



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

For

**Region 6 IDN Through
June 30, 2017**

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Introduction

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

This Reporting Guide is for use by the IDNs to identify required documentation for achieving project requirements according to the Special Terms and Conditions of the DSRIP Waiver. The state will use the information to review and document the IDNs’ progress on project implementation and to award incentive payments. IDNs are required to complete separate implementation plans for each of their statewide projects (i.e., workforce, health information technology and alternative payment models), core competency project, and community-driven projects. Required deliverables must be submitted to the Department of Health and Human Services by July 31, 2017 and within 31 days after each six-month reporting period, as indicated in below. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Submission of the semi-annual report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints your attachments should also be uploaded separately in the original file version as well (ms project, ms excel, etc.) Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted. See below for illustration of attachment for project B1 deliverable 2A:

Attachment_B1.2A

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

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

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DSRIP IDN Project Plan Implementation (PPI)

Each IDN is required to develop implementation plans and demonstrate progress made toward the achievement of required milestones. Using Microsoft Project or similar platform, provide implementation plans that include required activities, timelines, key milestones, progress assessment check points, and evaluation metrics. Many milestones are within the statewide and community projects and should be reported in all relevant implementation plans. Use the format below to, at a minimum, identify progress made.

The Project Plan Implementation Timeline represents high level activities associated with each of the identified Project Plan Requirements. Some referenced activities are specified in deeper detail in the respective Statewide or Community Project Implementation Plans. Many of these meetings are scheduled in accordance with striking a balance between timeliness of critical content and stakeholder availability. The PPI timeline is detailed in Attachment PPI.1.

Soliciting Community Input: From Day One, IDN Region 6 has made a commitment to the meaningful engagement and input of a broad representation of community stakeholders in all our DSRIP design and implementation efforts.

- All three of the Community Projects in IDN 6 have been designed, and implementation will continue to be guided, by Workgroups comprised of multiple clinical and non-clinical stakeholders throughout the Region. These Workgroups will continue to meet at least three or more times per reporting period to guide implementation of respective projects.
- A Workgroup dedicated to the integration of resources and services that address the Social determinants of Health through Region 6 projects was formed after two community outreach information sharing and solicitation meetings. The group formally met twice in May and June 2017, and will continue to meet twice per reporting period.
- After two consultative meetings in early 2017, a formal Clinical Advisory Team has been formed and begun a series of eight meetings to provide expert input on operational considerations and problem-solving related to the care integration objectives across IDN projects (particular emphasis on B.1).
- IDN partner representatives have joined the Operations Team in Statewide HIT and Workforce Workgroups, and will continue to participate in relevant committees and subcommittees as they develop.
- We solicited considerable input from consumers (beneficiaries, their families and support networks) in our original planning processes. We are currently recruiting, through the assistance of our Network Partners, consumers to sit on each of our Workgroups and our Executive Committee to provide meaningful representation and input to all aspects of IDN implementation. Likewise, we will continue to solicit feedback from identified consumer groups and individuals in private settings without service providers present.
- All Partner Meetings have been a key aspect of network development throughout the initiative. We will continue to offer two to three All Partner meetings per reporting period as a forum to provide detail and answer questions related to IDN updates and progress. The All Partner meetings have become an especially useful forum to conduct breakout group exercises to solicit feedback from multiple perspectives, and a forum to inform and engage new network partners.
- We also participate in numerous opportunities throughout the region to inform, engage and solicit input from groups like Welfare Directors, Public Housing Authorities, Police Chiefs, Recovery Community Organizations, Elder Wrap, existing Care Coordination efforts, and more.

Network Development: We have undertaken several strategies to conduct continuous development of the IDN 6 Network.

- 1:1 meetings were held with all major stakeholders (4 Hospitals, 3 FQHCs and 2 CMHCs) to share detailed information about DSRIP projects to multiple staff members in each agency, and to learn about the current and planned agency efforts related to the coordination and/or integration of care and services.
- Two members of the IDN Operations Team have been engaged in the development of the Community Care Teams operating in our region since their inception. Originally an initiative of the Greater Seacoast Coalition to End Homelessness, the oversight, facilitation and resourcing of the CCTs was officially adopted by the IDN in August of 2017. With 48 clinical and non-clinical agencies and organizations actively participating in the CCTs (all on one Release of Information), this ongoing initiative has continued to grow and thrive, and will be a vital vehicle for continued network development. Two CCTs currently meet monthly, although we anticipate ramping up to higher frequency towards the end of 2017 or early 2018.
- The roughly thirty-two thousand attributed members in Region Six are distributed among communities with highly diverse socio-economic profiles and associated partner agencies and organizations. The Operations Team has developed the concept of Health Neighborhoods in the Region to facilitate an understanding and awareness of interagency relational networks that operate among and between four sub-regional clusters of partners.
- Our Region Six All Partner Meetings, held roughly every two months (depending on competing meetings, priorities, etc.) have been a key stable of network development since Day One, and will continue to serve as our largest and most diverse in-person network audience.
- The Operations Team held two open community brainstorming sessions early in 2017 to inform the formation and approach to establishing and conducting our Social Determinants Workgroup. Now operating with formal meetings of a wide range of non-clinical partners, as with all of our Workgroups, we will continue to actively build membership throughout our network.
- The Region 6 IDN contacted the two NH MCOs (Wellsense and NHHF) to host information sharing meetings with all IDN partners in order to start building the critical connections between MCO services and data with DSRIP objectives and activities.
- Operations Team Members are heavily involved in many IDN-related Network activities (e.g. seat on Public Health Advisory Committee; Commissioner of Dover Housing Authority; members of Greater Seacoast Coalition to end Homelessness Steering Committee and Workgroups; Medical Reserve Corps; Recovery Community Organization Advisory Board; and many more). All together and across members, the Operations Team engages in hundreds of contacts, engagements, meetings and interactions of all types that are relevant to Network Development that are too numerous to document or predict systematically.

Addressing the Opioid Epidemic: The Operations Team

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

- Members of the Operations Team have been actively involved in existing Network efforts (two Team members were staff members of our two respective Public Health Networks), and regularly participate in such groups as the Prevention, Treatment and Recovery Roundtable; The Opioid Taskforce, etc.
- Members of the Operations Team have been very actively involved in providing multiple Overdose Prevention trainings before and since the inception of DSRIP. Additional trainings to be offered include those to First Responders and other non-clinical personnel. Likewise, these team members have also been instrumental in creating one of the first Syringe Services Programs in NH (serving our region).
- In addition to our D.3 Community Project (Building Capacity to Provide Intensive Substance Use Treatment Options), our overall Regional Training offerings include several opportunities for Partners to send staff members to acquire knowledge and competencies that directly or indirectly serve to build our capacity to respond to the negative consequences of opioid use throughout the network.

Governance: The primary component of our governance model is the Executive Committee, which is comprised of fourteen people, each representing a different sector of the IDN.

Budget: Our Master Budget has been reviewed and approved by the Executive Committee. Our current Master Budget is based on projected revenues that reflect and anticipate our previous payment (approximately 85%). Our Director of Finance conducts Monthly Reconciliation of the budget. The Master Budget can be found in Attachment_PPI.2. Budget narrative is detailed in this document via the A1,A2,B1,C1,D3, and E5 projects budgets that comprise the composite Master Budget.

Strengthening Operational Capacity to Administer the DSRIP: Region 6 has made significant investments to build and continue to strengthen our Operations Team membership and capacity.

- We added two part-time, but key members to our team so far in 2017. First, Project Coordinator Maria Sillari, a consultant with over 20 years of experience working in a variety of multi-agency initiatives in our region. And second, Dr. Bill Gunn, a widely recognized and respected expert in integrated care, recently retired from Concord Hospital and related to the Seacoast Region.
- We anticipate the hiring of four additional key positions that will greatly strengthen our Operations Team capacity: 1) a Data/HIT Architect, 2) Director of Care Coordination, and 3) two Integration Coaches to focus on implementation of B.1 and associated IDN efforts.
- We continuously seek opportunities to build our internal knowledge, skills and capacity to implement the DSRIP. Some examples include our participation in the full day training on Alternative Payment Models (APMs), the full Privacy Boot Camp offered by UNH Law, and the MSLC Learning Collaborative.

Strengthening Network Partner Readiness for DSRIP Initiatives: Overlap with other activities

- We invited and hosted Roland Lamy, expert in Alternative Payment Models, to share his knowledge, wisdom and advice with the Executive Team.
- We contributed to the development of the Critical Time Intervention kickoff event that was held in Plymouth on June 1, 2017.
- We have created and will deliver a robust menu of Trainings and Technical Assistance to ensure that all Network Partners have not only the initial skills-building required to deliver integrated care, but the ongoing learning and support required to affect systems and culture change that are sustainable.

- One of our foremost efforts to build partner readiness will be the key partner visits that we conduct to establish current status, opportunities and plans for building capacity to move towards “integrated care” status as part of Project B.1.

The Region 6 evaluation plan for this project includes assessment of progress toward meeting the milestones identified in the Implementation Timeline in Attachment PPI.1. Milestones are identified in the domains of Community Input, Network Development, Addressing the Opioid Crisis, Governance, Budget, Capacity to Administer the DSRIP, and Partner Readiness for DSRIP Initiatives. This assessment is conducted on a rolling basis, reviewed quarterly by the IDN, and reported to DHHS via the Semi-Annual Report mechanism submitted for the 6 month periods ending on 12/31/17, 6/30/18, and 12/31/18. The Region 6 IDN Executive Committee is tasked with review and acceptance of the Semi-Annual Report results certifying they are accurate representations of effort and progress during reporting periods.

Attachment_PPI.1

Project Plan Implementation		6/30/2017	12/31/2017	6/30/2018	12/31/2018	Milestone/Deliverable
Community Input						
Objective	Convene Work Groups to guide Project Design/Implementation					
Group 1	C.1 Care Transitions	8 meetings	4 meetings	4 meetings	4 meetings	
Group 2	D.3 SUD Capacity	8 meetings	3 meetings	4 meetings	4 meetings	
Group 3	E.5 Enhanced Care Coordination	3 meetings	8 meetings	8 meetings	4 meetings	
Group 4	Social Determinants of Health	2 meetings	1 meeting	1 meeting	1 meeting	5/24 and 6/27
Group 5	Clinical Advisory Team	2 meetings	4 meetings	8 meetings	4 meetings	9/13 kick-off meeting
Objective	Convene/Conduct Regional All Partner Meetings	2 meetings held	meeting held 10/3/17	1 meeting	1 meeting	
Objective	Continued Community Outreach and Engagement					
	Consumer Engagement and Input (see narrative)	ongoing	strategy update	ongoing	ongoing	10/3 All Partner Strategy Meeting
Network Development						
Objective	Establish Partnerships/Inclusion of All potential Network Agencies/Orgs					
Task	Conduct 1:1 Info/Assessment Meetings with Regional Partners					FF 1/10; WDH 2/9; EH 2/10; GCH 2/21; SCMH 2/22; Lamprey 3/2; PRH 3/3
Task	Conduct F/U 1:1 Phase 1 (B.1) Meetings with Regional Partners		5 meetings	5 meetings	F/U as needed	scheduling currently underway
Task	Establish linkage with Community Care Teams in Region	facilitative role	responsible role	lead role	lead role	IDN adopts operation of CCT August 2017
Task	Develop Regional Health Neighborhood Framework	draft concept	review w/ partners	TBD	TBD	
Task	Convene/Conduct Regional All Partner Meetings	3 meetings	2 meetings	2 meetings	2 formal mtgs	minimum of 2 meetings per reporting period
Task	Convene Social Determinants Workgroup	2 formative mtgs	2 formal mtgs	2 formal mtgs	2 formal mtgs	2 meetings per reporting period
Task	Outreach to MCOs	convene 2 mtgs	ongoing	ongoing	ongoing	2/3/17 (Well Sense) and 2/10/17 (NHHF)
Task	Ops Team Memberships in Network Activities	ongoing	ongoing	ongoing	ongoing	dozens of activities per period
Addressing the Opioid Crisis						
Objective	Integrate proactive and intentional efforts to address Opioid Crisis					
Task	Ops Team Members direct involvement in Regional Activities					
	-Prevention, Treatment & Recovery Roundtable	2 meetings	1 meeting	1 meeting	1 meeting	attend, provide IDN updates and alignment
	-Strafford County Opioid Taskforce	2 meetings	1 meeting	1 meeting	1 meeting	attend, provide IDN updates and alignment
	-Board Chair: Hope on Haven Hill Residential SUD Treatment for Women	6 meetings	5 meetings	TBD	TBD	alignment
	Governor's Comm on Alcohol & Drug Abuse Prevention, Treatment,	2 meetings	2 meetings	2 meetings	TBD	alignment
	-Chair of Governor's Commission Recovery Taskforce	4 meetings	4 meetings	4 meetings	TBD	attend, provide IDN updates and alignment
	-Seat on Governor's Commission Data Taskforce		5 meetings	2 meetings	TBD	attend, provide IDN updates and alignment
Task	Training and Support of efforts to address negative consequences of SUD					

	-Overdose Prevention Trainings Delivered by Ops Team		3 trainings	3 trainings	TBD	delivered upon request
	-Training & Capacity Building for Syringe Services Programs		1 training	TA	TA	developing model for statewide programs
	-Trainings offered for First Responders		1 training	1 training	1 training	delivered upon request
Task	Implementation of D.3: Building Capacity for Intensive SUD Treatment		ongoing	ongoing	ongoing	See D.3 Implementation Plan
Governance						
Objective	Formalize IDN Governance through establishment of Executive Committee					
Task	Exec Committee Members ID'd, recruited & approved by All Partner	complete				
Task	Executive Committee Charter developed and approved	complete				
Task	Convene Regular Meetings of Executive Committee	6 meetings held	4 meetings	4 meetings	4 meetings	
Budget						
Objective	Establish Master Budget for IDN 6					
Task	Master Budget Created; approved by Executive Committee	budget created	budget approved			Master Budget approved 9/7/2017
Task	Update Accounting System Chart of Accounts	complete				Updated Chart of Accounts in use
Task	Monthly Reconciliation	monthly	monthly	monthly	monthly	Accounts are reconciled on a monthly basis
Capacity to Administer the DSRIP						
Objective	Build Region 6 IDN Core Operations Team					
Task	Hire Project Coordinator & Clinical Director to Ops Team	complete				Project Coordinator and Clinical Director hired as of 1/1/17
Task	Hire HIT/Data Architect		12/30/2017			HIT/Data Architect hired
Task	Hire Director of Care Coordination		12/30/2017			Director of Care Coordination hired
Task	Hire 2 Integration Coaches		12/30/2017			Two Integration Coaches hired
Objective	Build Ops Team Technical Capacity					
Task	Participate in full day training Re: VBP/APM Readiness	5/31/2017				3 Ops Team members
Task	Agreed to participate in SAMHSA Zero Suicide application	4/15/2017				Letter of Commitment provided to NAMI NH
Task	Agreed to participate and host up to 5 Americorps Members	5/1/2017	onboarding Dec			
Task	Commitment from 2 Public Housing Authorities to preference Sec 8 vouchers	5/31/2017				Dover and Rochester PHAs committed to preference Section 8 vouchers
Task	Participate in MSLC Learning Collaborative	N/A	8/28/2017	TBD	TBD	Participated in inaugural Learning Collaborative session
Task	Participate in Privacy Boot Camp	1st 2 sessions	3rd session			Completed 3 sessions of Privacy Boot Camp: 6/6; 6/29; 7/17/17
Partner Readiness for DSRIP Initiatives						
Objective	Execute strategies focused on building implementation readiness					

Task	Hosted Forum for Exec Comm on APM readiness		6/9/2017			12 Exec Committee members and 4 IDN staff participated in APM readiness forum led by Roland Lamy of Helms & Co.
Task	Contributed to Planning & Invested in CTI Kickoff event	6/1/2017				Contributed funding to and participated in the planning and development of the June 1 CTI Kickoff event; 2 IDN staff and 7 IDN partners attended.
Task	Offer and deliver comprehensive Menu of trainings to Network Partners		Begins Nov 2017	ongoing	ongoing	
Task	Comprehensive Partner Agency Needs Assmt and Planning for B1		5 meetings	5 meetings	F/U as needed	scheduling currently underway

	Q3-Q4,2016	Q1-Q2, 2017	Q3-Q4, 2017	2018	2019	2020	TOTAL
PROJECTED EXPENSES (IDN Network + IDN Projects)							
IDN NETWORK Expenses (Capacity Building)							
WORKFORCE							
CAPACITY BUILDING FOR DIRECT CARE OR SERVICE PROVISION:							
Recruitment & Hiring:	\$0	\$0	\$35,000	\$180,000	\$215,000	\$230,000	\$660,000
Retention:	\$0	\$0	\$40,000	\$210,000	\$245,000	\$260,000	\$755,000
Training:	\$0	\$0	\$45,000	\$200,000	\$230,000	\$250,000	\$725,000
Americorps Vista Community Health Worker staff (5)			\$5,625	\$22,500	\$22,500	\$22,500	\$73,125
New/expanded Partner Positions to Support Overall Network Goals							
Pediatric Psychiatry Consultation							
Emergency Licensed Mental Health Provider							
Same Day Access Clinical Services							
School/Youth Mental Health Integration Clinician							
			\$30,000	\$80,000	\$90,000	\$100,000	\$300,000
TOTAL	\$0	\$0	\$235,625	\$1,016,500	\$1,141,500	\$1,216,500	\$3,610,125
HIT INFRASTRUCTURE							
GIS Mapping Capabilities/Network Analysis Software/Support	\$0	\$0	\$5,000	\$10,000	\$5,000	\$0	\$20,000
Event Notification/& possible shared care plan Solution			\$30,000	\$114,000	\$114,000	\$114,000	\$372,000
Data Aggregator Solution (Vendor TBD - costs estimated)			\$230,000	\$50,000	\$50,000	\$50,000	\$380,000
Care Coordination Solution (Vendor TBD - costs estimated)			\$35,000	\$150,000	\$10,000	\$10,000	\$205,000
TOTAL	\$0	\$0	\$300,000	\$324,000	\$179,000	\$174,000	\$977,000
ESTABLISHMENT OF IDN ADMINISTRATIVE/MGMT. INFRASTRUCTURE							
Director of Population Health							
Director of Operations							
Finance Staff							
IT Staff - County							
IT Staff: IDN HIT/Data Architect							
IT Staff: IDN Director of Care Coordination							
Administrative Staff							
Longevity							
Accrued Benefits Expense							
Social Security							
Dental Insurance							
Health, Life & Disability Insurance							
Retirement							
Workers Compensation Insurance							
Unemployment Insurance							
Contracted Labor - Executive Director*							
Contracted Labor - Clinical Director							
Fees & Outside Services							
Audit	\$0	\$0	\$10,000	\$12,000	\$12,000	\$15,000	\$49,000
Photo Copy Expense	\$21	\$500	\$500	\$1,000	\$1,000	\$1,000	\$4,021
Office Supplies	\$95	\$2,000	\$1,000	\$2,000	\$2,000	\$2,000	\$9,095
Postage	\$0	\$500	\$600	\$1,200	\$1,200	\$1,200	\$4,700
Telephone	\$0	\$1,200	\$1,200	\$2,400	\$2,400	\$2,400	\$9,600
Travel & Mileage	\$372	\$3,000	\$3,000	\$6,000	\$6,000	\$6,000	\$24,372
New Equipment	\$3,970	\$5,000	\$3,000	\$3,000	\$1,000	\$1,000	\$16,970
Total	\$144,123	\$272,137	\$364,979	\$779,914	\$778,334	\$797,563	\$3,137,050
TOTAL IDN Network Capacity Building Expenses	\$144,123	\$272,137	\$900,604	\$2,120,414	\$2,098,834	\$2,188,063	\$7,724,175
IDN PROJECT Expenses							
	Q3-Q4,2016	Q1-Q2, 2017	Q3-Q4, 2017	2018	2019	2020	TOTAL
STATEWIDE PROJECTS							
A1 - Workforce	\$0	\$0	\$62,000	\$215,000	\$261,000	\$282,000	\$820,000
A2 - HIT	\$0	\$0	\$10,000	\$90,000	\$100,000	\$100,000	\$300,000
CORE COMPETENCY PROJECT							
B1 - Integration	\$0	\$0	\$148,500	\$935,000	\$852,000	\$624,000	\$2,559,500
COMMUNITY PROJECTS							
C1 - Care Transitions	\$0	\$0	\$80,500	\$452,000	\$553,000	\$553,000	\$1,638,500
D3 - SUD Expansion	\$0	\$0	\$82,000	\$409,000	\$493,200	\$493,200	\$1,477,400
E5 - Enhanced Care Coordination	\$0	\$0	\$64,300	\$371,200	\$468,400	\$468,400	\$1,372,300
TOTAL IDN Project Expenses	\$0	\$0	\$447,300	\$2,472,200	\$2,727,600	\$2,520,600	\$8,167,700
TOTAL: Network Expenses + Project Expenses	\$144,123	\$272,137	\$1,347,904	\$4,592,614	\$4,826,434	\$4,708,663	\$15,891,875
PROJECTED REVENUE (Base + Incentive)							
TOTALS							
Estimated Payments (base + performance incentives)	\$ 4,006,604	\$ 2,296,556.00	\$ 2,296,556.00	\$4,600,000	\$4,850,000	\$4,850,000	\$ 22,899,716
contingency for lower DSHP @ 15% of payment		\$ 344,483.40	\$ 344,483.40	\$690,000	\$727,500	\$727,500	\$ 2,833,967
Estimated Payment - Contingency	\$ 4,006,604	\$ 1,952,072.60	\$ 1,952,072.60	\$3,910,000	\$4,122,500	\$4,122,500	\$ 20,065,749
Running Balance of Revenue - Expenses:	\$3,862,481	\$5,942,418	\$6,146,585	\$5,463,971	\$4,760,037	\$4,173,874	

Project A1

Integration Workforce Development

Project A1: Behavioral Health Workforce Capacity Development

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

A1.2: IDN-level Workforce: Gap Analysis

The Region 6 IDN identified a number of workforce gaps and barriers during the Project Plan Phase completed in October 2016. Unfortunately, there is no one workforce role that, upon expansion, would instantly create adequate capacity to meet behavioral health integration needs in the Region 6 IDN.

