family Therapy (BFT)
  - Multisystemic Family Therapy (MFT)
- Consumer self-help groups
  - Double Trouble/Dual Recovery Anonymous (DRA)
  - Alcoholics Anonymous (AA)
  - Narcotics Anonymous (NA)
  - Cocaine Anonymous (CA)
  - Depression and Bipolar Support Alliance (DBSA)
  - Schizophrenics Anonymous (SA)
  - Emotions Anonymous (EA)

4 ACQUIRE AND INTEGRATE TRAINING

It is important for all administrators, team leaders, clinical supervisors, and service team members to acquire the knowledge and skills necessary to translate IDDT principles into their practice specialties. For this to happen, your organization should make every effort to create a lifelong-learning environment that makes training an essential part of everyone's professional development. In addition, team leaders and supervisors should model new skills and offer supervision in the context of everyday practice (e.g., in the community, in groups, in individual counseling). This training-in-action approach helps accelerate the integration of training into practice. Here are three key points to remember:

- Training is important.
- Training must continually be applied in the work environment with supervision.
- Training is a waste of time and resources if not supported by the policies and procedures of the organization or if not applied and reinforced in supervision.

Program administrators, team leaders, and supervisors should ensure that the work environment emphasizes the following:

- Exploration and implementation of EBPs
- Experiential learning
- Clinical supervision in the context of everyday practice (i.e., in vivo)
- Attention to the work environment
- Staff support
- Attention to removing barriers for the newly implemented practice
- Attention to cultural appropriateness
- Celebrating successes of clients and staff

Supervision in the community

Team leaders and clinical supervisors observe team members at work in the community to ensure that clients are receiving quality care. They also provide team members with immediate feedback about their strengths, weaknesses, and opportunities for professional growth. For instance, the success of motivational interventions depends upon the skillful use of the self, such as body posture, word choice, tone of voice, timing, and the ability to help clients develop discrepancy between their stated recovery goals and their current thoughts and behaviors. Even the most experienced service providers can benefit from in-vivo supervision. Mastery of new knowledge and skills simply cannot be accomplished as effectively with supervision that occurs solely in an office.

Training topics

Plan to make a wide variety of training topics available to your administrative team, service team, and steering committee. Assemble a menu of trainings that address IDDT service development, team building, supervision, and clinical treatment. Check with your technical-assistance organization (or other source of technical support) about the training it offers. For instance, the Ohio SAMI CCOE offers introductory and advanced training events in community locations for providers interested in IDDT. It also offers intensive onsite training to individual organizations. The onsite training addresses the following topics with no less than 30 contact hours:

- Research and efficacy of IDDT
- Issues in the professional relationship
- Stage-wise treatment
- Engagement skills
- Motivational interviewing (basic and advanced skills)
- Assessment (functional and integrated)
- Treatment planning (stage-related interventions)
- Principles of mental health and substance abuse treatment
- Active treatment (substance use/abuse and mental health)
- Group treatment: principles, stages, skills, types (basic and advanced)
- Medical and health issues
- Family treatment interventions
- Relapse prevention
- Supervision
- Introduction to Cognitive Behavioral Therapy (CBT)

continued on next page

"We now have thousands of experiments across the country which have proven that, in mental health, training is not enough to create change."

–Robert Drake, MD, Principal author of the Integrated Dual Disorder Treatment model

Consultation is provided onsite at organizations, in the community with supervisors and service providers, and via teleconferences.

Train non-IDDT providers in your organization

It is also useful to provide IDDT training to staff members who are not a part of your current IDDT team but demonstrate an interest in and commitment to integrated treatment. This will enhance the sustainability of your current IDDT services, because there will be a pool of qualified individuals to fill team roles that become vacant through attrition, such as retirement, illness, and career changes. Staff turnover is inevitable, so plan accordingly. Develop and maintain a systematic method for training new people when they join your organization or IDDT team (i.e., use training expertise from individuals, technical-assistance organizations, and other sources of technical support). Build your training initiative upon important resources, such as the following:

- Training manuals and videos
- Online training
- Training events (e.g., conferences, workshops)
- Onsite clinical consultation (i.e., grand rounds)

The ongoing training of service providers who are not currently a member of your IDDT team will also prepare your organization for the expansion of its IDDT services in the maintenance stage (see page 28), because there will be a pool of qualified and trained team members from which to recruit.

Train stakeholders

See "Continue to educate and train stakeholders" on page 27.

5 ENGAGE IN CLINICAL CONSULTATION

Your technical-assistance consultants continue to work closely with your organization and IDDT team to transform your administrative and service environments (see page 12). Clinical trainers provide one-on-one and group clinical consultation to team leaders, clinical supervisors, and service providers to help them integrate new knowledge and skills into practice. They provide consultation onsite (at the agency), in the community, and via teleconferences. Consultants will participate in treatment-team meetings as a way to demonstrate new leadership and supervision skills, and they will accompany supervisors and team members during outreach activities with clients to demonstrate clinical skills, such as motivational interviewing. This active approach to consultation is an important way to make training come alive—to make it skill-based and experiential. It supports IDDT team members through the process of translating new knowledge and skills into daily routines.

6 PROVIDE STAGE-WISE INTERVENTIONS

You have already identified specific clients who might benefit from IDDT services (see "Plan to start small" on page 20). Your service team will need to utilize an effective instrument ("staging tool") to evaluate each client for a stage of treatment that addresses his or her current needs (see Figure 1 on page 36). Your organization and service team should compare available instruments and choose one that will produce the most accurate assessment of clients served by your organization. To be most effective, staging tools must inform an effective treatment plan. Include each completed staging tool in the front of each treatment plan as a reminder to team members to use it continuously to inform each revision of the plan. Examples of staging instruments include the following:

- SATS (Substance Abuse Treatment Scales)
- URICA (University of Rhode Island Change Assessment)
- SOCRATES (Stages of Change Readiness and Treatment Eagerness Scale)

(See URICA, SAMHSA, and Miller in Sources on page 38.)

7 DEVELOP AND MONITOR OUTCOMES

Outcomes data measure the effectiveness of IDDT services. The data enable everyone to step back from their day-to-day work and ask some important questions, like "How are we doing?" and "Is there something we can do better?" It is essential that organizations invest in a mechanism for collecting, evaluating, and reporting outcomes to everyone involved with IDDT, including the following:

- Clients
- Family members
- Service providers
- Agency administrators
- Community stakeholders
- Policy makers
- Foundations
- Local communities

An investment in an outcomes process will help your organization and community make an informed decision about future investments in IDDT and other EBPs. The Needs Assessment exercise in the contemplation stage of implementation provides baseline data for measuring outcomes over time (see page 10). There are a number of outcomes that your organization should continuously monitor, including the following:

- Individual client
- Family outcomes
- Service provider caseload
- Service team aggregate
- Organization (program)
- Systems

(For more information, see Figure 2 on page 37.)

Evaluate outcomes instruments

A variety of outcomes instruments are available from a number of sources. Choose the tools that meet your needs. Here are a few basic tips to keep in mind when choosing outcomes tools:

- Does the instrument measure the client outcomes, organizational outcomes, and service system outcomes that you need to track?
- Has the instrument been designed and tested for the client population served by IDDT?
- Is the instrument simple enough to use in everyday practice?
- Is the instrument evidence-based and does it contain the core components of a valid research instrument (see "Check it out/Review the literature" on pages 10-11)?

(For more information, see SAMHSA 2003 and SAMHSA 2006 in Sources on page 38.)

8 CONTINUE TO EDUCATE AND TRAIN STAKEHOLDERS

Your service team and administrative team are acquiring training and hands-on experience with IDDT principles and practices. This is a good opportunity to share the new knowledge and skills with community stakeholders and other partners. Take your learning into the community. Visit their organizations and invite them to yours. Also, ask them to attend training sessions, and when appropriate, invite them to consultations with your technical-assistance organization (or other source of technical support). The training of stakeholders (and other individuals) from multiple service systems will help develop a continuity of IDDT philosophies and practices in the community and promote cross-system communication and collaboration. For example, in Ohio, several IDDT programs have invited and included judges, police officers, parole officers, and probation officers in training events as a way to maintain consistent communication with the criminal justice system. Ohio providers have also invited and included instructors from social work departments in local colleges and universities as a way to promote IDDT among the next generation of licensed social workers and certified chemical dependency counselors.

Continue to welcome stakeholders into the implementation process and give them opportunities to contribute their experience, expertise, and resources to the IDDT cause. It will be helpful to publicize the progress and successes of your IDDT program to stakeholders as another way to keep them informed (e.g., quarterly newsletter). Build relationships and service compatibility through constant communication.

9 ADDRESS BARRIERS

In the contemplation stage, you identified some potential barriers to implementation (see "Develop informed consent and consensus" and "Explore concerns" on pages 12 and 13). Now that you are actually implementing IDDT, you will come face-to-face with these and other barriers. You will recognize the barriers when you feel that you have stopped making progress. Remember that the policies and practices of your organization, collaborating organizations, and service systems are among the most common barriers. For example, IDDT provides time-unlimited services. Yet, if your agency has a policy to close a case after 90 days of no contact, this policy will be a barrier to helping clients with long-term recovery issues (e.g., relapse, hospitalization, incarceration, and homelessness). Your steering committee should develop a plan to address and remove implementation barriers. Integrate the committee's ideas into your Implementation Plan (see page 21).

10 ADDRESS UNINTENDED CONSEQUENCES

There will be anticipated consequences of IDDT implementation (see "Address barriers" section above), and there will also be unanticipated (or unintended) consequences, which can have both negative and positive impacts. For instance, you may see an increased demand for integrated services through traditional and non-traditional sources (e.g, courts, families, and consumers). You may also experience a shift from a silo-like service structure that is defined by grant-funded programs to integrated and collaborative work teams that address the comprehensive needs of consumers. Bring all positive and negative consequences of implementation to your steering committee members for their problem-solving recommendations (see "Assemble a steering committee" on page 18).