Gaps and barriers were identified during development of the Statewide Behavioral Health Workforce Capacity Development Strategic Plan, through community needs assessment activities in Region 6, and through engagement with partners, providers and community members during conceptual development of the community projects selected by the Region 6 IDN. Critical issues that impact education, recruitment, retention and training include:

For Master Licensed Alcohol & Drug Counselors

- Licensing expense and reciprocity challenges impact the recruitment and retention of staff in CMHC, SUD and FQHC environments
- Cost and revenue implications required to provide or obtain clinical supervision are burdensome
- Dedicating time to coordinating/provide supervision decreases capacity to see clients
- Inefficient supervision situations impact cost for supervisors and time-to-completion for supervisees
- A historical lack of treatment options has resulted in decreased competence/confidence to adequately assess SUD treatment needs among some MLADCs. Re-education will be required for some providers to encourage appropriate referral to expanded treatment options not previously available.
- Extreme competition for MLADCs favors private SUD providers that pay higher wages.
- Multi-service agencies tend to seek LMHCs or LCSWs (some also with MLADC) due to broader range of billable services.

For Licensed Mental Health Counselors

- Cross-border reciprocity limitations with the border states of Maine and Massachusetts was consistently cited by the partners as a significant barrier to employment and practice catchment areas.

- Average LMHC salaries in CMHCs and other agencies that carry high ratios of Medicaid beneficiaries are very low compared to a) agencies that serve higher ratio of patients with commercial insurance, and b) agencies in nearby Massachusetts.

For Peer Recovery Coaches

- Like most partners, Peer Recovery partners cited a lack of funds for professional development budgets. Outside of hospital systems, partners have very limited in-house education capacity. As one of the newest sectors of the current healthcare workforce, professional development capacity is a critical need, yet the budgets of Recovery Community Organizations are not yet robust enough to cover the cost of MLAD supervision required for CRSW credentialing.
- Although three Recovery Community Organizations have emerged and are rapidly developing in Region Six, uncertainty around professional standards of practice, appropriate skills and experience, and reimbursement mechanisms hinder workforce development in this rapidly expanding sector. RCOs report very low yield among those people who participate in Recovery Coach Academies (40-hour training) who end up working regularly in Peer Recovery Support Services (PRSS). Currently, none of the 3 RCOs in our region are billing Medicaid for CRSW services.
- To be eligible for Medicaid billing for Peer Recovery Support services requires certification as a Clinical Recovery Support Worker (CRSW). There are numerous factors operating against a viable pipeline of new CRSWs in this field: 1) the large majority of PRSS trainees identify as volunteers and do not pursue CRSW, 2) among the very few PRSS volunteers who obtain CRSW, most are attracted to SUD treatment providers that are able to pay wages and benefits regardless of Medicaid billing, 3) the emerging field largely preserves a non-clinical identity and role, creating tension with pursuit of Medicaid reimbursement, and 4) Medicaid reimbursement rates for PRSS are perceived to be very low.
- Despite being non-clinical positions, PRSS workers can often have high contact and exposure to symptomatic behaviors and crisis situations that require considerable training and ongoing clinical supervision and support. This depth of training is not available or reimbursed in the CRSW pipeline, and agencies seldom have the requisite resources to provide clinical supervision.

For Other Front Line Providers

- A strong economy, especially in Rockingham County, drives up wages that are already higher than state averages due to the need to compete for staff with border states that can also offer lower housing costs. Significant economic disparity between the northern (Strafford County) and southern (Rockingham County) portions of the Region 6 IDN also present a challenge to workforce development.
- Low wages combined with the stressors of working in high intensity community environments with clients with complex needs and presenting behaviors leads to high rates of burnout, compassion fatigue and turnover.

Some themes were identified both within and across partner sectors during the Region 6 IDN analysis of Workforce gaps and barriers. Those include:

- The CMHCs cited an excessive regulatory paperwork burden that requires increasing administrative time in the face of stagnant or decreasing reimbursement. This burden increases care complexity, contributing to stress on the staff and higher caseloads.
- High housing costs and very low vacancy rates contribute to partner reports of difficulty recruiting and, in some circumstances, inability to retain staff. This is especially challenging in the more densely populated southern area of the Region 6 IDN in Rockingham County.
- Limited workforce is available for pediatric attributed members and their families to receive behavioral health care and support in school community based settings. Some schools have partnerships with mental health providers from CMHCs to provide limited counseling. Most do not. This is a significant unmet need.
- For many partners, administrative costs associated with the hiring process (recruiting/interviewing/staff time to interview, lost revenue due to open clinician position) are perceived as wasted when the process fails to produce a viable candidate or the candidate rejects an offer. Recruitment budgets are very tight and can't absorb multiple do-overs.

Despite the trends identified above and a variety of assessment efforts, gaps in specific clinical roles/positions within the Region 6 IDN could not be clearly quantified. This is due, in large part, to our partners' creativity and commitment to keep critical programs and services open despite less-than-ideal staffing ratios. Partners report that they re-assign staff, re-balance caseloads, and redistribute work so clinicians are encouraged to practice at the top of their license in response to staffing shortages. This flexibility makes the impact of position-specific gaps harder to quantify. Our partners report that credential-specific gaps in the workforce are difficult to assess because a) continuous turnover creates a dynamic workforce that operates against a static number of predicted positions, and b) demand is such that agencies often look for MLADCs and/or LCSWs and/or LCMHCs either as stand-alone or combined credentials and will accommodate any such qualified new staff accordingly.

One visible sign of the strain these gaps do have on agencies and across the system is increasing wait-times for services in Region 6, especially for emergency or acute behavioral health issues. As an entire team/practice/organization picks up the slack left by an open position, that increased workload slows productivity. The impact of this adjustment is significant, but solutions may be misapplied if only unfilled clinical/provider positions are considered in the measurement of workforce gaps.

Finally, while not traditionally considered health care partners, our law enforcement (police) partners have identified a training need for additional knowledge and skills to identify and respond to citizens who may have behavioral health conditions. While some police departments have formal partnerships with behavioral health providers, it is clear that there is unmet need for additional support for these partners and the people they serve.

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

The Region 6 IDN Workforce Implementation Plan has identified three significant strategies designed to close the gaps and surmount barriers to integrated care identified in section A1-2 above.

The first of these strategies is to directly recruit or support partner led recruitment to fill critical workforce roles that increase the region’s capacity to improve integration between behavioral and primary health care and improve outcomes for attributed members. Table A1.1 illustrates the critical positions identified by regional partners projected to be included in IDN recruitment efforts. It is the collective belief affirmed by Region 6 IDN partners, Executive Committee members, and staff that these specific roles will add capacity to regional efforts to serve attributed members with behavioral health needs across the care continuum.

Table A1.1 Strategy 1: Critical Workforce Roles to Develop Capacity Region-wide

Role/Capacity	Possible Hiring Entity
Pediatric Psychiatry Consultation	IDN/CMHC/Alt Vendor
School/Youth Mental Health Integration Clinician	BH Partner
Emergency Licensed MH Provider	CMHC/SUD or BH partner
Same Day Access Clinician	CMHC or BH partner
Director of Care Coordination	IDN

Strategy 1: Critical Workforce Roles

This section further describes the Region 6 specific response activities identified in Table A1.1

Recruitment to expand Pediatric Psychiatry Consultation capacity is strategy identified in response to overwhelming evidence of a gap in workforce qualified and/or engaged to serve youth within their communities, which are often schools. A number of models are under consideration to expand this capacity including HIT based communication (video-conferencing), 24/7 specialty group call-based availability, and embedded individual(s) employed by regional IDN partners who rotate service sites, whether those sites be school or primary care based.) Further model consideration will be informed by behavioral health partners including both the Seacoast and Portsmouth Youth WRAP Teams of diverse youth-involved partners and the IDN affiliated Clinical Advisory Team.

Regardless of the staffing and program models developed to increase regional network capacity to care for youth with severe and persistent mental illness and/or medical and behavioral health comorbidities, the Region 6 IDN recognizes that expanded partnerships with school communities will be necessary. That recognition led to the engagement of a consultant with experience facilitating school community and mental health collaboration, LICSW and psychotherapist Ben Hillyard, to co-lead the Clinical Advisory Team and provide strategic guidance to support the implementation of all plans with emphasis on E5 – Enhanced Care Coordination. One of Mr. Hillyard’s most important roles is knowledge transfer to clinicians and providers on the CAT regarding best practices to encourage family, school, and provider collaboration.

Recruitment of additional capacity in the Emergency Licensed Mental Health Provider and Same Day Access Clinician roles was deemed critical in response to gaps identified both in off-hour availability

and daytime flexibility and scope of mental health assessment and referral capacity. Law enforcement partners identified a frequently shared scenario in which police transport an adult to an Emergency Room for evaluation of what officers assess to be a significant mental health crisis, like suicidal ideation. Police report being regularly dispatched back to the hospital to pick up that adult after evaluation and treatment - often before they are back on duty after leaving the hospital.

That this experience is common and increasing in frequency suggests a number of conditions that the IDN Workforce Development project will attempt to impact. The first is that Law Enforcement employees may be over-assessing behavioral health risk and transporting clients for emergency services who may not be in crisis. This suggests a potential knowledge deficit the Region 6 IDN proposes to close with training and education. It also suggests that availability of field-based behavioral health clinicians after business hours may offer law enforcement staff an alternative to emergency room evaluation by being able to provide or inform far more timely assessments that consider many aspects of the unfolding situation that aren't present in an Emergency Room. Avoiding unnecessary transport avoids costs and restores capacity of receiving providers to see people who do need urgent care. The Region 6 IDN has budgeted for the implementation of a team based model of crisis intervention to respond to these gaps

The model within which these roles will add capacity is still under development, but will be different from other crisis and ACT teams in that they that will provide consultation upon request of community partners including Law Enforcement and because providers may continue a therapeutic relationship with members beyond emergency assessment and referral. This strategy is modeled on other crisis response teams that respond regionally in Law Enforcement like the Drug Task Force, SWAT, and HAZ-Mat teams.

Recruitment of a Director of Care Coordination will allow the IDN to consolidate oversight of multiple care coordination efforts across and between projects. The Director of Care Coordination will function as the air-traffic-controller for IDN affiliated care coordination, guiding, modeling, and overseeing development and improvement of practices and policies to inform transition and integration. This role is critical to the Region 6 IDN DSRIP effort because partners repeatedly acknowledged that clients may have multiple care/case managers/coordinators from different agencies working with them, but critical gaps were still happening because there was poor coordination of the coordinators.

Strategy 2a: Workforce Development: Region-Wide Capacity

The second strategy includes efforts, at both the regional and agency levels, to provide training, incentive funding and/or technical assistance for education, recruitment, retention, and professional development. A model of this second strategy, the Region 6 Workforce Implementation Plan, is presented in Attachment_A1 Region-wide initiatives in this plan include activities sponsored or facilitated by the IDN to increase workforce capacity across all regional IDN partners, regardless of sector or IDN project involvement.

One region-wide initiative identified in Attachment_B1.8b identifies all the IDN initiated/delivered/sponsored trainings open to all partners with commonly shared learning needs like Mental Health First Aid and Cultural Competence. The IDN recognizes that some training topics that are required/recommended for project specific key partner agencies may still be of interest to the community at-large and will make them available to all partners when resources and interest align.

Other examples of this initiative include IDN facilitation of Region-Wide Career Fair for partners to recruit workforce, an Integration Summit to share inter and intra-regional best practices, and the development of the Clinical Advisory Team. Clinical Advisory Team members receive an incentive

stipend, paid to their agency, to encourage broad sectoral involvement to address four important charges including:

1. Guiding development of the clinical protocols required by the 1115 Waiver Special Terms & Conditions
2. Informing and advocating for the vital training and use of enabling health information technologies
3. Providing expert review and informed analysis of any implementation and measurement concerns identified by the Operations team across the six projects that make up the IDN program
4. Assisting practices, in a coaching oversight capacity, to set goals and move forward along the integration continuum

Strategy 2b: Workforce Development: Specific Partner Capacity

The Region 6 IDN has identified 3 mechanisms by which partner agencies can receive workforce support to improve capacity to meet DSRIP goals specific to their agency's unique needs. In each mechanism, support is defined as incentive funding or technical assistance. These mechanisms are illustrated in Attachment_A1.3b.

The first mechanism allows support to be collaboratively identified and designed by agency and IDN Operations Team staff during A2, B1, C1, D3, or E5 project implementation. Agency specific Memorandum of Commitments (MOCs) detail project scope and commitments. Only key project partner agencies are eligible to receive support via this mechanism. Oversight for this mechanism includes Project specific Workgroup review of budget projections, MOCs, and expenditures and provide ongoing collective oversight. This mechanism allows support for new staffing to initiate IDN projects or current staffing for project support.

The second mechanism allows partner agencies to submit letters of inquiry for a specific support need (funding or technical assistance) related to workforce education/recruitment/retention/training. Requests are reviewed by Operations Team for fit and feasibility of award against budget and project goal parameters. Oversight includes regular IDN Executive Committee review of awards and provision of ongoing thematic guidance.

The third and final mechanism by which IDN partners may receive workforce capacity support allows partner agencies to respond to IDN published opportunities detailing support/scholarships available for specific training, recruitment, retention, or alternate workforce capacity development activities. The IDN Operations Team reviews opportunities for fit and feasibility with DSRIP goals and publishes selected opportunities believed to be in the best interest of IDN partners for selection. For example, the IDN anticipates requesting applications for support for a two day (Friday/Saturday) seminar titled "Working Together: Integrating Mental health and Medical Care" offered with CME by Harvard Medical School in November. This mechanism allows the IDN to make a variety of professional development opportunities available that would otherwise be cost or time prohibitive on a regional scale. Oversight of Operations Team management of this mechanism is provided via Executive Committee review of expenditures/awards and provision of ongoing thematic guidance. Of course, IDN partners are always

encouraged to submit or respond to requests for support in collaboration with same-sector or shared health neighborhood partners.

Strategy 3: Workforce Development: Project Capacity

Finally, the Region 6 IDN plans to increase workforce capacity to support DSRIP goals in Projects A2 (HIT), B1 (Integration), C1 (Care Transitions), D3 (SUD Expansion), and E5 (Enhanced Care Coordination). Table A1.2 identifies the positions projected for recruitment to support those projects. Detailed workforce development plans for these positions and the resources and strategies dedicated to support workforce education, recruitment, and retention for key participating project partners can be found in the project specific implementation plans in this submission.

Table A1.2 Roles anticipated to Enhance Project Specific Workforce Capacity

Project	Role/Capacity	Qty to be Recruited	Projected Hiring Entity
A2 - HIT	HIT/Data Architect	1	IDN
B1 - Integration	Integration Coach	2	IDN
C1 – Care Transitions	CTI Case Manager	Up to 6	IDN
C1 – Care Transitions	Licensed Clinical Mental Health Counselor	Up to 2	IDN
D1 – SUD Expansion	MLADC	Up to 2	SENHS
D1 – SUD Expansion	SUD Case Managers	Up to 6	SENHS
D1 – SUD Expansion	Clinical Supervision Consultation	Varies	SENHS
E5 – Enhanced Coordination	Clinical Care Coordinators	Up to 6	SCMH
E5 – Enhanced Coordination	Clinical Supervision Consultation	Varies	SCMH

Attachment_A1.3b

Region 6 Workforce Development Plan

Region Wide Initiatives



- Whole-Region Training
 - Mental Health First Aid
 - Cultural Competence
- Workforce Fair
- Integration Summit
- Clinical Advisory Team

Partner Specific Initiatives



Additional Region 6 IDN Mechanisms to Deliver Workforce Support to Partners	IDN Key Project Partners Eligible?	IDN Non-Project Partners Eligible?
1. Support (funding or technical assistance) is collaboratively identified and designed during project development and included in agency specific Memorandum of Commitments. Project specific Workgroups review budget projections, MOUs, and expenditures and provide ongoing collective oversight. This mechanism allows support for new staffing to initiate IDN projects or current staffing for project support.	YES	NO
2. Agency/Partner submits letter of inquiry for specific organizational need (funding or technical assistance) related to education/recruitment/ retention/training. Request reviewed by Operations Team for fit and feasibility of award against budget and project goal parameters. IDN Executive Committee reviews awards and provides ongoing thematic guidance.	YES	YES
3. Agency/Partner responds to IDN published opportunities for support/scholarship for specific training, recruitment, retention, or alternate workforce capacity development activity. IDN Operations Team reviews for fit and feasibility. Executive Committee reviews expenditures/awards and provides ongoing thematic guidance.	YES	YES

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of participating partner agencies who receive recruitment and/or retention support from the IDN.	10			
% of participating partner agencies receiving recruitment and/or retention support from the IDN who report positive	70% (or 7)			
# of participating partner agency staff who receive IDN sponsored training.	150			
% of participating partner agency staff who receive IDN sponsored training who report positive impact on knowledge or practice.	75% (or 113)			
# of eligible participating provider agencies who receive a stipend for staff participation on the Clinical Advisory Team	15			
# of Members Demonstrating Initiation of Alcohol and Other Drug Dependence Treatment	Target Pending Baseline Measurement			
# and % of new patient calls or referrals from other providers for CMHC intake appointment within 7 calendar days	Target Pending Baseline Measurement			
# and % of new patients for whom time between intake and first follow-up visit was 7 days or less.	Target Pending Baseline Measurement			
# and % of new patients for whom time between intake and first psychiatrist visit was 30 days or less	Target Pending Baseline Measurement			
Staff to support IDN infrastructure are recruited and retained:				
HIT/Data Architect	1			
Director of Care Coordination	1			
Pediatric Psychiatry Consultation	Up to 2			
Emergency Licensed MH Provider	1			
Same Day Access Clinician	1			
Behavioral Health Coordinator	1			
Staff to support IDN Projects are recruited and retained:				
B1: Integration Coach	2			
C1: Licensed Clinical Mental Health Counselor	2			
C1: CTI case manager	6			
D3: MLADC	2			
D3: SUD Case Managers	6			
D3: Clinical Supervision Consultation	0.5			
E5: Clinical Care Coordinators	6			
E5: Clinical Supervision consultation	0.5			

Baseline Measurement data projected to be received by Dec 31, 2017.