Remember that staff members and community stakeholders must adjust to the changes that your organization has made, is in the process of making, and will continue to make. Be strategic about how you address any potential reactions, such as doubt and disbelief in the IDDT model. Timing is important. You may need to be patient. Negativity is sometimes just an initial reaction to change that actually foreshadows an individual's movement toward positive actions (e.g., a transition from the contemplation stage to the preparation stage of personal change). However, negativity is sometimes a definite heels-in-the-sand resistance that keeps a person firmly rooted in the pre-contemplation stage–the business-as-usual disposition (see page 6). Consider the potential consequences of changing the organizational status quo. It is often difficult to predict how people will react to your promotion of IDDT. It will be helpful to develop a plan to address any potential negative feelings and reactions that staff members may have to your new organizational priorities and evidence-based clinical practice standards. You may need to find allies who can help preserve your IDDT program, especially your collaborations with community stakeholders.

Ask your technical-assistance consultants (or other source of technical support) for advice about managing unintended consequences. They may have helped other IDDT programs deal with similar situations in other communities. They may be able to suggest strategies that will work for you. Service providers and systems have learned many lessons from their implementation of the model and are often willing to share them with organizations who are developing IDDT. These perspectives are an invaluable resource to programs in all stages of implementation.

Fidelity scores measure the process of implementation. Outcomes data measure the effectiveness of services.

Before you initiate the *Action* stage of implementation, make sure your steering committee and implementation team have identified the outcomes that your organization wants to measure (see Figure 2 on page 37). Also, make sure that your team has outlined the process by which the outcomes will be collected, recorded, analyzed, and reviewed by everyone involved with IDDT implementation.

STAGE 5
MAINTENANCE

"The goal during this stage is the long-term survival and continued effectiveness of the implementation... in the context of a changing world."

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Loius de la Parte Florida Mental Health Institute, p17.

Sustaining

In all the previous stages of implementation, your organization was building a quality-improvement process centered upon the IDDT model. If you have followed and continue to follow the stages and steps outlined in this booklet, you now have a process in place from which to develop IDDT services and to grow and improve continuously.

In this stage of IDDT implementation, your organization will sustain its quality-improvement process by continuing to integrate the principles, practices, and structure of IDDT into the service culture of the entire organization and within the community. Therefore, the strategies described on the following pages are intended to help your organization sustain all the advances it has made thus far. For instance, your implementation team and steering committee will continue to focus on fidelity and outcomes as your organization expands its IDDT services by adding more service teams, by serving more clients, and by utilizing integrated treatment principles in other services that it provides. In addition, your implementation team and steering committee will prepare for periods of change and transition that may result from the following:

- Service expansion
- Increased referrals and demands for services
- Staff turnover
- Loss of IDDT champions
- Loss of steering committee members
- Leadership changes at your organization and community stakeholder organizations
- Leadership changes at state and county authorities
- Changes in public policies
- Changes in funding streams
- Addition or attrition of community stakeholders
- Implementation of additional EBPs and other service innovations

(For more information, see Torrey in Sources on page 38.)

Sustain your quality improvement process and continue to innovate.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

1 MAINTAIN OVERSIGHT

2 MONITOR FIDELITY

3 MONITOR OUTCOMES

4 NETWORK WITH OTHERS

5 PROVIDE ONGOING TRAINING

6 ENGAGE IN ONGOING CONSULTATION

7 EXPAND IDDT SERVICES

8 TRANSFORM THE ORGANIZATIONAL CULTURE

STAGE 5: MAINTENANCE *continued*

The steering committee oversees the quality-improvement process.

1 MAINTAIN OVERSIGHT

At this point, your IDDT service is experiencing fewer system barriers to implementation, so your steering committee meets less frequently. However, the internal work team (which is part of the steering committee) continues to provide oversight of fidelity reviews and fidelity action plans (see "Assemble a steering committee" on page 18). The work team also provides continuity of leadership during periods of administrative change. Although the steering committee itself meets less frequently, the internal work team of your organization continues to meet monthly or quarterly. The work team and steering committee oversee a number of activities related to IDDT's continuous quality-improvement process. They perform the following tasks:

- Review annual fidelity reports
- Revise the fidelity action plan
- Track desired outcomes
- Review outcome reports
- Review and recommend enhancements to administrative policies and practices
- Identify and minimize organizational barriers and systems barriers to fidelity and improved outcomes
- Plan for continued funding

2 MONITOR FIDELITY

Without consistent and regularly scheduled fidelity reviews, reports, and action plans, your program may run the risk of drifting away from the principles of IDDT and into non-evidence-based practices. For example, if your organization experiences a budget crisis and decides to cut case managers from the IDDT team to save money, the ratio of clients to case managers will increase beyond the 15:1 or 20:1 suggested by the research. This will compromise quality and outcomes. In addition, if another program within your agency or community wants to "buy" or "borrow" some time from the team nurse, this may compromise his or her ability to give IDDT clients the attention they need and deserve. When your program achieves high fidelity, you should continue to pay attention to it. Remember that new programs typically engage in a fidelity review process every six months. Established programs with high fidelity continue to engage in annual fidelity reviews.

(For more information, see these sections: "Conduct a baseline fidelity review" and "Develop a baseline fidelity action plan" on page 24.)

3 MONITOR OUTCOMES

Pay close attention to outcomes data at the same time you pay attention to fidelity. A drop in outcomes may indicate a drop in fidelity. Likewise, an increase in outcomes may indicate an improvement in fidelity. Invest in a mechanism for collecting, evaluating, and reporting outcomes to everyone involved with IDDT, including service providers, clients, family members, community stakeholders, policy makers, foundations, and other departments within your organization. Your openness and honesty will inspire hope about improvements and help from others if outcomes begin to slip. There are a number of outcomes categories that your program should continuously monitor. They include the following:

- Client
- Family
- Organization (program)
- System

(For more information, see the "Develop and monitor outcomes" section on page 26.)

4 NETWORK WITH OTHERS

It is important for program administrators, team leaders, and service providers to maintain the formal and informal networks of professional peer support that they developed during the contemplation, preparation, and action stages of implementation. These networks provide a forum for everyone to share the lessons they are learning about implementation. This form of dissemination helps new and existing IDDT services avoid common pitfalls, overcome barriers, and capitalize on strategies that work.

While it is important to maintain your current networks, it is also important to expand them. Develop relationships with colleagues in other systems and disciplines as a way to promote IDDT's principles and practices and as a way to integrate the knowledge and practice of your peers into your work. For instance, there is a growing interest among law enforcement and criminal justice professionals for crisis intervention training (CIT) to learn how to intervene more effectively with people who have co-occurring disorders. Use the training events as an opportunity to engage in dialogue with your peers from other professional disciplines and/or service systems. Stay open to learning something new from them: the two-way exchange of information may serve as a foundation for future collaborations.

Your organization or a technical-assistance organization may sponsor professional peer networks, such as the following:

- Monthly team-leader consultation (onsite or teleconference)
- Family program-development consultation (teleconference)
- Regional networks
- Online networks (e.g., message boards, listserves)

(Participate in a free online implementation network: www.ohiosamiccoe.case.edu/training/messageboard_fr.html)

5 PROVIDE ONGOING TRAINING

Training is an integral part of your organization's quality-improvement process. It equips administrators, clinical supervisors, team leaders, and service providers with the knowledge and skills they need to improve their practices continuously. In the preparation stage of implementation, you identified and recruited team members who are committed to lifelong learning. Therefore, it is important to maintain a work environment that supports lifelong learning: you should provide ongoing advanced and updated training in core components of the IDDT model to support the professional development of your team members.

Promote cross-training

With incremental change, your organization builds capacity to serve all people with co-occurring disorders in your community. In doing so, your team members will likely interact with more service providers from other sectors of the community and other professional disciplines. "Cross-training" helps integrate multidisciplinary knowledge, which makes services more integrated and comprehensive. One way to promote cross-training within your organization is to include an overview of integrated treatment as part of the orientation process for *all* new employees. It is important to establish a training and implementation plan for co-occurring disorders throughout your organization. This will prepare a roster of qualified individuals to fill team roles that will become available when your IDDT services expand and when positions become available through staff attrition, such as retirement, illness, and career changes.

Remember to continue to extend training opportunities to individuals at organizations in other service systems. The training will help maintain a continuity of IDDT philosophies and practices across service systems, as well as maintain cross-system communication and collaboration.

(For more information, see the "Acquire and integrate training" section on page 25. Also see the "Continue to educate and train stakeholders" section on page 27.)

6 ENGAGE IN ONGOING CONSULTATION

Stay connected with peers at other organizations who are implementing IDDT, and stay connected to consultants and trainers at technical-assistance organizations (or other sources of technical support). These people will help you navigate transitional periods and incorporate lessons learned at other high-fidelity IDDT programs. Many technical-assistance organizations provide organizational consultation to address the administration of IDDT programs and clinical consultation to address the quality of service delivery.

(For more information, see the "Engage technical assistance" section on page 12.)

7 EXPAND IDDT SERVICES

In the contemplation and preparation stages of implementation, you identified the total number of clients in your local mental health and substance abuse systems who would benefit from IDDT services. However, you most likely have been working with a subset of this group as a way to facilitate manageable change in your organization and community. For instance, you may have identified 1,000 eligible clients but chose to assemble one multidisciplinary team to work with 50 clients. As this team approaches high fidelity and improves outcomes, it is time to begin the expansion of integrated treatment activities: for example, additional service teams now begin to work with additional client groups. It is important that your steering committee, administrative team, and direct-service team ask this question: "How do we reach the greatest number of eligible clients?"