Baseline Measurement Data Sources include

1. MCOs (request pending)
2. Partner Providers (requests pending)
3. DHHS claim/utilization data (to be requested if data from sources #1 & #2 cannot be procured)

Targets projected to be set by Jan 31, 2017 and provided with next Semi-Annual Report.

A1.5: IDN-level Workforce: Staffing Targets

The Region 6 IDN has identified the following staffing targets intended to develop regional capacity to meet project goals.

Provider Type & Project Association (I = Infrastructure, B1 = Integrated Healthcare, C1/D3/E5 = Community Projects)	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Director of Care Coordination (I)	1	0			
Administrative Assistant (I/B1)	Up to 2	0			
HIT/Data Architect (I)	1	0			
School/Youth Mental Health (I) Integration Clinician	Up to 0.2	0			
Integration Coaches (B1)	Up to 2				
Master Licensed Alcohol and Drug (D3) Counselor Navigators	Up to 2	0			
Licensed Mental Health Counselors (C1)	Up to 2	0			
Peer Recovery Coaches (n/a)	0	0			
Other Front Line Providers :					
Pediatric Psychiatry Consultation (I)	Up to 1	0			
Emergency Licensed MH Counselor (I)	Up to 1	0			
Same Day Access Clinician (I)	Up to 1	0			
Behavioral Health Coordinator (D3)	Up to 1	0			
CTI Case Manager (C1)	Up to 6	0			
SUD Case Manager (D3)	Up to 6	0			
Clinical Care Coordinator (E5)	Up to 6	0			
Clinical Supervision Consultation (D1/E5)	Up to 2	0			

A1.6 Workforce Budget

Budget A1 Workforce Development	Q3-Q4 2017	Q1-Q2 2018	Q3- Q4 2018	2019	2020	TOTAL
Infrastructure						
Director of Care Coordination						
Administrative Assistance						
HIT/Data Architect						
School/Youth Mental Health Integration Clinician						
Pediatric Psychiatry Consultation						
Emergency Licensed MH Provider						
Same Day Access Clinician						
Training/Education for Infrastructure workforce	5,000	20,000	30,000	55,000	60,000	170,000
Section Subtotal	126,000	291,000	326,000	676,000	704,000	2,123,000
Regional Capacity						
Mechanism 1 - Project Driven Support						0
Recruitment/Staffing	20,000	25,000	25,000	50,000	50,000	170,000
Retention	10,000	20,000	30,000	60,000	50,000	170,000
Training/Education	10,000	20,000	20,000	45,000	50,000	145,000
Mechanism 2 - Partner Driven Support						
Recruitment	5,000	30,000	40,000	90,000	95,000	260,000
Retention	20,000	50,000	50,000	120,000	140,000	380,000
Training/Education	15,000	30,000	40,000	80,000	80,000	245,000
Mechanism 3 - IDN Driven Support						
Recruitment	10,000	30,000	30,000	75,000	85,000	230,000
Retention	10,000	30,000	30,000	65,000	70,000	205,000
Training/Education	15,000	20,000	20,000	50,000	60,000	165,000
Operations						
Office Space	15,000	30,000	30,000	65,000	70,000	210,000
Furniture	5,000	10,000	10,000	10,000	10,000	45,000
Supplies/Materials/Equipment	10,000	10,000	10,000	25,000	25,000	80,000
Travel	2,000	10,000	10,000	26,000	27,000	75,000
Clinical Advisory Team	30,000	40,000	40,000	90,000	100,000	300,000
Workforce Development Initiatives to support sustainability of IDN investments	15,000	20,000	25,000	60,000	75,000	195,000
Administrative Mgmt Fees for Partners	15,000	25,000	25,000	75,000	75,000	215,000
Section Subtotal	62,000	105,000	110,000	261,000	282,000	3,090,000
						5,213,000

The budget above outlines projected workforce development costs in two categories – Infrastructure and Regional Capacity.

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

- Director of Care Coordination
- Administrative Assistant
- HIT/Data Architect
- School/Youth Mental Health Integration Clinician
- Pediatric Psychiatry Consultation
- Emergency Licensed MH Provider
- Same Day Access Clinician

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

The first mechanism, Project Driven Workforce support, provides support (funding or technical assistance) to individual partner agencies to meet collaboratively identified needs during project development for IDN Projects A2, B1, and Community Projects C1, D3, and E5. This funding may be designated to support workforce recruitment/position salaries, retention, training, or education needs associated with participation in one or multiple specific projects. This mechanism allows support for new staffing to initiate IDN projects or increase the capacity of current staffing to provide project support. Funding scope and partner commitments are negotiated during project development and reflected in agency specific Memorandum of Commitments. The IDN Operations Team has administrative oversight for this mechanism. Project specific Workgroups review budget projections, MOUs, and expenditures and provide ongoing collective oversight. The Executive Committee reviews budget expenditures quarterly. Community Project workforce staffing plans can be found in Sections C3, D3, and E3 (add pages).

The second mechanism, Partner Driven Workforce Support, creates a process for partners to request support (funding or technical assistance) for recruitment, retention, and education/training on a non-emergency basis for strategies that benefit integration efforts but are not otherwise provided by the IDN. To access this mechanism, any IDN agency/partner can submit a letter of inquiry for a specific organizational need related to education/recruitment/retention/training. Requests are reviewed by Operations Team for fit and feasibility of award against budget and project goal parameters. The IDN Executive Committee reviews awards and provides ongoing thematic guidance on a quarterly basis.

The third mechanism, Regional Capacity Building Workforce Support, enables IDN partners to receive support (funding or technical assistance) when they respond to IDN published opportunities for support/scholarship for specific training, recruitment, retention, or alternate workforce capacity development activities. This mechanism may also support development of and partner attendance at region wide IDN sponsored trainings that build workforce capacity beyond those trainings associated with

specific projects. The IDN Operations Team reviews opportunities and responses for fit and feasibility. The Executive Committee reviews expenditures/awards and provides ongoing thematic guidance.

The A1 Workforce Budget also includes funding for Operational expenses to support workforce development initiatives. This category includes funding for office space, furniture, supplies/materials/equipment, and travel for Infrastructure and Project staff.

The A1 Workforce Budget also includes funding to support stipends, travel, and other meeting, administrative and operational expenses associated with the work of the Clinical Advisory Team, a working advisory group comprised of acute and primary care provider-level representatives from our behavioral health (mental health and SUD), medical care, school, and community agency partners. The Clinical Advisory Team is considered a workforce development initiative of Project A1 because members will become expert resources on integration design and evaluation. For many, they will assume Champion or key support roles in their agencies during execution of the B1 and the Community Projects.

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

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

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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Frisbie Memorial Hospital	Hospital	A2, B1, C1, D3
Wentworth Douglass Hospital	Hospital	A2, B1, C1, D3
Portsmouth Regional Hospital	Hospital	A2, B1, C1, D3
Lamprey Health Care	FQHC	A1, A2, B1, C1, E5
Families First Health & Support Center	FQHC	A1,A2, B1, C1, E5
Goodwin Health Center	FQHC	A1, A2, B1, C1, D3
Community Partners	CMHC	A1, A2, B1, C1, E5
Seacoast Mental Health Center	CMHC	A1, A2, B1, C1, E5
Southeastern NH Services	SUD	A1, A2, B1, C1, D3
Frisbie Hospital Primary Care Practices (selected)	HBPC	A1, A2, B1, C1, D3
Wentworth Douglass Hospital Primary Care Practices (selected)	HBPC	A1, A2, B1, C1, D3
Portsmouth Hospital Primary Care Practices (selected)	HBPC	A1, A2, B1, C1, D3
Crossroads House Homeless Shelter	Soc Service	A1, A2, B1, C1, E5
Strafford County Corrections	Corrections	A1, A2, C1, D3
Rockingham County Corrections	Corrections	A1, A2, C1
ROAD to Recovery	SUD	A1,A2, D3
Cornerstone VNA	HomeCare	A1,A2, C1
Strafford CAP	Soc Service	A1,A2, C1
Granite/Seacoast Pathways	Peer Support	A1,A2, C1
Rockingham CAP	Soc Service	A1,A2, C1
Seacoast Youth Services	SUD	A1,A2, C1
City of Portsmouth Welfare	Soc Service	A1,A2, C1
City of Dover Welfare	Soc Service	A1,A2, C1
Safe Harbor Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
SOS Recovery Community Organization	Peer Recovery	A1, A2, C1, D3,E5
One Sky Community Services	Area Agency	A1,A2,E5
Hope On Haven Hill	Residential SUD Treatment	A1,A2,D3

COMMISSIONERS
GEORGE MAGLARAS, *Chairman*
ROBERT J. WATSON, *Vice Chairman*
LEO E. LESSARD, *Clerk*

STRAFFORD COUNTY
COMMISSIONERS

WILLIAM A. GRIMES
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TREASURER
PAMELA J. ARNOLD
COUNTY ADMINISTRATOR
RAYMOND F. BOWER

Integrated Delivery Network Administrative Lead Contract
Attestation Form

I, Nicholas Toungas, a representative of Region # 6, attest that I have reviewed and am in acceptance on behalf of Strafford County of the Statewide Workforce Capacity Development Strategic Plan as outlined in the New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver, IDN Process Measures Semi-Annual Reporting Guide for year 2 (CY2017) and Year 3 (CY2018), 2017-03-22 v.23

Nicholas Toungas
(Signature)

STATE OF NEW HAMPSHIRE

County of Strafford

The forgoing instrument was acknowledged before me this 24th day of July, 2017.

Jean L. Miccolo
(Notary Public Justice of the Peace)

(NOTARY SEAL)

Commission Expires: 1/14/2020



A1.9: Project Scoring: IDN Workforce Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A1-1	Participation in Statewide BH Workforce Capacity Taskforce Strategic Plan Activity	Table				
A1-2	IDN-level Workforce Gap Analysis	Narrative				
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Microsoft Project or similar platform				
A1-4	Evaluation Project Targets	Table				
A1-5	IDN-level Workforce Staffing Targets	Table				
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet				
A1-7	IDN Workforce Key Organizational and Provider Participants	Table				
A1-8	Review and Acceptance of Statewide BH Workforce Capacity Strategic Plan	Signed Attestation				

Project A2

Health Information Technology

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

A2.1: IDN Participation in Statewide HIT Taskforce

Statewide HIT Taskforce Participation	Yes/No
Participation in HIT Taskforce meetings	Yes
Participation in current state assessment	Yes
Completion of IDN member assessment of existing and scheduled HIT efforts and statewide report	Yes
Participation in the review of pertinent State and Federal laws	Yes
Participation in the creation of the gap analysis	Yes
Participation on work to achieve consensus on a set of minimally required, desired, and optional IT HIE infrastructure projects for IDNs to pursue	Yes

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

The Region 6 IDN identified gaps in health information technologies related to both infrastructure and culture across the region. Gaps were identified via review of responses to the MSLC HIT tool that informed the Statewide HIT Taskforce’s assessment and inquiries into current regional HIT capacity and community needs. Facilitated Partner discussions, key informant interviews, regional HIT workgroup meetings and select on-site HIT evaluations provided additional information about the challenges and opportunities facing implementation of the Project Plans in Region 6 IDN. These inquiries revealed qualitative and contextual understanding of the gaps and barriers affecting HIT integration for IDN partners in this project.

Key HIT gaps in both the infrastructure and culture in Region 6 are summarized below.

Infrastructure/Software:

- Differing levels of HIT utilization among mental health, primary care and hospital system providers
- Limited HIT utilization among SUD and SS providers
- Very limited/no HIT utilization among community and social service providers
- Variability in integration of in-house systems within Partner agencies
- Variability in integration of systems between Partner agencies
- Inconsistent use of client management tools by Partner agencies
- HIT product incompatibility results in decreased interoperability between current HIT Partner agencies
- Differing Inter- and Intra-agency reporting and regulatory requirements result in complicated agency IT networks and confound organizational capacity to contribute data to inform population level health

Culture

- Knowledge gaps around HIPAA, 42 CFR, and confidentiality constraints
- Limited IDN partner participation in NHHIO, the New Hampshire Health Information Organization
- Variable levels of Partner comfort and experience with information sharing
- Variability in data literacy, especially regarding Provider valuation and use of data at the individual, panel, and practice level

- Lack of clarity at the organizational and regional levels about how to assess data quality and how to collect, manage and report data to meet population health level goals leads to uncertainty about what types of HIT are necessary to do so.
- Limited electronic data exchange with Managed Care Organizations to inform care management/ improvement. Currently, data exchange is a very manual and cumbersome process for those health centers that are attempting to share.

The Region 6 IDN Implementation Plan includes investment in HIT solutions, training, and workforce to meet project objectives.

Objective 1: To reduce unnecessary use of inpatient and ED services, hospital readmissions and wait times, the Region 6 IDN plans strategic investment in HIT solutions that improve provider awareness of client utilization habits so clients at high risk of unnecessary use of inpatient and ED services can be targeted for proactive outreach and/or diversion. The use of an event notification solution will allow IDN partners to access information about attributed member admissions, discharges and transfers at all participating facilities, expanding situational awareness of member use patterns. The Region 6 IDN is currently exercising due diligence to evaluate event notification vendors for this required minimum capability.

The IDN anticipates that a shared care plan solution will improve communication and care coordination among regional partners to decrease the number of members readmitted to the hospital when members aren't able to maintain their health status upon discharge. Better care coordination and referral tracking will allow care team members to ensure that appropriate services and supports are actually activated, not simply recommended. The ability to more reliably track all the dates, times, and brief outcomes of an individual's clinical care and engagements with social service providers will promote better integration among those sectors by providing everyone a much more complete sense of an individual's circumstance and encourage more timely and accurate information exchange.

The Region 6 IDN is currently evaluating vendor options to provide this required minimum capability of a shared care plan solution, as regional use cases illustrate that a solution that is robust and expandable to social service partners is best suited to meet the needs of the mature care coordination strategies currently under development in Region 6. The Region 6 IDN anticipates that the shared care plan solution, properly scoped and implemented, will help decrease wait times for outpatient care because it will speed up communication across care team partners by clearly identifying roles and affiliations and better facilitate communication and information exchange between care team members who work on opposite shifts to ensure barriers to follow-up care are identified, shared, and collaboratively addressed.

Objective 2: The Region 6 IDN will make a number of investments in HIT to promote the integration of primary care, behavioral providers (mental health and SUD providers) and community based organizations. These investments include implementation of a shared care plan solution that facilitates care coordination between behavioral health, medical health, and social service providers, development of partner capacity to contribute data to a state-wide shared data aggregator, and development of training and technical assistance to increase partner/provider health literacy to use information available from the data aggregator, MCO partners, and other quality improvement initiatives to inform integration efforts.

Objective 3: The Region 6 IDN will build HIT capacity to support care transitions in a number of ways. Most importantly, IDN staff will utilize data from partners and the data aggregator solution to identify those attributed members who demonstrate or are at high risk of demonstrating frequent transitions. Frequent transitions from institutional care can be an indicator of inadequate discharge planning. The shared care plan/care coordination solution will allow care team members to access information about an attributed

member's vulnerabilities based on the Core Standardized Assessment results, allowing improved discharge planning within agencies and facilitating planning across agencies when indicated by care complexity.

The use of Direct Secure Messaging, another minimum required capability, will allow communication between primary care providers engaged in the Region 6 IDN's D3 project, Ambulatory detoxification, to communicate with project staff who coordinate and provide wrap around services to ensure participating attributed members can be supported through safe medical detoxification, which will result in increased accuracy of assessment for to determine the most appropriate next level of treatment.

Objective 4: The Region 6 IDN is investing in a number of HIT strategies to support alternative payment models. With the ability to receive, retrieve, organize, and present a variety of data formats in a variety of ways, a data aggregator will expand each IDN's ability to collect and analyze data from clinical and social service partners. This data is essential both to report on process and outcome measures for this DSRIP and to measure and monitor population health performance measures across the region. The data aggregator will allow analysis of large amounts of data that have not historically shared space together. As a result, new insights into our population's use of clinical and social services at the regional, partner, practice and provider level will drastically improve our ability to identify, resource and manage whole population health priorities. This capacity is essential to develop in support of alternative payment models, as a strong data informed evidence base is necessary to establish value and manage costs.

The Region 6 IDN anticipates that a shared care plan solution will support alternative payment models because it will allow better identification of value by monitoring outcomes against participation of key health and social service partners based on ability to track time involved in care coordination and closed loop referral success rates. In addition, access to both event notification information and Core Standard Assessment data can help inform risk stratification and the development of client engagement strategies to reduce unnecessary, ill-timed, or redundant care consumption.



**New Hampshire
Department of Health and Human Services**

**Building Capacity for Transformation Waiver
Integrated Delivery Network
Health Information Technology Implementation
Plan
IDN 6**

July 31, 2017

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1. Introduction

1.1 Purpose of Document

To support the New Hampshire Department of Health and Human Services (DHHS) Delivery System Reform Incentive Payment (DSRIP) Building Capacity for Transformation, Section 1115 Medicaid demonstration waiver, IDN Region 6 is participating in two statewide projects as defined in the Special Terms and Conditions (STC).¹ The second of the two statewide projects, *A2. Health Information Technology (HIT) Infrastructure to Support Integration*, required each IDN to develop this plan to deploy the HIT infrastructure required to support integrated, high-quality care throughout the region and, as resources allow, across the state.

This HIT Implementation Plan reflects an IDN-specific plan and timeline that align with the HIT Task Force's recommendations adopted on April 5, 2017. This HIT Implementation Plan is based on the IDN's assessment of current HIT capacity, community needs assessments², and extensive project planning. These regional assessments scanned partner capacity to use HIT to collect, exchange, evaluate and analyze data related to care management, process evaluation, and performance management.

1.2 Summary of Statewide Task Force Process

In addition to the overall goals of the demonstration project, an HIT Task Force including representatives for each IDN was formed to support the statewide planning effort. All IDNs were required to participate in the monthly, in-person HIT Task Force meetings. Facilitated by Myers and Stauffer, the HIT Task Force was charged with³:

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

In addition to the monthly HIT Task Force meetings, work sessions were established and conducted via WebEx and facilitated jointly by the elected Chairs of the HIT Task Force and Myers and Stauffer, LC. These work sessions were scheduled to occur weekly (if necessary) with the exception of the weeks in which an in-person HIT Task Force meeting was held. On average, a minimum of three (and up to 5) IDN Region 6 staff and/or partners participated in both the monthly in-person and weekly call-in sessions.

2. 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 consumer-focused entities. The results facilitated discussions on defining required, optional, and desired statewide HIT implementation priorities by the HIT Task Force and will inform the HIT Implementation Plan below.

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

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

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

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

The Region 6 IDN conducted a number of additional assessments to compliment the MSLC HIT tool and allow additional qualitative and contextual understanding of the gaps and barriers IDN partners face around HIT integration. Facilitated Partner Discussions, key informant interviews, regional HIT workgroup meetings and selected on-site HIT evaluations provided additional information about the challenges and opportunities facing implementation of the Project Plans in Region 6 IDN.

Key gaps and barriers in both the infrastructure and culture domains are summarized below.

Infrastructure/Software:

- Differing levels of HIT utilization among mental health, primary care and hospital system providers
- Limited HIT utilization among SUD and SS providers
- Very limited/no HIT utilization among community and social service providers
- Variability in integration of in-house systems within Partner agencies
- Variability in integration of systems between Partner agencies
- Inconsistent use of client management tools by Partner agencies
- HIT product incompatibility results in decreased interoperability between current HIT Partner agencies
- Differing Inter- and Intra-agency reporting and regulatory requirements result in complicated agency IT networks and confound organizational capacity to contribute data to inform population level health.

Culture

- Knowledge gaps around HIPPA, 42 CFR, and confidentiality constraints
- Limited IDN partner participation in NHHIO, the New Hampshire Health Information Organization
- Variable levels of Partner comfort and experience with information sharing
- Variability in how Providers value and use data at the individual, panel, and practice level
- Lack of clarity at the organizational and regional levels about how to assess data quality and how to collect, manage and report data to meet population health level goals leads to uncertainty about what types of HIT are necessary to do so
- Limited electronic data exchange with Managed Care Organizations to inform care management/ improvement. Currently, data exchange is a very manual and cumbersome process for those health centers that are attempting to share.