Serve more clients incrementally as a way to manage organizational change.

8 TRANSFORM THE ORGANIZATIONAL CULTURE

As your organization adds more IDDT teams and clients and cross-trains more service providers, your entire organization continues to change. So does the service environment in your community. An integrated approach becomes the cultural norm.

Accommodate innovations

Once IDDT is completely implemented with all targeted client groups and is achieving high fidelity and good outcomes, it is time to test those service innovations that seem like "good ideas" but are not a part of the evidence-based practices research. For instance, many consumers report experiences of trauma. As a result, service providers are exploring how they might include trauma services as part of IDDT. Inform your steering committee if you decide to experiment with an innovation like this and ask it to keep a close eye on fidelity scores and outcomes. If the data show a drop in performance, explore and assess the reasons. If the data show a rise in performance, spread the news to other high-fidelity programs in your professional peer network. They might be interested in trying to duplicate the favorable results.

continued on next page

Implement additional EBPs

The knowledge and experience that you accumulate from implementing IDDT with high fidelity and positive outcomes can be transferred to the implementation of additional EBPs. It is time to start the implementation process again. Return to your comprehensive Needs Assessment, which you conducted in the contemplation stage of implementation. Which client group on the list demonstrates the next highest need? From which services will they most benefit? Raise these important questions with your IDDT steering committee members, then begin the process of identifying potential committee members for the next EBP. You might find some of your best candidates on the IDDT committee.

(For more information, see the "Develop awareness of available options" section on page 10.)

Celebrate and evaluate successes

The pace of work in most service organizations is very fast. It seems that service providers and administrators alike are constantly "moving on" to the next opportunity, the next challenge. While working at a fast pace, there is often little time to notice, celebrate, and evaluate your successes. However, these activities are important, because they provide opportunities for organizational self-reflection and, therefore, quality improvement.

Take time to celebrate and evaluate successes together, so everyone becomes conscious of the organizational processes that produce positive outcomes. Be sure to include direct-service providers, administrators, steering committee members, community stakeholders, consumers, and family members in the celebration and evaluation and share the results openly. The process of organizational self-reflection will provide energy for future innovations.

Maintain your momentum as you implement the next EBP. Think about the future. There are service systems, community stakeholders, and clients and their families who will benefit from the positive outcomes of other EBPs. Invite them to contribute their knowledge, their experiences, and their hope to the next phase of the journey.

✔ ✔ ✔

IMPLEMENTING IDDT: AT-A

STAGE	1	2	3
Stages of change	Pre-Contemplation	Contemplation	Preparation
Stages of implementation	Unaware or uninterested	Consensus building	Motivating

1. ASK IMPORTANT QUESTIONS
2. BEGIN THE CHANGE PROCESS

1. CONDUCT A NEEDS ASSESSMENT
2. DEVELOP AWARENESS OF AVAILABLE OPTIONS
3. IDENTIFY CURRENT PRACTICES AND RATIONALES
4. EXAMINE YOUR MISSION, VALUES, GOALS, AND VISION
5. CHECK IT OUT
6. ENGAGE TECHNICAL ASSISTANCE
7. ASSESS THE PROS AND CONS
8. DEVELOP INFORMED CONSENT AND CONSENSUS
9. EXPLORE CONCERNS

1. DEFINE YOUR RATIONALE
2. IDENTIFY STAKEHOLDERS
3. BUILD CONSENSUS
4. FIND YOUR IDDT "CHAMPIONS"
5. IDENTIFY FINANCIAL RESOURCES
6. ASSEMBLE A STEERING COMMITTEE
7. CONDUCT A READINESS ASSESSMENT
8. DECIDE TO IMPLEMENT OR NOT
9. RECRUIT A TEAM LEADER
10. PLAN TO START SMALL
11. ASSEMBLE THE MULTIDISCIPLINARY SERVICE TEAM
12. BEGIN AN IMPLEMENTATION PLAN

-GLANCE

4	5
Action	Maintenance
Implementing	Sustaining

1 CONDUCT A BASELINE FIDELITY REVIEW

2 DEVELOP A BASELINE FIDELITY ACTION PLAN

3 DEVELOP STAGE-WISE INTERVENTIONS

4 ACQUIRE AND INTEGRATE TRAINING

5 ENGAGE IN CLINICAL CONSULTATION

6 PROVIDE STAGE-WISE INTERVENTIONS

7 DEVELOP AND MONITOR OUTCOMES

8 CONTINUE TO EDUCATE AND TRAIN STAKEHOLDERS

9 ADDRESS BARRIERS

10 ADDRESS UNINTENDED CONSEQUENCES

1 MAINTAIN OVERSIGHT

2 MONITOR FIDELITY

3 MONITOR OUTCOMES

4 NETWORK WITH OTHERS

5 PROVIDE ONGOING TRAINING

6 ENGAGE IN ONGOING CONSULTATION

7 EXPAND IDDT SERVICES

8 TRANSFORM THE ORGANIZATIONAL CULTURE

FIGURE 1

Stages of Personal Change	*Stages of IDDT Treatment*	*Clinical Focus*

Pre-Contemplation	**Engagement**	**Outreach**
		• Provide outreach in community-based settings
		Trusting Relationship
		• Gain permission from consumers to share in their process of change
		  • Ask consumers what is important to them
		  • Listen to and respect their priorities
		  • Get to know the person for who they are
		Practical Support
		• Provide support for daily living (i.e., food, clothing, housing, medicine, safety, crisis intervention)
		Assessment
		• Assess continuously for consumers' personal histories, goals, and readiness-to-change