2.1 Statewide Key Findings

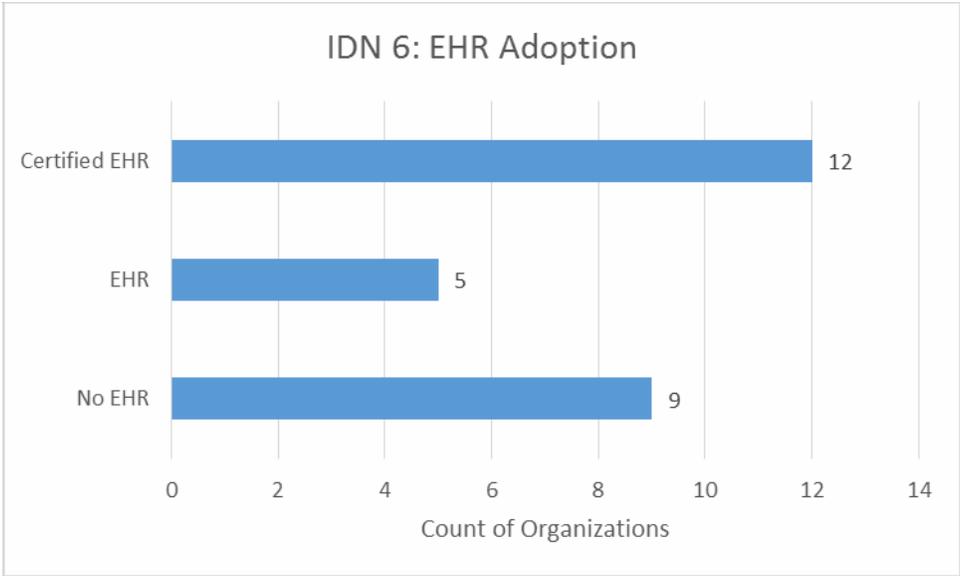
Key areas of HIT maturity were analyzed for every IDN region and included Electronic Health Record (EHR) adoption, Health Information Exchange (HIE) adoption, patient access to their health information, and the ability to track patient consents electronically. While HIT adoption was high for many traditional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

Key findings from the New Hampshire health IT assessment include:

- 1. Electronic health data capture capabilities are not widespread among IDN members.** While New Hampshire benefits from a high number of providers having adopted electronic health records (EHRs) at 74% of IDN members, there are several key provider types that have less than 60% adoption rate including SUD treatment organizations at 57%, community-based organizations at 48%, and public health organizations at only 33%.
- 2. Limited capabilities for electronic health data sharing throughout the state, but IDN members use available options.** Despite the limitations in electronic health data sharing among New Hampshire's providers, due in part to legislative restrictions, 48% of IDN member organizations are using or have plans to use Direct Secure Messaging (DSM) through the New Hampshire Health Information Organization (NHHIO).
- 3. Low rate of patient consents are captured electronically.** The ability to electronically capture patient consents still appears to be in its infancy among IDN members with only 21% of all responding organizations doing so. High adopters of health IT such as hospitals, community mental health centers, and federally qualified health centers (FQHCs) are all below 50% for collecting and storing patient consents by electronic means.
- 4. Patient referrals are mostly manual processes.** Sixty-one percent of IDN members responding to the assessment stated that patient referrals are performed manually by either fax, U.S. mail, or telephone. Only a small percentage of organizations, just 15%, are using DSM for referrals.
- 5. Patients have limited options to access their health information electronically.** Currently, only 28% of all IDN members responding to the Assessment Tool have a patient portal.
- 6. A higher than expected number of IDN members capture at least one social determinant of health data element.** While collection of social determinants of health data is fragmented and inconsistent across the health care continuum⁶, 62% of all IDN member respondents electronically capture at least one area of social determinants of health such as economic stability, education, food, community, and social context.
- 7. Funding is available to advance health IT in New Hampshire.** Several of the health IT-related needs identified by IDN members during the assessment and information gathering process may be funded through the Health Information Technology for Economic and Clinical Health (HITECH) Act administrative matching funds or other grant opportunities identified in this report.

2.2 IDN-Specific Findings

Figure 1. EHR Adoption

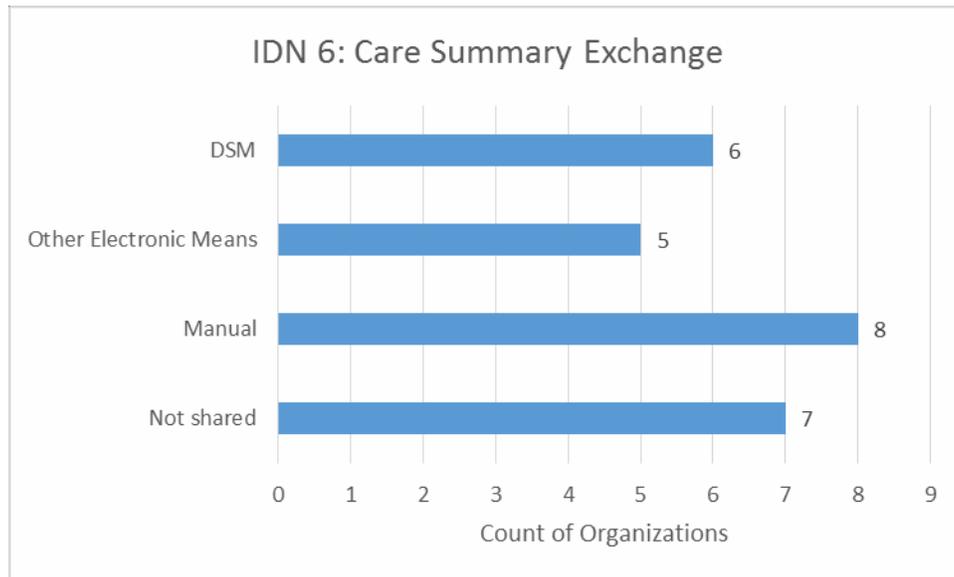


A total of twenty-six (n=26) organizations completed the HIT Assessment tool in Region 6. Of those respondents, twelve (n=12) organizations attested to having a certified EHR system and five (n=5) organizations attested to having a non-certified EHR system. Nine (n=9) organizations stated that they had no EHR system at all, which is not surprising given that guidance to distribute the HIT assessment to all partners resulted in a number of responses from social service and advocacy agencies. While they don't see patients and thus have no need for an EHR, the HIT assessment tool did provide a snapshot of their HIT capacity in other areas.

Ongoing evaluation of the role those partners play in adding value to client health outcomes is a critical part of our region's implementation work and informs our HIT planning.

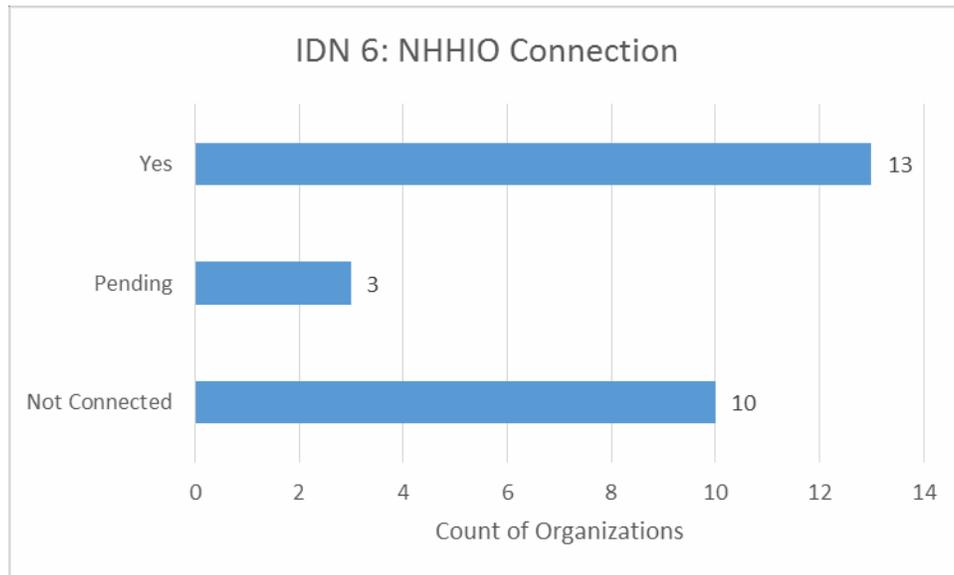
Of note, the Region 6 IDN EHR/HIT landscape is constantly shifting based on organizational needs and priorities that are independent of IDN efforts. One of the four hospital systems serving clients within Region 6 changed EHR vendors in May 2017. Two federally qualified health centers have announced that they will merge in the Fall of 2017. One of the region's two community mental health centers and all three of the region's federally qualified health centers anticipate a significant system upgrade in 2017. These shifts require constant communication and re-evaluation of implementation planning efforts. For example, the initial 'wave' of primary care practices expected to be included in the Region 6 B1 Core Competency Integration project has changed over the last 3 months to allow entire health systems (and individual practices within health systems) to stabilize their HIT environment because we heard very clearly from partners, understandably, that IDN efforts to introduce new HIT tools as part of practice or even work redesign during any concurrent significant organizational HIT initiative would decrease the likelihood that either/both would be successful.

Figure 2. Direct Secure Messaging



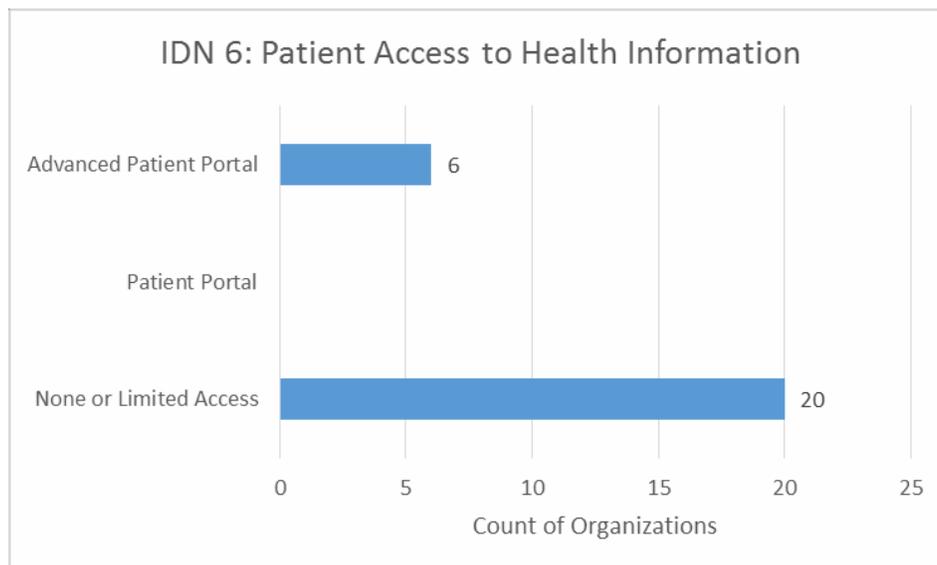
Limitations in electronic health data sharing among New Hampshire’s providers exist in part because of legislative restrictions. These legislative restrictions specifically limit the use of Direct Secure Messaging (DSM) services through the New Hampshire Health Information Organization (NHHIO). NHHIO has historically served as a Health Information Service Provider (HISP) with a statewide Healthcare Provider Directory (HPD) to support Transfers of Care. Due to these restrictions, NHHIO converted existing clients using the web-based Orion Health DSM platform to a new vendor Kno2 (<https://kno2.com/>) in early 2017. This shift was made to ensure clients have a strong platform moving forward, with a sustainable contract and support model in place that will not require the intervention of NHHIO, which is currently in the process of a mission and strategy redesign. Current vendors for statewide solutions to event notification and data aggregator products offer DSM capability. Many EHR vendors also provide DSM capability, so the Region 6 IDN will continue to exercise due diligence to identify the most feasible, appropriate and cost-effective DSM solution for our regional partners as upstream vendor decisions are made.

Figure 3. Electronic Health Data Sharing



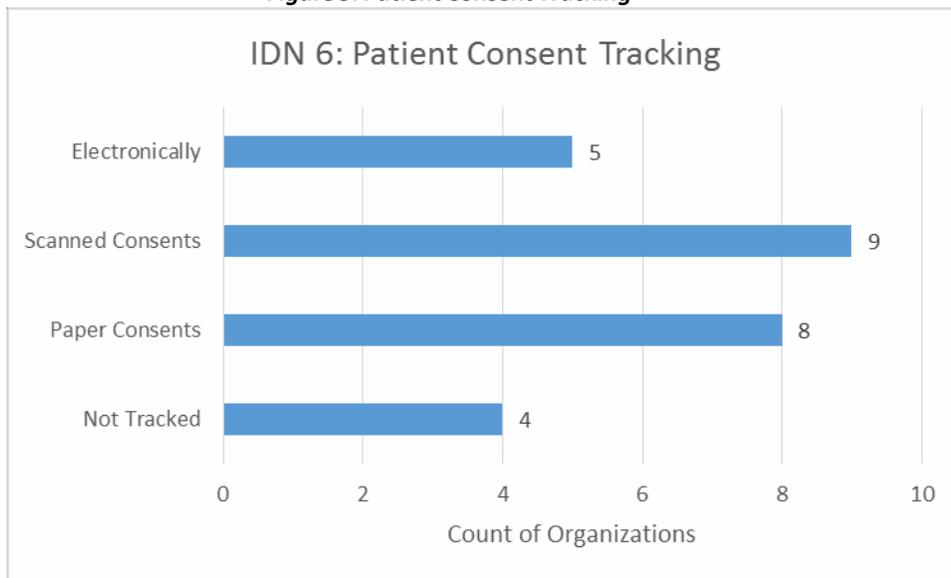
All organizations that completed the HIT Assessment tool were cross referenced with NHHIO’s official list of connected organizations. Thirteen (n=13) organizations in Region 6 were connected to NHHIO. An additional three (n=3) organizations reported that they were in the process of connecting to NHHIO. Ten (n=10) organizations were not connected or were not planning to connect to NHHIO. Since NHHIO is transferring direct services to other vendors in order to re-strategize, the Region 6 IDN will continue to evaluate options for basic sharing protocols like direct secure messaging to ensure organizations that are not yet connected can make informed capacity building decisions to meet the minimal HIT standards for participation in IDN efforts.

Figure 4. Patient Access to Health Information



Respondents were also asked about patient access to health information in the HIT Assessment. In Region 6, six (n=6) organizations reported availability of 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 group includes all 3 FQHCs and two of the four hospital systems in Region 6. Neither the two CMHCs nor the other two hospital systems in the region reported portal-like capacity for patient access to health information. This feature is usually available (for an additional cost) within the certified EHR platforms used by those partners so availability of a patient portal may be a business decision, more than a capacity/tool deficit. Finally, twenty (n=20) organizations reported that they do not provide a patient portal at all and provide limited access to their client information. This is to be expected given the preponderance of social service and advocacy providers in that group of respondents. The Region 6 IDN understands how important it is to create capacity to allow patients access to their health information, especially sensitive substance abuse records. This understanding is reflected in the subcontract the Region 6 IDN has engaged in with the Citizens Health Initiative, UNH Institute for Health Policy and Practice, and UNH School of Law to provide technical assistance around development of privacy protocols and practices to build this capacity.

Figure 5. Patient Consent Tracking



Another critical area for the waiver program is the processing and tracking of patient consents for treatment and information sharing. Already recognized as a statewide concern, it is imperative to define a standardized process to ensure patient care is not comprised across IDN Regional boundaries. In Region 6, five (n=5) organizations report that they capture patient consent information entirely electronically in an EHR system. Nine (n=9) organizations scan paper consents into an electronic system while another eight (n=8) organizations only capture consents on paper. Four (n=4) organizations do not track patient consents at all because they do not track PHI or provide services that require written consent. The HIT Taskforce determined that defining a statewide consent form and process should be a priority. A standardized consent form, while outside the scope of the HIT Taskforce, is within the scope of the privacy subcontract that 6 regions share with the CHI. Should a statewide standard be identified through that work, each region will be responsible for ensuring the infrastructure to enable sharing is implemented.

2.3 HIT Workforce Capacity

Workforce gaps in the Region 6 IDN can be recognized as two main categories. The first category is lack of qualified technical/HIT workforce staff. Gaps in this category result because experience managing/administering HIT on one vendor solution (like an EHR) rarely translates easily to a different EHR. Vendor specific products can require significant investment in proprietary knowledge development that is not easily transferable. Differences in agency HIT models and culture can make transferring HIT skills harder. Institutional HIT knowledge has outsized value for hospitals, so significant effort is made to retain staff. When a hospital system changes or deploys a new vendor, finding qualified staff can be a challenge.

Agency efforts to retain staff with expertise on one vendor/system/agency infrastructure can limit interoperability. Staff who don't change jobs are often unfamiliar with other regional HIT systems/capabilities. This gap certainly contributes to a lack of interoperability between same (EHR to EHR) products and complimentary (e.g. HMIS to EHR) products.

The second gap category includes a lack of adequate HIT/data literacy among clinical provider, clinical support, and social service providers. Many workers in these sectors are reluctant to adopt current HIT solutions due to a lack of familiarity and comfort with the technology. The perception that technology negatively impacts relationships with patients and clients also impacts willingness to adopt HIT into practice. This gap was first identified in conversation between Region 6 Operations team members and Managed Care Organization (MCO) representatives focused on identifying opportunities for collaboration. Staff from both NH Medicaid MCOs identified a gap in provider utilization of data and reports MCOs made available to them regarding their clients. Follow-up interviews with providers and MCO staff confirmed that, while MCOs did occasionally provide data to practices, it rarely went to the 'right' person at a practice, reports did not include data in a format that providers found informational or actionable, and communication between MCOs and most providers was limited to claims and reimbursement and did not address care coordination. The inability of medical and behavioral health staff to access, interpret, and/or apply data about their patients and their practice is a gap that the IDN must address to improve data informed integration and care coordination.

3. Health Information Technology Standards

IDN Region 6 collaborated with members of the Statewide HIT Taskforce Project to define and adopt minimum, desired, and optional health IT standards required for the demonstration project. These standards are described below.

3.1 Minimum, Desired, and Optional HIT Standards Definitions

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 STCs⁷, the identified statewide and local health IT standards are defined as either “Minimum,” “Desired,” or “Optional.”

- **Minimum** – standards that apply to all IDN participants except where provider type is defined in the Minimum Standards Table
 - Includes minimally-required technologies to ensure all participants are at a basic level in order to meet the overall HIT goals of the program.
 - Minimally-required technologies required for meeting the requirements of the statewide initiative, project B1: Integrated Health Care.
 - Each IDN will keep the HIT Task Force members informed on the progress for each minimum standard, along with required reporting to the state.
- **Desired** – standards that apply to only some IDN participants.
 - Includes more advanced technologies that may only apply to certain types of organizations
 - Identifies standards that are strongly encouraged but not required to be adopted by every IDN in order to meet the overall HIT goals of the program.
 - Applies, in some cases, to a statewide initiative or a regional initiative but will not arrest the advancement of the initiative, project B1: Integrated Health Care.
 - Each IDN will keep the HIT Task Force members informed on the progress for each desired standard, along with required reporting to the state.
- **Optional** – standards that apply to only some IDN participants
 - Not required but could better enable IDN members' ability to support the demonstration project goals.
 - Each IDN will keep the HIT Task Force members informed on the progress for each optional standard, along with required reporting to the state.

3.2 HIT Standards Tables

The following tables outline the minimum, desired, and optional standards for the statewide and local health IT standards required for the demonstration projects, as agreed upon and adopted by the HIT Task Force. As described above in the Process for Reaching Consensus section, standards in each table had extensive input from each IDN. Consensus was achieved on April 5, 2017 via an official, in-person vote with a response collected from each IDN.

Table 1. Minimum HIT Standards

New Hampshire Building Capacity for Transformation Waiver					
Health IT Minimum Standards					
Minimum Definition: Standards that apply to all IDN participants except where provider type is defined					
Capability & Standard	Description	Provider Type	Role of IDN	DSRIP Project	Rationale for Standard Classification
Data Extraction / Validation	Using a single vendor is an option for all IDNs; reporting metrics is mandatory - the distinction will be made in the implementation plans	All	Procurement and payment of a single collector for all IDNs. Assist organizations with transmitting data	All	All IDNs are required to report metrics
Internet Connectivity	Securely connected to the internet	All	Determine if they have it, do they need it?	All	
Secured Data Storage	Ability and knowledge to secure PHI through technology and training	All	Educate or assist organization with standards. Determine PHI at organization level	All	HIPAA regulations
Electronic Data Capture	Ability to capture and convert documents to an electronic format as a minimum.	All	Education of electronic data capture solutions including EHRs, certified EHRs, and other solutions. Assist in procurement	All	Capturing discreet data is essential for sharing and analyzing data for population health, care coordination, etc.
Direct Secure Messaging (DSM)	Ability to use the protocol DSM to transmit patient information between providers.	All	Education of DSM to organizations including use cases, assist in procurement	All	DSM establishes standards and documentation to support pushing data from where it is to where it's needed, supporting more robust interoperability in the future.

New Hampshire Building Capacity for Transformation Waiver

Health IT Minimum Standards

Minimum Definition: Standards that apply to all IDN participants except where provider type is defined

Capability & Standard	Description	Provider Type	Role of IDN	DSRIP Project	Rationale for Standard Classification
Shared Care Plan	Ability to access and/or contribute to an electronic shared care plan for an individual patient	Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment	Education of shared care plan to organizations including use cases, assist in procurement and payment	All	A shared care plan is a patient-centered health record designed to facilitate communication and sharing data among members of the care team, including the patient. A shared plan of care combines physical and behavioral health aspects to encourage a team approach to care.
Event Notification Service	Ability to receive notifications as a minimum for all organizations	Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment	Education of ENS to organizations including use cases, assist in procurement and payment	All, except B1 2017	An automated service that provides timely alert messages when patients are discharged from a hospital or emergency department. Delivers alerts about a patient's medical services encounter to an authorized recipient with an existing relationship to the patient.
Transmit Event Notification Service	Hospitals that have the ability to produce Admission, Discharge or Transfers (ADT) must transmit as a minimum	Hospital Facility	Ensure that organizations that produce ADTs are transmitting	All, except B1 2017	Leverage hospital generated ADT data elements for alerts to downstream clinical, behavioral and community providers

Table 2. Desired HIT Standards

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

Table 3. Optional HIT Standards

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

3.3 IDN Specific Standards

The Region 6 IDN intends to implement all Minimum standards as defined in Table 4.

Table 4. Implementation Plan for Minimum Required HIT Capabilities & Standards

Minimum Required Capabilities & Standards	Planned &/or Available Solutions
Data Extraction / Validation	via Data Aggregator (vendor selection currently underway)
Internet Connectivity	Rolling assessment & response as necessary
Secured Data Storage	Rolling assessment & response as necessary
Electronic Data Capture	via EHRs, Client Mgmt solutions, Care Coord solution,
Direct Secure Messaging (DSM)	via EHRs, Client Mgmt solutions, Care Coord. solution, other vendor/solutions as necessary (Kno2)
Shared Care Plan	via EHRs and solutions to be determined October-Dec 2017
Event Notification Service	To be determined October – Dec 2017
Transmit Event Notification Service	Via EHRs

The Region 6 IDN intends to implement the Optional standards of Integrated Direct Secure Messaging and Discrete Electronic Data Capture as defined in Table 2 with partners, as appropriate, pending procurement of a Care Coordination solution that will allow social service providers to connect with providers via DSM, electronic data capture and exchange, or similar proprietary solution. For those partners who require/desire DSM capability but are ineligible/unable to use the Care Coordination solution, a separate DSM solution (like Kno2) will be procured and implemented to allow them to meet the minimum requirement. The IDN will provide support for partners committed to pursuing ONC Certified Electronic Health Records. Query-based exchange is not a priority standard in Region 6 at this time. While a desirable capability, implementation would likely require infrastructure and resources that are not available in the Region. In addition, other HIT solutions were determined

The Region 6 IDN is currently and will continue to evaluate the feasibility of implementing the following Optional standards (Table 3) as they apply to the projects selected and as resources and partner capabilities allow; Closed Loop Referrals, Secure Text, Data Analysis/Validation, Population Health Tool, Capacity Management Tools, Patient Engagement Technology. Two primary modes of this evaluation include Project B1 – the Integration Core Competency project, and the Community Projects C1, D3, and E5. The resources, capabilities and goals of partners participating in those projects will continue to be assessed to inform the implementation of Optional standards. The Region 6 IDN is currently participating in due diligence evaluation with vendors for Data Analysis/Validation and Population Health Tools.

4. Implementation Strategy

4.1 Future Vision

The Region 6 IDN anticipates that implementation of the minimum standards and select desired and optional standards identified by the HIT Taskforce will profoundly change the way information is created and exchanged, transforming the culture of communication in a number of ways that will impact care and address the goals of the waiver. Efforts to implement the minimum standards, especially direct secure messaging and event notification, will enable providers to better understand the resources and services their clients currently access and encourage proactive, anticipatory care coordination on a scale not currently possible due to a dearth of interoperable communication and information sharing solutions. Workforce development and investment efforts to implement select desired and optional standards, as identified in Section 3.3 above, will allow Region 6 IDN partners to move beyond exchanging data to organizing, structuring, processing, and interpreting that exchanged data so it becomes timely, meaningful and actionable information.

The Region 6 IDN has identified a number of HIT initiatives underway in the region that must be considered during implementation. These include an EHR vendor change in one partner hospital system that will result in newly standardized clinical, billing, and reporting systems across primary, acute, and specialty care providers, a merger of 2 FQHCs in the region that will involve some system integration at levels that have yet to be disclosed, an alliance between a partner hospital system and a Massachusetts hospital system that requires an as yet undisclosed level of HIT re-engineering and integration, and the redesign of proprietary client management system for Community Action Programs statewide. In consultation with a national academic research center, the Region 6 IDN is also evaluating the feasibility of exploring novel patient engagement technologies to better understand how wearable technology and fog-level computing solutions can be used as behavioral health care management and population health tools.

The Region 6 IDN envisions a future state of integrated behavioral and primary health care that incents a data literate workforce to leverage interoperable to meet the complex medical, behavioral, and social care needs of our attributed population.

4.2 Populations and Providers in Scope

Table 4.2 illustrates the projected framework the Region 6 IDN will use to assess HIT capacity and appropriate resources to ensure all participating providers are meeting appropriate Health IT minimum standards. It is important to support alignment in this implementation for all key traditional health care system sectors to improve capacity to exchange information and coordinate care across the network. It is also important to include, when appropriate, those social and community service providers who also participate in and contribute to network efforts to ensure attributed members have the information, skills and resources they need to be strong advocates and informed consumers of their own care. The DSRIP initiative demands that regions better understand the role social and community supports play in health

outcomes in order to transform systems. The Region 6 IDN will assess the contributions of those less traditional partners who are not currently reimbursed by Medicaid throughout the entirety of this project, as part of that attempt to better understand their impact. The Region 6 IDN implementation plan illustrates that these assessments are upcoming, and then will be ongoing. Future semi-annual reporting will identify those agencies and partners who are identified as included/excluded per the methodology in Table 4.2.

4.2 Populations and Providers in Scope				
Health IT Minimum Standards - Excluded Provider Types				
Minimum Definition: Standards that apply to all IDN participants except where provider type is defined				
Capability & Standard	Description	Provider Type Excluded	Rationale for Exclusion	Included Providers (Projected)
Data Extraction / Validation	Using a single vendor is an option for all IDNs; reporting metrics is mandatory - the distinction will be made in partner specific implementation plans	Any identified as a non-creator or non-collector of actionable data required to meet 1115 reporting metrics for attributed members.	Contract negotiations with statewide vendor for data extraction beyond minimum fields required to meet mandatory IDN reporting metrics have not been completed. May be cost or process prohibitive.	<ul style="list-style-type: none"> - Hospitals - Primary Care Providers - Mental Health Providers - SUD Providers - Community Care Team Partners
Internet Connectivity	Securely connected to the internet	None	None	All IDN Partners
Secured Data Storage	Ability and knowledge to secure PHI through technology and training	Any identified as a non-creator, non-receiver, or non-collector of PHI for attributed members.	Creation/development of capability to securely store data that won't exist is not a Region 6 IDN HIT priority.	All IDN Partners
Electronic Data Capture	Ability to capture and convert documents to an electronic format as a minimum.	None	None	All IDN Partners

<p>Direct Secure Messaging (DSM)</p>	<p>Ability to use the protocol DSM to transmit patient information between providers.</p>	<p>Any identified as a non- primary creator, receiver, or collector of patient information.</p>	<p>Region 6 IDN resources will be directed to the first/best creator, receiver, or collector of patient information to ensure preservation of core standard integrity. Providers maintaining redundant systems will be supported as resources allow and as network efficiencies indicate.</p>	<ul style="list-style-type: none"> - Hospitals - Primary Care Providers - Mental Health Providers - SUD Providers - Community Care Team Partners
<p>Shared Care Plan</p>	<p>Ability to access and/or contribute to an electronic shared care plan for an individual patient.</p>	<p>Any identified as NOT providing individual; behavioral care, primary care, care/case management, or social services for attributed members.</p>	<p>The Region 6 IDN includes individual and agency subject matter expert partners. Those partners who do not provide care to individual patients do not require the capacity to share what they do not do.</p>	<ul style="list-style-type: none"> - Hospitals - Primary Care Providers - Mental Health Providers - SUD Providers - Community Care Team Partners
<p>Event Notification Service</p>	<p>Ability to receive notifications as a minimum for all organizations.</p>	<p>Any identified as NOT providing individual; behavioral care, primary care, care/case management, or social services for attributed members.</p>	<p>The Region 6 IDN network includes individual and agency subject matter expert partners. Those partners who do not provide care to individual patients do not require the capacity to receive information about people they do not serve.</p>	<ul style="list-style-type: none"> - Hospitals - Primary Care Providers - Mental Health Providers - SUD Providers - Community Care Team Partners
<p>Transmit Event Notification Service</p>	<p>Hospitals that have the ability to produce Admission, Discharge or Transfers (ADT) must transmit as a minimum.</p>	<p>Any not identified as hospitals.</p>	<p>Non-hospital providers do not currently produce data equivalent to ADT files.</p>	<ul style="list-style-type: none"> - Wentworth Douglass Hospital - Frisbie Memorial Hospital - Portsmouth Regional Hospital

4.3 Priorities

The Region 6 IDN envisions a future state of integrated behavioral and primary health care that incents a data literate workforce to leverage interoperable to meet the complex medical, behavioral, and social care needs of our attributed population.

Priorities for the Region 6 IDN include participating in the creation of a robust and flexible HIT architecture at the state level to facilitate reporting and data sharing with state and regional partners, developing regional partner capacity to contribute and consume quality data through that architecture, and driving evolution of communication culture across the region to encourage exchange of information with between those partners who most influence outcomes and value in an integrated health model for attributed members.

The Region 6 IDN is participating in creation of a statewide roadmap for HIT architecture as the statewide HIT taskforce evolves. Efforts to increase regional partner capacity to contribute and consume data include assessing partner capacity to meet minimum and desired standards and collaboratively creating development plans with them, focusing within the context of the B1 and community projects whenever possible. These efforts also include training and education to increase partner knowledge and understanding of health data, especially how to get it, read it, and apply it to improve patient, panel and practice outcomes.

In an effort to transform the culture of communication required to deliver sustainable integrated care, the Region 6 IDN is committed to help partners implement the minimum standards and select desired and optional standards identified by the HIT Taskforce. Pursuit of these standards will profoundly change the way information is created and exchanged, transforming the culture of communication in a number of ways that will impact care and address the goals of the waiver. Efforts to implement the minimum standards, especially direct secure messaging and event notification, will enable providers to better understand the resources and services their clients currently access and encourage proactive, anticipatory care coordination on a scale not currently possible due to a dearth of interoperable communication and information sharing solutions. Workforce development and investment efforts to implement select desired and optional standards, as identified in Section 3.3 above, will allow Region 6 IDN partners to move beyond exchanging data to organizing, structuring, processing, and interpreting that exchanged data so it becomes timely, meaningful and actionable information.

4.4 Technology

4.4 Technology					
Capability & Standard	Planned Outreach	Education/Training	Procurement/Vendor Selection	OnBoarding	Workflow Design
Data Extraction / Validation	<p>By Identification of eligible providers/partners in order of priority:</p> <ol style="list-style-type: none"> 1. Project B1/C1/D3/E5 Participation rosters 2. Review of attributed member utilization data from DHHS 	<p>Agency, site and individual education ongoing re: technical capabilities per vendor guidance and business/reporting needs.</p> <p>Health Data Literacy training will be available to providers (and staff) based on available practice/provider level reports, to be determined based on selected vendor capabilities.</p> <p>IDN to audit via quality review of reporting/extractions to ensure capability is</p>	<p>Procurement process underway. Multiple vendor demonstrations reviewed by HIT Taskforce. Statewide data aggregation vendor to be recommended by HIT Taskforce after next round of demonstrations.</p>	<p>Per selected vendor recommendations. Ongoing quality oversight maintained by IDN Clinical Advisory Team via dashboard review.</p>	<p>Per selected vendor recommendations. IDN anticipates initial workflow design assessment will be led by vendor. Subsequent workflow design will be led by Partner agency in collaboration with vendor and IDN HIT/Population Health/Operations/Clinical staff. Ongoing technical support will be led by the Vendor, with IDN coordination and collaboration as necessary.</p>
Internet Connectivity	<p>Survey of any IDN partners who are new and/or did not affirm capability exists during initial HIT assessment</p>	<p>IDN Ops Team, Project team, or delegate to review importance of internet connectivity relative to IDN communication and information exchange priorities with partner leadership/IT staff and provide contact information for vendors, if necessary. No audit indicated.</p>	<p>None anticipated. Procurement process and vendor selection under purview of partner agency as a business function.</p>	<p>Per selected vendor recommendations.</p>	<p>Limited IDN involvement for specific capability. Advanced utilization informed by degree of participation in order of:</p> <ol style="list-style-type: none"> 1. IDN projects 2. IDN Community Care Team 3. Core Standardized Assessment

<p>Secured Data Storage</p>	<p>Assessment of partner capability in order of priority: 1. Project B1/C1/D3/E5 Participation rosters 2. CHI Integration Self-Survey Assessment respondents 3. Partners contributing to Core Standardized</p>	<p>IDN Ops Team, Project team, or delegate to review best practices to meet and maintain standard via on-site sessions with HIT/IT/project staff or delegate. IDN to audit annually to ensure capability to protect PHI is maintained.</p>	<p>None anticipated. Procurement process and vendor selection under purview of partner agency as a business function.</p>	<p>Per selected vendor recommendations.</p>	<p>Limited IDN involvement for specific capability. Assistance with advanced architecture may be provided based on need informed by degree of participation in 1. IDN projects 2. IDN Community Care Team 3. Core Standardized Assessment</p>
<p>Electronic Data Capture</p>	<p>Survey of any IDN partners who are new and/or did not affirm capability exists during initial HIT assessment</p>	<p>IDN Ops Team, Project team, or delegate to review best practices to meet and maintain standard in on-site sessions with HIT/IT/project staff or delegate. IDN to audit annually to ensure capability is maintained.</p>	<p>Procurement process and vendor selection under purview of partner agency as a business function. Limited assistance may be provided by IDN.</p>	<p>Per selected vendor recommendations and Project team expertise upon request.</p>	<p>IDN to maintain situational awareness of certified EHRs in use within network. When indicated, IDN Ops or Project Team staff or delegate will provide consultation/review to ensure all PHI is protected per recommended privacy standards currently under development via multi-region contract with CHI/UNH Law.</p>
<p>Direct Secure Messaging (DSM)</p>	<p>Assessment and development of partner capability in order of priority: 1. Project B1/C1/D3/E5 Participation rosters 2. Community Care Team participation 3. Contribution Core Standardized Assessment</p>	<p>IDN Ops Team, Project team, or delegate to review best practices to meet and maintain standard in on-site sessions with HIT/IT/project staff or delegate. IDN to audit annually to ensure capability is maintained.</p>	<p>Procurement process and vendor selection is currently under evaluation. IDN to assist with procurement, use training, and infrastructure support.</p>	<p>Per selected vendor recommendations and Project team expertise upon request.</p>	<p>Per selected vendor recommendations. IDN anticipates initial workflow design assessment will be led by vendor. Subsequent workflow design will be led by Partner agency in collaboration with vendor and IDN HIT/Population Health/Operations/Clinical staff. Ongoing technical support will be led by the Vendor, with IDN coordination and collaboration as necessary.</p>

<p>Shared Care Plan</p>	<p>Assessment and development of partner capability in order of priority: 1. Project B1/C1/D3/E5 Participation rosters 2. Community Care Team participation 3. Primary Care or Behavioral Health care management with social service involvement 4. Primary Care or Behavioral Health care</p>	<p>Educate partners to use shared care plans and to educate patients about shared care plans.</p>	<p>Procurement process underway. Multiple vendor demonstrations reviewed by HIT Taskforce. Shared Care Plan utility is being evaluated in multiple solution categories due to extensive multi-capability crossover in current market. Region 6 IDN is exploring solutions with IDN Region 4 that deliver a shared care plan solution in the context of desired and/or optional standards identified by the HIT Taskforce for expanded transformational capacity.</p>	<p>Coordinate onboarding timeline to ensure continuity of operations in high- priority projects to maximize solution development. <i>(Use it first in project(s) it most informs until its well tweaked, then scale out)</i></p>	<p>Coordinate development of clinical protocols, patient handouts, and use cases to guide efficient,</p>
<p>Event Notification Service</p>	<p>Assessment and development of partner capability in order of priority: 1. Project B1/C1/D3/E5 Participation 2. Community Care Team participation 3. Delivering care/case</p>	<p>Procure solution. Oversee On-Boarding. Audit use cases.</p>	<p>HIT solutions to receive and make meaningful use of event notification data are currently being investigated by the IDN HIT Taskforce.</p>	<p>Per selected vendor recommendations. Ongoing quality and utility oversight maintained by IDN Clinical Advisory Team via dashboard review, record audit and provider survey.</p>	
<p>Transmit Event Notification Service</p>	<p>Targeted inquiry/consultation with partner organization leadership/clinical IT staff to identify current protocols within IDN participating hospitals.</p>	<p>Dissemination of recommended standard timeframe for capability. IDN to audit frequently to ensure transmissions are sent and received via to be determined solution(s).</p>	<p>The IDN anticipates that transmission of event notification data will require no additional solution procurement beyond current hospital business system capacity.</p>	<p>Per selected vendor recommendations.</p>	

4.5 HIT Workforce Capacity

Two specific roles have been identified to close two of the most significant HIT gaps identified in Region 6. The first gap is in data sharing capacity across the region. This gap exists due to a current lack of interoperability between some (EHR to EHR) products and complimentary (e.g. HMIS to EHR) products. The first role, a Data/HIT Architect, will coordinate the design and delivery of a framework to support the integration of multiple new solutions to be implemented across the Region as required by the IDN project. These solutions, including event notification and data aggregation, will require technical expertise to plan and manage alignment with each other and with other HIT systems currently deployed in partner agencies.

The second HIT oriented role necessary to meet the region's goals is a Population Health Coordinator. This position was identified in response to conversation between Region 6 Operations team members and Managed Care Organization (MCO) representatives focused on identifying opportunities for collaboration. Staff from both NH Medicaid MCOs identified a gap in provider utilization of data and reports MCOs made available to them regarding their clients. Follow-up interviews with providers and MCO staff confirmed that, while MCOs did occasionally provide data to practices, it rarely went to the 'right' person at a practice, reports did not include data in a format that providers found informational or actionable, and communication between MCOs and most providers was limited to claims and reimbursement and did not address care coordination. Behavioral health providers reported slightly better access to and information from managed care representatives, but noted that behavioral health needs are often managed by a contracted administrator or specialty sector of the MCO. This position will support increasing health related data literacy among our partner practices via data analysis technical assistance, support for training in data analysis and population health management, and coordination of those HIT solutions that are intended to support population health management, like a care coordination software.