Contemplation and Preparation	**Persuasion**	**Motivational Interventions** • Commit yourself to understanding consumers' goals • Help consumers understand the pros and cons of personal change • Help consumers establish the discrepancy between their goals, their substance use, and their lifestyles (e.g., thoughts, feelings, behavior) • Help consumers begin to reduce substance use and take medications regularly • Help consumers recognize and take pride in their own strengths and successes **Ambivalence is Normal** • Assure consumers that ambivalence to change is a normal human response (change may occur slowly over time) **Pay-Off Matrix** • Use a pay-off matrix to help consumers tip decisions away from ambivalence and toward positive action **Education** • Teach consumers about alcohol, drugs, mental illness, and activities that promote health and wellness • Offer skills-training opportunities • Reach out and provide support to families
Action	**Active Treatment**	**Skill Building** • Teach illness management skills for both disorders (e.g, refusal skills, managing triggers and cravings, recognizing symptom onset, communication skills, etc.) **Social Support** • Encourage positive peer supports (e.g., self-help groups) **Cognitive Behavioral Interventions** • Assist consumers with transforming negative thoughts and behaviors into coping skills for both disorders
Maintenance	**Relapse Prevention**	**Planning** • Develop a relapse-prevention plan • Support consumers as they maintain lifestyle changes learned in active treatment **Recovery Lifestyle** • Help consumers set new goals for enhancing their quality of life **Social Support** • Reduce the frequency, intensity, and duration of relapses with positive peer relationships and supportive clinical relationships

Resources

This table is also available as a 24″x36″ poster. Consult this resource from the IDDT Library and Links database:

IDDT Poster: Stages of Change & Treatment (2004).
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=85

FIGURE 2

OUTCOMES DATA	Individual client outcomes	Family outcomes	Organi-zation/ program outcomes	Systems outcomes
Quality of life	X	X		
Psychiatric symptoms	X			
Alcohol and other substance use	X	X		
Abstinence rates	X		X	X
Progress through stages of substance abuse treatment	X		X	X
Educational status	X			
Family and peer relationships	X	X		
Criminal justice system involvement (arrest and incarceration)	X		X	X
Satisfaction with services	X	X	X	X
Employment (hours worked in competitive employment)	X		X	X
Housing/Independent living status	X		X	X
Psychiatric hospitalization rates	X		X	X
Improved problem-solving skills	X	X		
Reduced burden and stress		X		
Greater awareness about mental illness and substance use disorders	X	X		
Service utilization (e.g., episodes of care, case management, treatment groups, individual services)	X		X	X
Crisis/emergency service utilization	X		X	X
Bed days/detox or subacute detox days	X		X	X
Cost-effectiveness			X	X

Resources

Consult the online Library and Links database and select "IDDT" then "fidelity and outcomes":
www.ohiosamiccoe.case.edu/library/

Also consult this resource from the Library and Links database:
SAMHSA (Substance Abuse and Mental Health Services Administration) (2006).
National Outcomes Measures (NOM) web site. Rockville: SAMHSA, U.S. Department of Health and Human Services. Retrieved December 30, 2005, from www.nationaloutcomemeasures.samhsa.gov/outcome/index.asp

SOURCES & RESOURCES

Hyperlinks to many of these resources may be obtained from our free online IDDT Library and Links database:

www.ohiosamiccoe.case.edu/library

Gregory A. Aarons (2004). Mental Health Provider Attitudes toward Adoption of Evidence-Based Practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research,* v6, n2, p61-74.

Addiction Technology Transfer Centers (ATTC) Network (2000). *The Change Book: A Blueprint for Technology Transfer.* Kansas City: ATTC National Office.

Patrick E. Boyle, MSSA, LISW, LICDC (2005). Consultation, training, and practice experiences: Interviews with Patrick E. Boyle by Paul M. Kubek, January 2003-June 2005.

Patrick Boyle, Christina M. Delos Reyes, and Richard A. Kruszynski (2005). Integrated Dual Disorder Treatment. Chapter 15 in *Evidence-Based Mental Health Practice: A Textbook.* New York: W. W. Norton & Company, Inc., p349-366.

Gerard J. Connors, Dennis M. Donovan, and Carlo C. DiClemente (2001). *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions.* New York: The Guilford Press.