The Region 6 IDN will expand what has been to date an intentionally lean regional HIT Taskforce in order to inform the next phase of implementation. All participating hospitals have CIOs, in some cases those roles are filled by medical/clinical providers. In other partner agencies the chief information officer role is fulfilled by someone with additional duties, like a CEO or COO. Unsurprisingly, there is a correlation between complexity of current HIT infrastructure and seniority/quantity of positions allocated to support it among our partners. Some social service providers have no dedicated IT staff and report outsourcing their HIT infrastructure and technical support needs to 3rd parties. It is unclear how those relationships may impact IDN efforts at this time. Further assessment will be done as part of a regional environmental HIT scan in the 3rd and 4th quarters of 2017. The refreshed HIT Taskforce will include CIOs, IT and tech support staff, and population health/data analysis/quality improvement staff, some of whom will be identified to serve as liaisons, with the Director of Population Health for Region 6, to the region's Clinical Advisory Team.

While the Region 6 IDN Operations team, Director of Population Health and HIT Architect will maintain daily oversight of HIT implementation efforts in collaboration with partner agency IT staff, the HIT Taskforce, Clinical Advisory Team, respective practice teams in Project B1, and all 3 community project workgroups will receive regular dashboard-style updates on the progress and performance of implemented solutions.

5. Governance

A 15 member Executive Committee serves as the lead governance entity for the DSRIP initiative in the Region 6 Integrated Delivery Network. The Strafford County Commissioners provide contract and administrative oversight as representatives of the Region 6 Administrative Lead agency, the Strafford County government. The Chair of the Strafford County Commissioners also serves as the IDN Executive Committee Chair.

The day-to-day work of the Region 6 IDN is currently overseen by an Executive Director and managed by an Operations Team comprised of the Executive Director, a Director of Operations, a Director of Population Health, a Clinical Director, a Finance Director, and a Project Coordinator. Both the Executive Director and Director of Population Health sit on the HIT Taskforce, which makes assessments and recommendations regarding planning, procurement, and implementation that the Operations Team reviews and, if necessary, brings to the Executive Committee for authorization/approval. The Region 6 IDN has submitted governance documents to DHHS describing the processes and organizational structure that inform project related governance. In brief summary, the Operations Team is responsible for facilitating diverse working groups of partner members to reach consensus on the identification of priority populations, projects, and plans. The Operations Team presents those priorities to the Regional All-Partner group for review at least twice a year. The Executive Committee informs, accepts and authorizes those priorities and the budgets that accompany them with a majority vote. The Executive Director is the designated member of the Operations Team accountable to the Executive Committee. The Executive Committee also reviews IDN expenditures at least quarterly to ensure fidelity to identified priorities is maintained. Finally, the Strafford County Commissioners, as the Region's Administrative Lead Agency, approve and accept the overall DSRIP project budget annually with a unanimous vote required.

The Region 6 HIT Taskforce will be expanded beginning in the 3rd quarter of 2017 to include CIO, data/informatics/network architects, HIT security experts, IT support, population health and quality improvement staff from all interested partner agencies, with specific sector representation invited from hospital, FQHC, CMHC, SUD and hospital based primary care partners.

6. Major Milestones

Major HIT project milestones are included in the table below. Additional detail can be drawn from Section 4; Implementation Strategy and/or Section 9.2: Detailed Implementation Plan Timeline in this document.

Major HIT Project Milestones	12/31/17	3/31/18	6/31/18	12/31/18
Data Aggregator Solution selected	X			
Direct Secure Messaging (DSM) options identified	X			
Direct Secure Messaging (DSM) initiated		X		
Event Notification <i>(transmitted & received)</i>		X		
Shared Care Plan exchange initiated		X		
Core Standard Assessment results reportable			X	
Core Standard Assessment results exchangeable				X
Care Coordination solution initiated		X		

7. Top Risks

At the statewide DSRIP program level, risk identification was processed through consensus driven discussion at HIT Task Force meetings and work sessions. Region 6 participation in the HIT Task Force work was informed by regional HIT workgroup, Partner Discussion, and All-Partner meetings.

- Potential risks already identified by the HIT leads and the HIT Task Force participants include:
 - Many community-based member organizations are non-covered entities as defined by the HIPAA Omnibus Rule, meaning they are not required to be familiar with policies and procedures regarding Protected Health Information (PHI). To mitigate this risk, additional education may be required for those who may handle PHI at these organizations, or become covered entities. Not necessarily all community-based organizations will have access to PHI or other sensitive information.
 - Some IDN member organizations lack any IT infrastructure today and are more susceptible to not meeting the standards.
 - While many IDN member organizations from each region participated in the HIT Taskforce, not everyone was represented. Some regions did not have their hospitals directly participate in the state level HIT Taskforce.
 - If the sharing of data consents is implemented, a standard outside of the scope of HIT must be realized.
 - The DSRIP program has a significant budget allocated for the implementation of the IDN's projects and health IT infrastructure over the course of the program; however, there is still a risk that not all IDN member health IT infrastructure projects will be fully covered by the budget because of other project priorities. Some financial reliance will be on the individual member organizations which could hamper implementation schedules over the course of the DSRIP program.
 - Because technology is constantly evolving, specifically in the shared care plan and event notification service areas, there is a risk involved when choosing a solution. Many vendors and solutions are relatively new and there is potential that more robust solutions evolve and vendors may need to change over time. A number of vendors provide solutions to more than one minimum standard, requiring extra diligence in the requirement and scope-setting process to ensure the vendor combination(s) that can deliver the most current and future value to the most providers to benefit the most patients are selected.
 - Cyber based threats to data security increase with every additional interface and shared connection. A robust security plan and frequent communication about and training in mitigation is critical to ensuring partners, providers, and patients have confidence in the IDN's HIT solutions and implementation plans.

Additional risks and potential mitigation strategies identified by the Region 6 IDN include :

Risks	Potential Mitigation Strategies
Low provider health literacy	<ul style="list-style-type: none"> - Hire Population Health Data Coordinator to support strategies to improve health literacy - Engage with MCOs to reformat actionable data
Lack of cost data	Pursue access to cost, claim, and utilization data to inform analysis and projections
MCO trepidation to partner for data sharing	Continue to develop working partnership to develop trust and define data sharing scope
Constantly evolving affiliations between partner organizations within/across regions that impact data systems and sharing	Perform continual environmental scan and charge HIT Taskforce to maintain situational awareness
High costs of interoperability with some products (like hospital EHRs) to protect market share for other solutions offered by same vendor	Perform due diligence in wide-market procurement efforts to identify creative and cost-effective solution partners.
Culture of impaired communication between providers due to (mis)perceptions of HIPAA restrictions	<ul style="list-style-type: none"> - Offer training and technical assistance to re-orient perceptions - Provide templates and best-practice recommendations for practice consideration around privacy and 42 CFR info management based on IDN Bootcamp knowledge base
Business models of many healthcare providers don't support adequate HIT workforce	Research and support implementation of shared solutions
Profoundly limited state HIT capacity to report reliable and current utilization data	Collaborate with DHHS, State of NH, and other HIT/Data stakeholders to develop capacity for data collection and management
HIT solutions to inform value-based care management and/or payment are at immature stage of development.	Participate in moving development forward via collaborative discussion, learning, and assumption testing through IDN regional projects
Lack of alignment between payment reform efforts for Medicare and Medicaid risk expensive, inefficient investment in non-interoperable clinical and population health solutions.	Design IDN community project implementations with as much fidelity to future interoperability as possible by investing in pursuit of ONC standards and increasing use of region and state wide solutions.
Low provider confidence in HIT solutions as tools to improve care outcomes and/or value.	<ul style="list-style-type: none"> - Support for additional training time (and trainings) to develop competence and thus confidence in use of HIT solutions. - Identification and dissemination of use cases that demonstrate added value of best practice HIT use
Competing initiatives at partner organizations	Maintain a commitment to transparency and equity in communication and implementation across the region informed by partner priorities and goals

8. Conclusion

This Implementation Plan reflects the Region 6 IDN’s understanding of and expectations for the work required to transform systems of care. The Plan outlines strategies to acquire, develop, deploy, and manage an array of HIT solutions to help partners attain and sustain the capacity to meet minimal, optional, and desired standards identified by the HIT Task Force that best support regional project goals. It is clear, however, that the most valuable component of this Region’s comprehensive strategy to improve data sharing among behavioral, medical, and social service providers across the continuum of care is not the expensive hardware and software. It is the culture change that comes from more efficient exchange of the right information at the right time, the right way, with the right people. This culture change is essential to the foundation of an integrated system designed to encourage coordinated, evidence informed care management for the whole person.

9. Appendices

9.1 Projects Selected by Each IDN

These project categories and requirements are *excerpts* from the New Hampshire Building Capacity for Transformation Attachment C: DSRIP Planning Protocol⁸.

Table 5. DSRIP Project and Participating IDNs

IDN Selected Projects							
IDN	B1	C1	C2	D1	D3	E4	E5
1	X	X			X		X
2	X		X	X			X
3	X	X			X	X	
4	X	X			X	X	
5	X		X		X		X
6	X	X			X		X
7	X	X			X		X

Core Competency Projects

- B1: Integrated Health Care (All IDNs)
 - Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest possible levels of collaboration/integration as defined within the Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare.

Community Driven Projects

The community driven projects are broken down into three categories and IDNs selected one project within each of the following projects:

- (C) Care Transition Projects
- (D) Capacity Building Projects
- (E) Integration Projects

(C)Care Transition Project

- C1: Care Transition Teams (IDNs 1, 3, 4, 6, and 7)
 - This project will follow the evidence-based “Critical Time Intervention” (CTI) approach to providing care at staged levels of intensity to patients with serious mental illness during transitions from the hospital setting to the community.

(D) Capacity Building Project

- D3: Expansion in Intensive Substance Use Disorder Treatment Options, including Partial Hospital and Residential Care (IDNs 1, 3, 4, 5, 6, and 7)
 - This project is aimed at expanding capacity within the IDN to deliver outpatient ambulatory substance detoxification in partnership with Southeastern NH Services (SUD Provider) and partner agency Primary Care providers.

(E) Integration Projects

- E5: Enhanced Care Coordination for High-need Populations (IDNs 1, 2, 5, 6, and 7)
 - This project aims to develop comprehensive care coordination/management services for high need youth with multiple physical health and behavioral health chronic conditions.

9.2 Detailed Project Plan

Please see Section A2.3 (p.36) and Attachment A2.3 (p. 67) for a detailed project plan description.

9.3 Member Organization List with Alignment to HIT Standards and Projects

This list will be updated as Project Implementation gets underway. For practices participating in B1 and all Community Projects, HIT capacity assessment is a required element to inform collaborative planning.

OrganizationName	Organization Type	Event Notific./ Shared Care Plan	Direct Secure Msg	Care Coord.	All Other Minimum Standards
Frisbie Memorial Hospital	Hospital	X	X	X	X
Wentworth Douglass Hospital	Hospital	X	X	X	X
Portsmouth Regional Hospital	Hospital	X	X	X	X
Lamprey Health Care	FQHC	X	X	X	X
Families First Health & Support Center	FQHC	X	X	X	X
Goodwin Health Center	FQHC	X	X	X	X
CommunityPartners	CMHC	X	X	X	X
Seacoast Mental Health Center	CMHC	X	X	X	X
Southeastern NH Services	SUD	X	X	X	X
Frisbie Primary Care Practices (to be selected)	HBPC	X	X	X	X
Wentworth Douglass Primary Care Practices (to be selected)	HBPC	X	X	X	X
Portsmouth Hospital Primary Care Practices (to be selected)	HBPC	X	X	X	X
Crossroads House Homeless Shelter	SocService	X		X	X
Strafford County Corrections	Corrections	X		X	X
Rockingham County Corrections	Corrections	X			X
ROAD to Recovery	SUD	(X)	(X)	(X)	(X)
Cornerstone VNA	HomeCare	(X)	(X)	(X)	(X)
Strafford CAP	Soc Service			(X)	(X)
Granite/Seacoast Pathways	Peer Support			(X)	(X)
Rockingham CAP	Soc Service			(X)	(X)
Seacoast Youth Services	SUD	(X)		(X)	(X)
City of Portsmouth Welfare	Soc Service	(X)		(X)	(X)
City of Dover Welfare	Soc Service	(X)		(X)	(X)
One Sky Community Services	SocService			(X)	(X)

X = planned

(X) = tentative/pending

¹ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 65.

² New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 68.

³ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 67.

⁴ <https://www.healthit.gov/standards-advisory/2016>

⁵ <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

⁶ <http://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html>

⁷ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 63.

⁸ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 69.

Attachment A2.3: IDN HIT/HIE: Implementation Plan, Requirements and Timeline

<u>A2 Project Implementation Plan</u>			Resp	12/31/17	12/31/17	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020	12/31/2020	Milestones/Deliverables
HIT Project Phase: Design/Procurement/Preparation												
Step 1	Participate in/perform selection due diligence with region/statewide solution Vendors		HIT/Ops		31-Dec							
	Event Notification - TBD											Event Notification vendor identified
	Data Aggregator - MAEHC											Data Scoping session held with vendor
	Shared Care Plan/Care Coordination - TBD											Shared Care Plan vendor selected
Step 2	Execute contracts with selected region/statewide solution vendors		IDN ED			31-Mar						
	Event Notification - TBD											Contract executed
	Data Aggregator - MAEHC											Contract executed
	Shared Care Plan/Care Coordination - TBD											Contract executed
Step 3	Engage region/statewide solution vendors in regional implementation planning		HIT/Ops		31-Dec							
	Event Notification - TBD											Implementation planning session held. Implementation plan collaboratively developed.
	Data Aggregator - MAEHC											
	Shared Care Plan/Care Coordination - TBD											
Step 5	Update/expand knowledge (list) of identified key HIT stakeholders in each partner agency		Ops		30-Nov							HIT Contacts & Champions List created and
Step 4	Perform HIT Environmental Scan of Region and Key Participating Partners to include assessment of ONC technology status, gaps to minimum standards, and capacity to assess/record/share/apply Core Standardized Assessment data		Ops									Environmental Scan complete for key stakeholders
	Regional Scan: Prioritizing Key partners participating in Community Projects											
	C1 - Frisbie Memorial Hospital					31-Jan						
	C1 - Community Partners					31-Jan						
	C1 - Crossroads House					31-Jan						
	D3 - Wentworth Douglass Hospital/Primary Care/Behavioral Health					31-Jan						
	D3 - Southeastern NH Services					31-Jan						
	D3 - Families First Health & Support Center					31-Jan						
	D3 - Goodwin Health Center					31-Jan						
	D3 - SOS Recovery Center					31-Jan						
	E5 - Seacoast Mental Health Center					31-Jan						
	E5 - Families First Health & Support Center					31-Jan						
	E5 - One Sky Developmental Services					31-Jan						
	Statewide - NH Hospital		HIT Taskforce		31-Dec							NH Hospital participates in Statewide HIT scoping session and HIT Taskforce
	Targeted Scan - Partners in Wave 1 of B1 Core Competency Project		Ops		31-Dec							
	Lamprey Health Care											HIT Scan completed
	Seacoast Mental Health											HIT Scan completed
	WDH Partner Practice											HIT Scan completed
	FMH Partner Practice											HIT Scan completed
	Targeted Scan - Partners in Wave 2 of B1 Core Competency Project		Ops/Integ Coaches			31-Mar						HIT Scans completed
	Targeted Scan - Partners in Wave 3 of B1 Core Competency Project					30-Jun						HIT Scans completed
	Targeted Scan - Partners in Wave 4 of B1 Core Competency Project						15-Aug					HIT Scans completed
	Targeted Scan - Partners receiving support to meet Regional Workforce Project goals				ongoing							Partner Profile completed for each agency with an A1 or A2 related Memorandum of Commitment
Step 5	Restructure and Expand HIT Team and establish meeting schedule		Ops		15-Nov							Restructured Team held initial meeting
Step 6	Hire HIT/Data Architect		Ops		31-Dec							HIT/Data Architect job description posted
Step 7	Assign HIT Team liaisons to support Clinical Advisory Team		Ops		30-Nov							Liaisons identified and oriented to CAT
HIT Project Phase: OnBoarding												
Step 1	Create HIT Roadmap to identify Region 6 HIT solutions to be implemented to support:											Roadmap planning meeting held, plan disseminated
	Regional HIT Infrastructure Goals				31-Dec							
	Regional Workforce Project Goals					31-Jan						
10/4/2017	B1 Core Competency Project Goals in 4 cohort Waves				31-Dec							67

			Wave 1		Project #1 Region 6 IDN	31-Mar						
			Wave 2			30-Jun						
			Wave 3				31-Aug					
			Wave 4				31-Oct					
		C1 Project Goals				30-Jun						
		D3 Project Goals				30-Jun						
		E5 Project Goals				30-Jun						
Step 2	Establish terms for partner Data Sharing Agreements			Ops								Data Sharing Agreement drafted
	Draft terms in HIT Team			HIT		15-Nov						
	Review Agreement terms during Collaborative Design Implementation Session											
	Implementation for B1 participating partners			Ops/ Integ Coaches								
			Wave 1			31-Dec						
			Wave 2				31-Mar					
			Wave 3				30-Jun					
			Wave 4					31-Aug				
	Review Agreements for other participating partners during Memorandum of Commitment process											Data Sharing Agreements executed
		Regional Workforce Project partners					ongoing					
		C1 Project Partners				15-Dec						
		D3 Project Partners				15-Dec						
		E5 Project Partners				15-Dec						
Step 3	Review and refine HIT budget to reflect Regional HIT Roadmap priorities					30-Jun		30-Jun		30-Jun		
	Region 6 IDN Executive Committee accepts budget					31-Dec		31-Dec		31-Dec		Exec Comm accepts budget annually
HIT Project Phase: Solution Implementation												
Step 1	Roll-out regional/statewide solutions to support Region 6 A1 workforce, B1 core											Partners meet minimum standards
	Regional Infrastructure Development					ongoing						Primary Care/Social Service partners identified to receive event notification
		Event Notification - TBD					31-Mar					Data aggregator able to receive partner data
		Data Aggregator - MAEHC				31-Dec						CCT Partners collaborating via shared care
		Shared Care Plan/Care Coordination - TBD					31-Mar					
Data Reporting												
	Semi Annual Reporting and document progress											Semi-Annual Reports submitted
	Period Ending 12/31/17					31-Jan						
	Period Ending 6/30/18						31-Jul					
	Period Ending 12/31/18							31-Jan				
	Period Ending 6/30/19								31-Jul			
	Period Ending 12/31/19									31-Jan		
	Period Ending 06/30/20										31-Jul	
	Period Ending 12/31/20										31-Jan-21	

The following details are provided regarding the Region 6 IDN HIE Integration Plan:

A2.3a: The Region 6 IDN's HIE integration plan includes the following IDN providers: 3 of the 4 region's hospital systems, both of the region's CMHCs, all of the region's community mental health providers that have been identified through DHHS data as providing care to more than 10 attributed beneficiaries annually, and the primary care and SUD providers that see a preponderance of attributed members. Plans include integration efforts with other IDN partners including two county nursing homes, two corrections facilities, developmental disability providers, family and peer support agencies, and other community and social support agencies like homeless shelters and both community action partnerships within Region 6. The HIE integration plan will include integration with both NH Hospital and DHHS according to the level of anticipated collaboration underway.

A2.3b: The Region 6 IDN's HIT implementation plan identifies processes through which participating partners will be assessed for utilization of ONC Certified Technologies. Processes vary based whether a partner is a key or supporting partner in an Integration (B1) or Community Project (C1, D3, E5) or is providing capacities outside of the project scopes. Upon completion of those assessments, the Region 6 IDN partners will adhere to the ONC's 2016 Interoperability Standards Advisory n efforts to increase capacity to utilizing ONC Certified Technologies and functions.

A2.3c: The Region 6 IDN's HIT implementation plan describes how HIT solutions are projected to support certain key population health management capabilities. Delays and challenges in meeting expected outcomes of the HIT Taskforce goals in the Spring of 2017 have resulted in many of those solutions to support individual and community risk assessments, care coordination and care management, health care transitions support, and quality measurement to be still under development. The Region 6 implementation plan reflects a commitment to continue to participate in, and in some cases, lead, procurement and development efforts to support health management capabilities.

A2.3d: The Region 6 IDN will incorporate the state-approved, interoperable standards for clinical and financial analytic systems' required inputs and outputs when the state identifies and approves them. The HIT implementation plan reflects ongoing Region 6 participation in the HIT Statewide Taskforce, the DSRIP Process and Performance Measures working group, and due diligence in procurement of solutions that will require identification of those standards for implementation.

A2.3e: The IDN's HIT implementation plan includes concepts and components that are designed to create strong and sustainable solutions to the HIT gaps identified in the Project Objectives in this document. Most notably, the Region 6 IDN envisions an interactive shared care plan solution to facilitate care coordination beyond static exchange of documents and point-in-time information. The Region 6 IDN anticipates procuring a Care Coordination solution, in partnership with 2 other IDN regions, that will allow coordination of care via sharing of care plans and via coordination of care coordinators through enhanced communication, task delegation, and client engagement. The coordination of care coordinators is not an element of the current minimum shared care plan standard, but Region 6 feels it is an essential component of an effective and value driven integrated system of care in this region.

The Region 6 IDN HIT Implementation Plan is included in this report, identified as Attachment_A2.3. Foundational elements of the Region 6 IDN HIT Implementation Plan include a revised environmental scan of current HIT capacity among our network partners, procurement and implementation of HIT solutions to improve care integration between medical, behavioral, and social service providers, and network capacity development to provide strong data informed practice and population health management to attributed members.

A2.4: IDN HIT: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of participating partners reporting access to a shared care plan solution	25			
# of participating partners reporting meaningful use of a shared care plan solution	20			
# of eligible participating partners utilizing ONC Certified EHRs (CEHRT)	16			
# of participating partners reporting contributions to data aggregator	20			
# of participating partners reporting access to event notification solution	16			
# of participating partners reporting meaningful use of event notification solution	10			
# of participating partner hospitals reporting ADT submissions to IDN associated event notification solution	3			
# of eligible participating partners utilizing ONC Certified technologies	18			
# of eligible participating partners capable of conducting e-prescribing	16			
# of eligible participating partners capable of creating and managing registries	16			
# of eligible participating partners able to electronically exchange relevant clinical data with others incl. NH Hospital	8			
# of eligible participating partners able to protect electronically exchanged data in a secure and confidential manner per state/federal and security laws	30			
# of eligible participating partners reporting client access to bidirectional secure messaging, records, appt scheduling, prescription and referral management	8			

A2.5: IDN HIT: Workforce Staffing

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
HIT/Data Architect	Up to 1.0	0.0			

Please refer to Attachment_A2.3, Section 4.5 – Workforce Capacity for additional information about the Region 6 IDN HIT Workforce Staffing plan.

A2.6: IDN HIT: Budget

Budget A2 Health Information Tech	Q3-Q4 2017	Q1-Q2 2018	Q3- Q4 2018	2019	2020	TOTAL
A2 HIT Network Expenses						
Solutions to Meet Standard Capabilities						
Event Notification & possible shared care plan	10,000	20,000	20,000	50,000	50,000	150,000
Data Aggregator Solution (Vendor TBD - costs estimated)	15,000	30,000	30,000	75,000	75,000	225,000
Care Coordination Solution (Vendor TBD - costs estimated)	35,000	75,000	75,000	10,000	10,000	205,000
GIS Mapping Capabilities/Network Analysis Software/Support	5,000	5,000	5,000	5,000	0	20,000
Section Subtotal	65,000	130,000	130,000	140,000	135,000	600,000
IDN HIT Project Expenses						
Enabling Technology						
Solutions to meet those minimum standards not identified above	10,000	20,000	20,000	50,000	50,000	150,000
Solutions to meet performance expectations not otherwise identified		25,000	25,000	50,000	50,000	150,000
Section Subtotal	10,000	45,000	45,000	100,000	100,000	300,000
TOTALS	75,000	175,000	175,000	240,000	235,000	900,000

The Region 6 IDN budget allocates funding to HIT solutions to meet minimum standard capabilities and build out network mapping resources. As HIT roadmapping, vendor selection and regional requirement scoping is not yet complete of as 7/31/17, the budget projections for these solutions may vary. The Region 6 IDN budget for this project also includes additional funding to support enabling technology. The IDN has allocated funds to solutions to meet the minimum standards (not otherwise identified above) as a contingency line to support partners to implement the solutions identified. These funds may be used (but are not limited to) additional solution training, ergonomic equipment, hardware to support implementation, and backfill for training time. Funding has been budgeted to accommodate any HIT/HIE solutions, training or equipment necessary to meet DSRIP performance expectations. These resources may be used (but are not limited to) to procure enhanced security solutions, upgrade information storage/exchange capacity, and incent partner participation in minimum solution implementation.

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

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

Specific key Hospital affiliated Primary Care Practices will be identified during Q3 & Q4 of 2017 as part of the B1 Core Competency project selection process. Please refer to Attachment_B1.2 for additional information about that project and process.

A2.8: IDN HIT: Data Agreement

Organization Name	Data Sharing Agreement Signed Y/N
Frisbie Memorial Hospital	In Process
Wentworth Douglass Hospital	In Process
Portsmouth Regional Hospital	In Process
Lamprey Health Care	In Process
Families First Health & Support Center	In Process
Goodwin Health Center	In Process
CommunityPartners	In Process
Seacoast Mental Health Center	In Process
Southeastern NH Services	In Process
Frisbie Primary Care Practices (selected)	In Process
Wentworth Douglass Primary Care Practices (selected)	In Process
Portsmouth Hospital Primary Care Practices (selected)	In Process
Crossroads House Homeless Shelter	In Process

The Region 6 IDN is in the process of developing data sharing agreements. It is premature to complete data sharing agreement discussions because not all statewide HIT solutions have been identified. Procurement specifications, technical requirements, onboarding timelines and exchange standards and protocols are still unknown. Vendor selection may influence the roster of organizations the Region 6 IDN develops data sharing agreements with due to capability expansion or limitation. Data agreements will address, at a minimum, all of the above, privacy and consent standards, and reporting standards.

A2.9: Project Scoring: IDN HIT Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A2-1	IDN Participation in Statewide HIT Taskforce	Table				
A2-2	IDN HIT/HIE Assessment and Gap Analysis	Narrative				
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Spreadsheet (Microsoft Project or similar platform)				
A2-4	Evaluation Project Targets	Table				
A2-5	IDN HIT Workforce Staffing	Table				
A2-6	IDN HIT Budget	Narrative and Spreadsheet				
A2-7	IDN HIT Key Organizational and Provider Participants	Table				
A2-8	IDN HIT Data Agreement	Table				

Project B1

Integration Core Competency

Project B1: Integrated Healthcare

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

Provide a narrative summarizing the results of the IDN's assessment and gap analysis of the primary care and behavioral health providers' current state of practice against the SAMHSA designation requirements and the Special Terms and Conditions. At a minimum, include the following:

- *Identification of gaps against the SAMHSA designation* requirements, and*
- *Steps and resources needed to achieve the designation(s) judged to be feasible by the provider and the IDN during the demonstration period. (p115)*

** Note: SAMHSA's designation of "Coordinated Care" and "Integrated Care" differ from the NH DSRIP STCs. While the SAMHSA framework should be used as a guideline, the IDN will be held accountable to the NH DSRIP designations.*

Summary

There is a gap between the level of integration within a local hospital, health center or community health center and the level of integration between these entities.

Currently all of our key partners meet the SAMHSA basic definition of early coordinated care. They identify patients with medical/behavioral needs and have working relationships with other agencies to refer to when needed. Each has internal treatment or care plans, however HIT interoperability limitations make sharing these plans a challenge. Community health centers typically have the ability to provide a higher level of integrated services on site than hospital practices or community mental health centers due to their more comprehensive mission and enhanced funding opportunities.

However, there are a number of key elements on the SAMHSA continuum and in the DSRIP requirements that can be developed or improved. We have divided the region into four "neighborhoods" which, if they increase their ability to work collaboratively they will be able to provide all required services together. The patient experience will be improved with a more seamless experience across the neighborhood.

To achieve integration, the IDN will need workforce resources including both the creation of new roles and the development of new knowledge and skills for a number of positions. Integration will also require culture change. Critical steps include the identification of regional health neighborhoods and the use of integration coaches within the neighborhood model to support culture change that will result in improved integration between neighborhood partners.

Practices have not historically been motivated to attain integration in this model because the reimbursement system has not incented it.

Process

We conducted a survey and followed up with 1:1 interviews key partners in Region 6.

They included Frisbie Memorial Hospital, Wentworth Douglas Hospital, Portsmouth Regional Hospital, Families First Community Health Center, Goodwin Community Health Center, Seacoast Community Mental Health Center, Community Partners Community Mental Health Center, Exeter Health Resources, Lamprey Health Care and Southeastern Substance Use Services.

We looked specifically at the components listed on the SAMHSA continuum and on the NH DSRIP guidelines in the special conditions. The context and ways of working internally and externally with other partners is very different in each entity. For example, the mental health center provides an internal treatment plan and has a multidisciplinary team however does not address the medical conditions present in the sub-population. The hospital owned practices provide good medical care including referral to behavioral health providers however assessment using the core standardized assessment is not happening on a regular basis. Referrals to mental health and substance use do not have closed loop processes built in.

Broad Observations

- Lack of role clarity and not understanding the perspectives of other key partners
- Changing landscape in partner structures and scope of services: expansion, mergers, increases in scope (examples are FMH opening a new mental health service in Rochester and Goodwin and Families First Health Centers merging)
- CMHCs struggling with recruiting and retaining staff, mostly due to salary issues. This is a root issue in wait times for services
- Providers and administrators in entities believe they are more integrated than they are particularly if they have co-located services
- Some use of innovative technologies to manage patients and deal with staff shortages but this could be expanded
- While the FQHCs are further along the integration continuum, the IDN recognizes practice teams have unique cultures within the organization that need to be considered.

Assessment of Gaps

- Hospital Based providers desire more behavioral health access during clinic sessions
- Screening and systematic assessment of behavioral health does not occur in a systematic way
- There was some sharing of information with social support services but little ability to track the process and outcomes of referrals. Connections to services is more relationship driven rather than systematic
- Referrals were inconsistent and unknown outcomes and results from the referral
- Gaps between partner's perception of integration and reality of day to day practice

Gaps related to the NH DSRIP special requirements

Each partner has the capability to do much of the CCSA but this is not being done consistently or between partners Practices do not all have agreement about the best way to do the core standardized assessment including housing, transportation, employment, legal involvement, risk assessment, functional assessment of activities and cognitive functioning. Developing the ability to screen for further assessment and referral will be addressed.

Pediatric screening is more prevalent but follow up protocols are not consistent

The use of multi-disciplinary teams was evident in some practices, but again, not systematic and there is a lack of a central point of contact to follow up complex care plans

We did not find strong evidence of an appropriate level of behavioral health training for non-clinical or administrative staff in medical settings who are often the first contact with patients

There is knowledge about the advantages of secure messaging however this has yet to be systematized and developed. The ability to exchange data is there but there are not processes in place about how these messages can be stored and used in treatment.

There is an ability to make referrals but not a universal process to systematically learn about the results of the referral made. It is dependent on the interest of the referral provider to reach out and discover what happened. There are challenges in referring from primary care settings to mental health centers due to the wait times and restrictions on eligibility.

Solid communication and coordination across disciplines is noted when the resources are internal to the centers, but there are challenges when referrals to others partners.

There are providers in the mental health centers and health centers who have the ability to do medically assisted therapy however the primary care providers in hospital owned practices have significantly less current capacity.

The use of registries to track and follow patients in one entity and as they move across the neighborhood will be further assessed during Collaborative Design Assessment.

The ability to share care or treatment plans for complex patient situations as well as have an identified person who is responsible for making sure the activities identified in the plan are carried out.

Training of medical staff in behavioral health conditions and intervention processes as well as training behavioral health providers in medical interventions and processes. Creation of multidisciplinary teams who know what the other team members do is critical.

Strong foundation for collaboration between SSS, hospitals, FQHCs, CMHCs and DHHS DO staff, but weak and inconsistent linkage to the MCOs and to the CFI case managers for those with BH needs

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

Using Microsoft Project or similar platform, provide a project plan that includes a timeline of milestones and targets for each of the Process Milestone requirements listed for reporting periods of Jan-June 2017; July-Dec 2017; Jan-June 2018; and July-Dec 2018. See the DSRIP STCs and the IDN Integrated Healthcare Coordinated Care Practice and Integrated Care Practice milestones for additional detail.

Attachment B1.2 details the implementation plan for this project. It illustrates the steps the Region 6 IDN proposes to take to work with primary care and behavioral health partners to identify specific steps and resources necessary to develop practice levels along the SAMHSA integration scale, the Collaborative Integration Design process. Partner agencies will begin the Collaborative Integration Design process in staggered cohorts of up to 5 practices. Members of the Region 6 IDN Operations Team, in concert with IDN Implementation Coaching staff, will facilitate detailed assessment of current practice capacities based on previous data collected in the project planning and HIT assessment efforts, current self-survey assessments of integration conducted and analyzed by the Community Health Institute, and extensive discussion with practice staff around current workforce, practice management, HIT, care coordination and integration practices.

This assessment will inform collaborative goal setting, a process the IDN and practice will engage in together to determine what level of integration constitutes an appropriate goal. Identification of the steps and resources necessary to reach that collaboratively determined integration goal will be captured in a Memorandum of Commitment that illustrates the incentive model and scope of services both the IDN and the practice agree to. Incentives include financial remuneration, technical assistance, access, implementation, and support for HIT solutions, and support for workforce recruitment, retention, training and education. IDN Implementation Coaches will then continue to support participating practices by providing some project coordination throughout execution of the scope of service.

In addition to ensuring that each B1 participating partner practice has the resources and support necessary to attain Coordinated Care Practice designation, the Region 6 IDN will also assess partner status and resources required to meet Integrated Practice designation. This assessment, completed during the Assessment Phase of each wave of the Integrated Collaborative Design process, will evaluate the protocols, practices, and current capacity in place to deliver Medication-Assisted treatment, evidence-based treatment of mild to moderate depression, and enhanced use of technology. These assessments are projected to be complete on Dec 31, 2017 for Wave 1, March 31, 2018 for Wave 2, June 30, 2018 for Wave 3, and August 15, 2018 for Wave 4. These assessment results will inform the collaborative design and resource allocation for each partner practice project to move toward increased integration. Interventions are expected to be implemented in stages. Pending potential uncertainties and unknowns, the Wave 1 partners are projected to complete Implementation by March 31, 2018; Wave 2 by May 31, 2018, Wave 3 by August 31, 2018; and Wave 4 by October 1, 2018. Implementation periods are intentionally condensed in later Phases in recognition that lessons learned will be more quickly identified and disseminated as the IDN refines assessment, design, implementation and evaluation strategies in the initial waves.

The Region 6 IDN plans to stagger enrollment in this Collaborative Integration Design process across at least 4 phases. While the length of time each assessment and project design stage takes will vary based on practice circumstances, the IDN anticipates that cohorts will share some common training and support opportunities. The IDN anticipates that practices will need more extensive and intensive support in the early weeks of project planning, so staggering enrollment will allow efficient use of a rapid cycle PDA process. Lessons learned from the first phase of partners can be applied to the second phase as the first phase matures through the Collaborative Design Process. Practices in each phase will go through the exact same Assessment/Design/Implement/Evaluate process. Each practice will be assigned an Integration Coach that will follow them throughout the project period. It is expected that Integration Coaches, with Operations Team assistance, will provide close project management support to up to 10 practices. As discussed, practices/partners will be added in waves so with each new phase, previous phase partners will demonstrate increasing capacity to self-direct project efforts. This expectation will be evaluated throughout the development of each Phase of the Collaborative Integration Design process to ensure that partners get the resources and technical assistance they need to be successful.

Practices for the first two phases of the Collaborative Design Process have been identified. A number of practices have been identified as potential participants in phases 3 and 4. The CHI Integration Self-Survey will help the IDN both perform detailed assessments of phase 1 and 2 partners and help prioritize those additional partners that are best positioned, most engaged, and for whom improved integration will help the region meet DSRIP goals.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	B1 Project Implementation Plan			Resp									Milestone/Deliverable
2					6/30/2017	12/31/2017	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020	12/31/2020	
48	Step 10	Execute interventions, custom per Partner/Practice		Ops									
49		Bi-weekly checkpoints											
50	Step 11	Initiate scheduling of Region-wide and targeted training options per training matrix				31-Oct							Training schedule drafted and initiated
51	Step 12	Repeat steps 1-10 for all Participating Partners level PCP, CMHC, SUD		Ops		31-Dec							
52	Step 13	Finalize Wave 1 Partners		Ops		30-Sep							
54	WAVE 1	Collaborative Integrated Design: Assessment											
55	Step 1	Review CHI dashboard and report on collected self-assessments		CAT		30-Nov							Report reviewed
56	Step 2	Conduct detail analysis of current state for each Wave 1 Partner		Ops									Analysis conducted
57		Document capability and progress against											
58		Comprehensive Screening and Assessment: general											
59		Comprehensive Screening and Assessment: pediatrics											
60		Document current use of core treatment teams											
61		Document current skills of core team											
62		Document current approach to communications and case conference											
63		Document use of secure messaging											
64		Document use of closed loop referrals											
65		Document use and evidence of written work flows				31-Dec							
66		Document use of and adherence to written protocols											
67		PCP to BH											
68		BH to PCP											
69		PCP and BH to SSS											
70		SSS to PCP and BH											
71		Document use of client/provider consent for 45 CFR Part 2											
72		Document status of MAT											
73		Document other EVP in use by partner											
74		Discuss partner's readiness for APM											
75	Step 3	Update the Detailed Partner Profile		Ops		31-Dec							
76	Step 4	Identify additional short term interventions		Ops		31-Dec							
77	Step 5	Execute against short term plans		Ops		31-Dec							Short term plans identified
78													
79	WAVE 1	Collaborative Integrated Design: Design Planning											
80	Step 6	Convene strategic discussion with partner leadership on current position, IDN regional needs and partner strategy for degree and timing for progressing on framework		Ops		31-Dec							
81	Step 7	Draft Practice-Integration Implementation Plan											
82		Workforce plan											
83		Data and technology implementation											
84		Strategic program implementation											
85		Pilot technology for client communication											
86		Bi-weekly monitoring plan											
87	Step 8	Develop Cost Proposal				31-Dec							
88	Step 9	Review and feedback by Clinical Advisory Team						31-Jan					
89	Step 10	Review and Approval by EC						31-Jan					
90	Step 11	Partner Implementation Plan Memorandum of Commitment (MOC)						31-Jan					
91													
92	WAVE 1	Collaborative Integrated Design: Implementation		Int Coaches									
93	Step 12	Integration Coaches Convene Project Teams identified during Assessment and Design				31-Dec							Project Teams convened
94	Step 13	Execute according to MOC						31-Mar					
95	Step 13a	Schedule supplemental trainings identified during Assessment & Design (not already included in Training Calendar)				31-Dec							Partner Training Schedule drafted
96													
97	WAVE 1	Collaborative Integrated Design: Evaluation		Ops									
98	Step 14	Dashboard reviewed for form and function						31-Mar					Dashboard updated, if necessary
99	Step 15	Identify/Analyze Process and Performance Outcomes evaluated for Rapid Cycle PDSA effort				31-Dec		30-Jun					PDSA process documented
100	Step 16	CHI to re-assess via Integration self-survey @ 12-18 months		CHI						30-Jun			Re-assessments complete