Robert E. Drake, Carolyn Mercer-McFadden, Kim T. Mueser, Gregory J. McHugo, and Gary R. Bond (1998). Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders. *Schizophrenia Bulletin,* v24, n4, p589-608.

Robert E. Drake, Susan M. Essock, Andrew Shaner, Kate B. Carey, Kenneth Minkoff, Lenore Kola, David Lynde, Fred C. Osher, Robin E. Clark, and Lawrence Rickards (2001). Implementing Dual Diagnosis Services for Clients with Severe Mental Illness. *Psychiatric Services,* v52, p469-476.

Robert E. Drake, Kim T. Mueser, Mary F. Brunette, and Gregory J. McHugo (2004). A Review of Treatments for People with Severe Mental Illnesses and Co-Occurring Substance Use Disorders. *Psychiatric Rehabilitation Journal,* v27, n4, p360-374.

- For "Stage 2: Contemplation/Check it out/Review the literature" (on pages 10-11), consult p361 of this resource.

Robert E. Drake, Matthew R. Merrens, and David W. Lynde, eds. (2005). *Evidence-Based Mental Health Practice: A Textbook.* New York: W. W. Norton & Company, Inc.

Dean L. Fixsen, Sandra F. Naoom, Karen A. Blase, Robert M. Friedman, and Frances Wallace (2005). *Implementation Research: A Synthesis of the Literature.* Tampa: University of South Florida, Loius de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Howard H. Goldman, Vijay Ganju, Robert E. Drake, Paul Gorman, Michael Hogan, Pamela S. Hyde, and Oscar Morgan (2001). Policy Implications for Implementing Evidence-Based Practices. *Psychiatric Services,* v52, n12, p1591-1597.

Pamela S. Hyde, Kathryn Falls, John A. Morris, and Sonja K. Schoenwald (2003). *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-Based Practices.* Boston: Technical Assistance Collaborative (TAC).

- For "Stage 2: Contemplation/Check it out" (on pages 10-11), consult p31, 34-36, 104-107 of this resource.

Ric Kruszynski, MSSA, LISW, LICDC (2005). Consultation, training, and practice experiences: Interviews with Ric Kruszynski by Paul M. Kubek, January 2003-June 2005.

Ric Kruszynski and Patrick E. Boyle. (In Press). Implementation of the Integrated Dual Disorders Treatment Model: Stage-Wise Strategies for Service Providers. *Journal of Dual Diagnosis.*

Gregory J. McHugo, Robert E. Drake, Gregory B. Teague, and Haiyi Xie (1999). Fidelity to Assertive Community Treatment and Client Outcomes in the New Hampshire Dual Disorders Study. *Psychiatric Services,* v50, p818-824.

Carolyn Mercer-McFadden, Robert E. Drake, Robin E. Clark, Nicholas Verven, Douglas L. Noordsy, and Thomas S. Fox (1998). *Substance Abuse Treatment for People with Severe Mental Disorders: A Program Manager's Guide.* Concord: New Hampshire-Dartmouth Psychiatric Research Center.

William R. Miller and J. Scott Tonigan (1996). Assessing Drinkers' Motivation for Change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors,* v10, n2, p81-89.

William R. Miller and J. Scott Tonigan (1996). SOCRATES (Stages of Change Readiness and Treatment Eagerness Scale) http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/62_SOCRATE.pdf

Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice.* New York: The Guilford Press.

Ohio SAMI CCOE (2005). IDDT Overview (The Trifold). Cleveland: Center for Evidence-Based Practices, Case Western Reserve University. www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87

Ohio SAMI CCOE (2005). Ohio SAMI CCOE web site. Cleveland: Center for Evidence-Based Practices, Case Western Reserve University. www.ohiosamiccoe.case.edu

James O. Prochaska, John C. Norcross, and Carlo O. DiClemente. (1995). Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. New York: Harper Collins.

D. A. Regier, M. E. Farmer, D. S. Rae, B. Z. Locke, S. J. Keith, L. L. Judd, and F. K. Goodwin (1990). Comorbidity of Mental Disorders with Alcohol and other Drug Abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association,* v264, n19, p2511-2518.

SAMHSA (Substance Abuse and Mental Health Services Administration) (2003). *Co-occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit.* Retrieved December 30, 2005, from www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

- For "Introduction/IDDT Fidelity Scale" (on page 5), consult the "Integrated Dual Disorder Treatment Fidelity Scale" section of this SAMHSA resource.
- For "Stage 2: Contemplation/Check it out/Review the literature" (on pages 10-11), consult the "Monitoring Client Outcomes" section of this SAMHSA resource.
- For "Stage 4: Action/Provide stage-wise interventions" (on page 26), consult page 29 of the "IDDT Workbook" section in this SAMHSA resource.
- For "Stage 4: Action/Develop and monitor outcomes/Evaluate outcomes instruments (on page 26) consult the "Monitoring Client Outcomes" section of this SAMHSA resource.

SAMHSA (Substance Abuse and Mental Health Services Administration) (2006). National Outcomes Measures (NOM) web site. Rockville: SAMHSA, U.S. Department of Health and Human Services. Retrieved December 30, 2005, from www.nationaloutcomemeasures.samhsa.gov/outcome/index.asp

William C. Torrey , Robert E. Drake, Michael Cohen, Lindy B. Fox, David Lynde, Paul Gorman, and Philip Wyzik (2002). The Challenge of Implementing and Sustaining Integrated Dual Disorders Treatment Programs. *Community Mental Health Journal,* v38, n6, p507-521.

URICA (University of Rhode Island Change Assessment) (2006). Kingston: Cancer Prevention Research Center (CPRC), University of Rhode Island.

For more resources to help implement and sustain the IDDT model, consult our free online IDDT Library and Links database.

CONTRIBUTORS

For information about writers, editors, and financial support for this publication, see back panel.

Additional contributors to the production of this booklet include the individuals listed to the right. The Ohio SAMI CCOE wishes to thank everyone who contributed their time, insight, and suggestions for enhancements. Most of all, we wish to thank you for sharing your talent and commitment to excellence.

We gratefully acknowledge the support of the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. We also wish to recognize and celebrate the contributions to service innovation that have been made by individuals at numerous service organizations throughout Ohio and around the country that are implementing the Integrated Dual Disorder Treatment (IDDT) model.

Reviewed by

- Ann D. Carden, Ph.D.
- David Ross, MEd, LPCC
- Deborah Myers, MEd, PCC
- Debra R. Hrouda, MSSA, LISW
- Landa Dorris, LPCC, CCDCIII-E
- Scott Gerhard, MA, LISW
- Steve Stone, MA, LPCC
- Terry Jones, MSW, LISW
- Wendy Williams, MS, LICDC, LPC

Designed by

David Cravener
Cravener | Holmes Creative
Sullivan, Ohio

Printed by

Master Printing
Gene Boron (printing rep.)
Cleveland, Ohio

OHIO SAMI CCOE

ABOUT US

The Ohio SAMI CCOE is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people with mental and substance use disorders. The SAMI CCOE helps service systems, organizations, and providers implement and sustain the Integrated Dual Disorder Treatment (IDDT) model, maintain fidelity to the model, and develop collaborations within local communities that enhance the quality of life for consumers and their families. The SAMI CCOE provides these services:

- Service systems consultation
- Program consultation
- Clinical consultation
- Training
- Research and evaluation

EVIDENCE-BASED

EBPs are service models that research has demonstrated to generate improved consumer outcomes, program outcomes, and systems outcomes. Research shows that organizations which maintain fidelity to the original design of each EBP achieve and sustain the best outcomes.

TRAINING & CONSULTING

Our consultants and trainers are experienced administrators, service providers, and researchers who offer personal attention and customized training and consultation throughout the implementation process. We understand that every service system and organization exists within a unique social, political, and economic context. Therefore, we work closely with you to adapt IDDT to the unique culture of your community and, at the same time, to maintain fidelity to the model.

This booklet is part of an evolving training and consultation process from the Ohio SAMI CCOE. It is written for policy makers, administrators, and service providers who want to implement and sustain the IDDT model.

Written & edited by
Ric Kruszynski, MSSA, LISW, LICDC, director of consultation and training, Ohio SAMI CCOE

Paul Kubek, MA, director of communications, Ohio SAMI CCOE

Patrick E. Boyle, MSSA, LISW, LICDC, director of implementation services, Ohio SAMI CCOE

Project editor
Lenore A. Kola, Ph.D., co-director, Ohio SAMI CCOE; associate professor of Social Work, Mandel School of Applied Social Sciences, Case Western Reserve University

Funded by
The Ohio SAMI CCOE is funded by the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. This project was funded by Eva L. and Joseph M. Bruening Foundation, Cleveland, Ohio.

Additional contributors
See page 39.

© Copyright 2006: Ohio SAMI CCOE, Case Western Reserve University

The Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE) is a program of the Center for Evidence-Based Practices at Case Western Reserve University, which is a partnership between the **Mandel School of Applied Social Sciences** at Case and the **Department of Psychiatry at the Case School of Medicine**. The partnership is in collaboration with and supported by the **Ohio Department of Mental Health** and the **Ohio Department of Alcohol and Drug Addiction Services.**

Build trust
Improve outcomes
Promote recovery

Resources

To obtain additional printed copies of this booklet, contact our office or visit our web site for an order form.

Additional resources are listed on page 38.

CASE
CASE WESTERN RESERVE UNIVERSITY

CONTACT US
Patrick E. Boyle, MSSA, LISW, LICDC, director of implementation services
Ohio SAMI CCOE
c/o Northcoast Behavioral Healthcare
Clinical Administration Bldg, Cottage 7, Room 303, PO Box 305
1756 Sagamore Road
Northfield, OH 44067-1086
330.468.8663

www.ohiosamiccoe.case.edu