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	B1 Project Implementation Plan			Resp									Milestone/Deliverable
2					6/30/2017	12/31/2017	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020	12/31/2020	
159			Repeat Practice Integration Design Plan and Implementation each Wave 3 Partner					30-Nov					
160			Repeat Practice Integration Design Plan and Implementation each Wave 4 Partner					31-Dec					
161													
163	WAVE 3	Collaborative Integrated Design: Assessment											
164	Step 1		Review CHI dashboard and report on collected self-assessments	CAT		30-Nov							Report reviewed
165	Step 2		Conduct detail analysis of current state for each Wave 3 Partner	Ops									Analysis conducted
166			Document capability and progress against										
167			Comprehensive Screening and Assessment: general										
168			Comprehensive Screening and Assessment: pediatrics										
169			Document current use of core treatment teams										
170			Document current skills of core team										
171			Document current approach to communications and case conference										
172			Document use of secure messaging										
173			Document use of closed loop referrals										
174			Document use and evidence of written work flows										
175			Document use of and adherence to written protocols										
176			PCP to BH										
177			BH to PCP										
178			PCP and BH to SSS										
179			SSS to PCP and BH										
180			Document use of client/provider consent for 45 CFR Part 2										
181			Document status of MAT										
182			Document other EVP in use by partner										
183			Discuss partner's readiness for APM										
184	Step 3		Update the Detailed Partner Profile	Ops			30-Jun						
185	Step 4		Identify additional short term interventions	Ops			30-Jun						
186	Step 5		Execute against short term plans	Ops				30-Sep					Short term plans identified
187													
189	WAVE 3	Collaborative Integrated Design: Design Planning											
190	Step 6		Convene strategic discussion with partner leadership on current position, IDN regional needs and partner strategy for degree and timing for progressing on framework	Ops				31-Jul					
191	Step 7		Draft Practice-Integration Implementation Plan										
192			Workforce plan										
193			Data and technology implementation					31-Jul					
194			Strategic program implementation										
195			Pilot technology for client communication										
196			Bi-weekly monitoring plan										
197	Step 8		Develop Cost Proposal	Ops				31-Aug					
198	Step 9		Review and feedback by Clinical Advisory Team	Ops				31-Aug					
199	Step 10		Review and Approval by EC	Ops				31-Aug					
200	Step 11		Partner Implementation Plan Memorandum of Commitment (MOC)	Ops				31-Aug					
201													
202	WAVE 3	Collaborative Integrated Design: Implementation		Int Coaches									
203	Step 12		Integration Coaches Convene Project Teams identified during Assessment and Design					31-Jul					Project Teams convened
204	Step 13		Execute according to MOC					31-Aug					
205	Step 13a		Schedule supplemental trainings identified during Assessment & Design (not already included in Training Calendar)					31-Jul					Partner Training Schedule drafted
206	WAVE 3	Collaborative Integrated Design: Evaluation		Ops									
207	Step 14		Dashboard reviewed for form and function					30-Sep					Dashboard updated, if necessary
208	Step 15		Process and Performance Outcomes evaluated for Rapid Cycle PDSA					31-Oct					PDSA process documented
209	Step 16		CHI to re-assess via Integration self-survey @ 12-18 months	CHI						30-Jun			Re-assessments complete
210	Step 17		Repeat steps 1-7 for each Wave 3 Partner	Ops				31-Oct					
211	Step 18		Confirm target partners for Wave 4	Ops			6/30/2017						
212													
213													
214	WAVE 4	Collaborative Integrated Design: Assessment											
215	Step 1		Review CHI dashboard and report on collected self-assessments	CAT		30-Nov							Report reviewed

	A	B	C	D	E	F	G	H	I	J	K	L	M	
1	B1 Project Implementation Plan			Resp									Milestone/Deliverable	
2					6/30/2017	12/31/2017	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020	12/31/2020		
216	Step 2	Conduct detail analysis of current state for each Wave 4 Partner.		Ops				15-Aug					Analysis conducted	
217		Document capability and progress against												
218		Comprehensive Screening and Assessment: general												
219		Comprehensive Screening and Assessment: pediatrics												
220		Document current use of core treatment teams												
221		Document current skills of core team												
222		Document current approach to communications and case conference												
223		Document use of secure messaging												
224		Document use of closed loop referrals												
225		Document use and evidence of written work flows												
226		Document use of and adherence to written protocols												
227		PCP to BH												
228		BH to PCP												
229		PCP and BH to SSS												
230		SSS to PCP and BH												
231		Document use of client/provider consent for 45 CFR Part 2												
232		Document status of MAT												
233		Document other EVP in use by partner												
234		Discuss partner's readiness for APM												
235	Step 3	Update the Detailed Partner Profile		Ops				15-Aug						
236	Step 4	Identify additional short term interventions		Ops				31-Aug						
237	Step 5	Execute against short term plans		Ops				30-Sep					Short term plans identified	
238														
239														
240	WAVE 4	Collaborative Integrated Design: Design Planning												
241	Step 6	Convene strategic discussion with partner leadership on current position, IDN regional needs and partner strategy for degree and timing for progressing on framework		Ops				30-Sep						
242	Step 7	Draft Practice-Integration Implementation Plan		Ops				15-Oct						
243		Workforce plan												
244		Data and technology implementation												
245		Strategic program implementation												
246		Pilot technology for client communication												
247		Bi-weekly monitoring plan												
248	Step 8	Develop Cost Proposal		Ops				31-Oct						
249	Step 9	Review and feedback by Clinical Advisory Team		Ops				31-Oct						
250	Step 10	Review and Approval by EC		Ops				31-Oct						
251	Step 11	Partner Implementation Plan Memorandum of Commitment (MOC)		Ops				31-Oct						
252														
253	WAVE 4	Collaborative Integrated Design: Implementation												
254	Step 12	Integration Coaches Convene Project Teams identified during Assessment and Design		Int Coaches				15-Oct					Project Teams convened	
255	Step 13	Execute according to MOC						31-Oct						
256	Step 13a	Schedule supplemental trainings identified during Assessment & Design (not already included in Training Calendar)						15-Oct					Partner Training Schedule drafted	
257	WAVE 4	Collaborative Integrated Design: Evaluation												
258	Step 14	Dashboard reviewed for form and function		Ops				30-Nov					Dashboard updated, if necessary	
259	Step 15	Process and Performance Outcomes evaluated for Rapid Cycle PDSA		Ops				31-Dec					PDSA process documented	
260	Step 16	CHI to re-assess via Integration self-survey @ 12-18 months		CHI							31-Dec		Re-assessments complete	
261	Step 17	Repeat steps 1-7 for each Wave 4 Partner		Ops				31-Dec						
262														
263														
266														
267	Semi Annual Process & Performance Progress Report													
268	Semi Annual Reporting and document progress													
269		Period Ending 12/31/17					31-Jan							
270		Period Ending 6/30/18						31-Jul						
271		Period Ending 12/31/18							31-Jan					
272		Period Ending 6/30/19								31-Jul				
273		Period Ending 12/31/19									31-Jan			

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

From the IDN HIT Implementation Plan, use the format below to identify the measurable process targets, or goals, that the project intends to achieve.

Performance Measure Name	Target	Progress Toward Target		
		12/31/17	6/30/18	12/31/18
IDN Operations Team conducts Environmental Scan w/Key Partners	Environmental Scan Complete for 10 Key Partners			
Integration Coaches Hired	2 Integration Coaches Recruited			
Selected IDN partners complete CHI Integration Self-Assessment	Up to 25 practices complete CHI Integration Practice Self- Assessment			
Partners/Practices/Providers Use Dashboard in Integration Planning	Dashboard template is developed by Clinical Advisory Team			
	105 Partners/Practices/Providers Report using Dashboard			
B1 Partner practices are enrolled in Collaborative Integrated Design Process	Up to 5 Practices in the first Wave (and up to 5 in each of the 3 successive Waves) will complete all 4 components of the Collaborative Integrated Design Process [components include Assessment/Integration Design Planning/ Implementation/Evaluation]			
Assessment				
Integration Design Planning				
Implementation				
Participating Practices report data on IDN Outcome Performance Measures	15 participating practices meet reporting standards for IDN Outcome Performance Measures			
Increase Number of attributed beneficiaries who received a Preventative Care visit in the previous calendar year by age range:				
Age 0-11:	Increase by 127, or 2% above baseline of 6335 (or most current baseline), then 2% increase each year thereafter			
Age 12-17:	Increase by 45, or 2% above baseline of 2239 (or most current baseline), then 2% increase each year thereafter			
Age 18-64:	Increase by 56, or 2% above baseline of 2817 (or most current baseline), then 2% increase each year thereafter			
Age 65:	Increase by 6, or 15% above baseline of 39 (or most current baseline), then 2% increase each year thereafter			
Increase number of Medicaid beneficiaries receiving Comprehensive Core Standardized Assessment (period & cumulative)	Target pending Determination of Baseline Population			
Increase number of Medicaid beneficiaries scoring positive on screening tools who are referred for additional intervention	Target pending Determination of Baseline Population			

B1-4. IDN Integrated Healthcare: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document workforce targets and timeline milestones specifically related to this project using the format below.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Implementation Coaches	2.0	0			

B1.5. IDN Integrated Healthcare: Budget

Budget B1 Core Competency	Q3-Q4 2017	Q1-Q2 2018	Q3-Q4 2018	2019	2020	TOTAL
B1 Core Competency Project Expenses						
Immediate Intervention Expenses						
Recruitment	15,000	30,000	30,000	40,000	30,000	145,000
Retention	15,000	30,000	30,000	60,000	60,000	195,000
Training/Education	10,000	30,000	30,000	70,000	60,000	200,000
Core Competency Project Design						
Wave 1						
Recruitment	10,000	15,000	15,000	30,000	20,000	90,000
Retention	10,000	30,000	20,000	40,000	20,000	120,000
Training/Education	10,000	35,000	35,000	50,000	10,000	140,000
Wave 2						
Recruitment		20,000	10,000	40,000	20,000	90,000
Retention		20,000	30,000	35,000	15,000	100,000
Training/Education		30,000	25,000	40,000	10,000	105,000
Wave 3						
Recruitment		15,000	25,000	30,000	20,000	90,000
Retention		20,000	20,000	30,000	20,000	90,000
Training/Education		10,000	30,000	40,000	10,000	90,000
Wave 4						
Recruitment		5,000	35,000	30,000	20,000	90,000
Retention		5,000	25,000	30,000	20,000	80,000
Training/Education		10,000	30,000	30,000	30,000	100,000
Enabling Technology	15,000	20,000	40,000	60,000	50,000	185,000
Operations						
Office Space	6,000	7,000	7,000	15,000	17,000	52,000
Furniture	2,000	2,000				4,000
Supplies/Materials/Equipment	2,000	2,000	2,000	5,000	5,000	16,000
Travel	1,000	5,000	5,000	12,000	12,000	35,000
Administrative Mgmt Fees for partners	2,500	5,000	5,000	15,000	15,000	42,500
Section Subtotal	98,500	346,000	449,000	702,000	464,000	2,059,500
B1 Core Competency Workforce Expenses						
Workforce						
Implementation Coach 1	25,000	35,000	35,000	75,000	80,000	250,000
Implementation Coach 2	25,000	35,000	35,000	75,000	80,000	250,000
Section Subtotal	50,000	70,000	70,000	150,000	160,000	500,000
TOTALS	148,500	416,000	519,000	852,000	624,000	2,559,500

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

(at the practice or independent practitioner level)

Organization/Provider	Agreement Executed (Y/N)
Frisbie Memorial Hospital & select primary care affiliates	No - Pending
Portsmouth Regional Hospital& select primary care affiliates	No - Pending
Wentworth Douglass Hospital& select primary care affiliates	No - Pending
Families First Health & Support Center	No - Pending
Goodwin Community Health	No - Pending
Lamprey Health Care (Newmarket & Raymond sites)	No - Pending
Southeastern NH Services	No - Pending
CommunityPartners	No - Pending
Seacoast Mental Health Center	No - Pending

Agreements/Memoranda of Commitments containing the scope of partner participation and responsibilities in the B1: Core Competency Project will be during the Collaborative Design Practice Profile session for participating primary care practices and concurrently for participating non-primary care entities. Refer to the timeline in Section B1-2 of this document or Attachment_B1-2 for additional detail on projected agreement execution.

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

The Region 6 IDN Executive Committee has signed their acceptance of this Implementation Plan, with one exception. The outstanding sign-off will be complete upon identification of a replacement member for the HCA Portsmouth Hospital designee, who has been reassigned by her agency. Replacement is anticipated in Oct 2017.

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

B1-8. Additional Documentation for B1-8a-8h per the Project Scoring Tool in B1-9

B1-8:

The Region 6 IDN will identify plans to stand up required elements of the Core Standard Assessment with each partner practice during the design segment of the Collaborative Integrated Design process. Plans will include any training, resource allocation, practice redesign, tool development, quality improvement, and HIT/data reporting and utilization necessary to ensure CSA results are integrated into care planning and collaboration.

B1-8a: Although participating partners have identified domains they believe to be actively assessed in their practices, the specific tools and workflows have not yet been identified, as they are part of the assessment phase of the Collaborative Integrated Design process. Acquisition of that level of practice intellectual property/business intelligence requires development of relationships protected by mutual business entity agreement. While some IDN regions may have already identified workflow protocols or tools in use by some partners, the Region 6 IDN is not embedded in any clinical entity. This administrative structure results in less readily available information for this accelerated planning process, but the Region 6 IDN believes that it will ultimately allow for the transparency and equity necessary to ensure all participating regional partners feel invested in and committed to DSRIP goals.

B1-8b: In addition to evaluation of current tools, workflows, and referral protocols related to CSA, the assessment segment of the Collaborative Integrated Design process will also include review of current multi-disciplinary core team efforts. The Region 6 IDN currently hosts 2 regional Community Care Teams comprised of 42 multi-sector health care and social/community service partners who come together monthly to review and collectively develop care plans for regional residents experiencing disruptions of health due to complex medical, behavioral, and/or socio-economic factors. The Region 6 IDN accepts referrals from any participating partner, manages notifications to Community Care Team members about each referral, and facilitates Community Care Team case presentation by the referring partner agency and the development of a collaborative care plan with all appropriate agencies. The Community Care Team currently functions as a regional core multi-disciplinary team for those cases that are tremendously complex. Additional information regarding the Community Care Teams as a precursor/model for regional multidisciplinary core teams can be found in Attachment B1_8e.

The Region 6 IDN anticipates development of practice/neighborhood level multi-disciplinary core teams that reflect aspects of the Community Care Team model through the Core Integration B1 project. The IDN will identify and provide resources and support to those teams to build team capacity to provide care coordination for clients with increasing complexity through the Integrated Collaborative Design Process so practice and health neighborhood variation in implementation is anticipated.

B1-8c: The provider practices for Phase 1 have been identified as Lamprey Health Care (Newmarket & Raymond sites), Seacoast Mental Health Center (CMHC), Community Partners (CMHC), and one primary care practice from both the Frisbie Memorial Hospital System and the Wentworth Douglass Hospital System. The number of providers by provider type to be trained in each of the trainings identified in the Region 6 IDN Training Matrix will be determined during the design phase of the Collaborative Integrated Design process. Phase 2 participating practices include Goodwin Community Health Center, Families First Health & Support Center, and a primary care practice in the Portsmouth Hospital System. Additional Phase 2, 3, and 4 practices will be identified and procured through continued assessment of network needs, number of attributed members associated with potential partner practices, and development of relational capital with partner leadership.

B1-8d: Counts of individuals to be trained by provider type will be assessed and identified during the assessment and design segments of the Collaborative Integrated Design process, as counts will be dependent on integration goals and current practice capabilities. The Region 6 IDN plan illustrates implementation activities designed to develop trust in business partner relationships with all participating agencies. The development of relational capital through collaboration is necessary to ensure partner willingness to share intellectual property and business

intelligence required to execute the project plans. The Region 6 IDN Training Matrix can be found in Attachment_B1.8d.

The Training Matrix identifies the trainings the Region 6 IDN anticipates developing or procuring to provide to partner agencies to support integration focused regional workforce development across the region and in specific partner agencies, to support partner agencies around specific learning objectives, and to support partners participating in projects B1,C1,D3 and E5. The Training Matrix identifies the type of provider and learning objectives for each projected training.

B1-8.e: While the Region 6 IDN has initiated development of 2 Community Core Teams representing 45 clinical, community, and social support partner agencies that currently meet monthly to practice regional care coordination, the Region 6 IDN will also develop multi-disciplinary Core Team capacity to provide care coordination within B1 participating partner agencies. Identification of those team members will take place during the Collaborative Integrated Design Assessment and Design phases of the B1 project.

B1-8f/B1-8g: Secure Messaging and Closed Loop Referral implantation are addressed in their respective following attachments (Attachment_B1.8f and Attachment_B1.8g).

B1-8h: Attachment_B1.8h reflects the current status of workflow development in the Region 6 IDN. Additional information regarding the Collaborative Integrated Design Assessment and Design phases may also be found in Attachment_B1.2, the implementation timeline.

Attachment_B1.8a

Region 6 IDN
as of 7/2017

Initial Assessment: Partner Use of Core Standard Assessments by Domain

Practice/Partner:	Frisbie Hospital and PCP Affiliates	Wentworth Douglass Hospital & PCP Affiliates	Portsmouth Hospital & PCP Affiliates	Families First Health & Support Center	Goodwin Health Center	Lamprey Health Care	Southeastern NH Services	Community Partners	Seacoast Mental Health Center
Domain									
• Demographic information	YES	YES	YES	YES	YES	YES	YES	YES	YES
• Physical health review	YES	YES	YES	YES	YES	YES	YES	YES	YES
• Substance use review	SOME	SOME	SOME	YES	YES	YES	YES	YES	YES
• Housing assessment	SOME	SOME	SOME	YES	YES	YES	YES	SOME	SOME
• Family and support services	SOME	SOME	SOME	YES	YES	YES	YES	YES	YES
• Educational attainment	RARELY	RARELY	RARELY	SOME	SOME	SOME	SOME	YES	YES
• Employment or entitlement	RARELY	RARELY	RARELY	YES	YES	YES	YES	YES	YES
• Access to legal services	RARELY	RARELY	RARELY	SOME	SOME	SOME	SOME	SOME	SOME
• Suicide risk assessment	RARELY	RARELY	RARELY	SOME	SOME	SOME	YES	YES	YES
• Functional status assessment	SOME	SOME	SOME	SOME	SOME	SOME	SOME	YES	YES
• Universal screening using depression screening (PHQ-2 & 9) and	RARELY	RARELY	RARELY	SOME	SOME	SOME	YES	YES	YES
• Universal screening using SBIRT	RARELY	RARELY	RARELY	SOME	SOME	SOME	YES	SOME	SOME
<i>For pediatric providers, the CCSA must also include:</i>									
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ:SE at 9, 18 and 24/30 month pediatric visits	UNKNOWN	UNKNOWN	UNKNOWN	YES	YES	YES	N/A	N/A	N/A
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	UNKNOWN	UNKNOWN	UNKNOWN	YES	YES	YES	N/A	N/A	N/A

R6 IDN: B1 Multi-Disciplinary Core Team Member Rosters

Name/Position

Practice

CORE Team

The names and positions of multi-disciplinary core team members will be collected during the Collaborative Design Assessment Phase of each wave of the B1 Project. See the B1 Project Implementation Plan for additional information.

As discussed in Section B1-8 narrative, information about multi-disciplinary core teams in each participating practice will be collected during the assessment segment of each wave of the Collaborative Integrated Design process. The assessment segment is projected to be complete for Wave 1 partners on Dec 31, 2017; for Wave 2 partners on March 31, 2018, for Wave 3 partners on June 30, 2018, and for Wave 4 partners on August 15, 2018.

Attachment_B1.8c.

TRAININGS	B1: Core Series				Mental Health First Aid	SBIRT	CTI Series	Resiliency & Retention Series	Cultural Competence	Withdrawal Management	Motivational Interviewing	Traum Informed Care	Chronic Disease Series		
	Behavioral Health 101	Core Standardized Assessment	Integration in Practice										Diabetes/Hyperglyc	Dyslipidemia	Hypertension
REQUIRED	OPTIONAL	<i>includes substance use overview</i>	<i>includes data analytics & pop health & 42 CFR (Part 2)</i>												
Region Wide (Open to all partners by probable provider type)															
PCP - clinical															
Mental Health															
SUD															
All Practices - Nonclinical															
Social Services															
Case Management															
Project Specific (available to all partners, prioritized for project participating partners)															
B1: Integration															
PCP - clinical															
Mental Health															
SUD															
All Practices - Nonclinical															
Social Services															
Case Management															
C1: Care Transitions															
CTI Supervisors															
CTI Workers															
Community Health Workers															
Affiliate Providers/Services															
D3: SUD Expansion															
PCP - Clinical															
Navigator															
Case Management															
E5: Enhanced Care Coord															
Clinical Care Coordinator															
Case Management															
Nonclinical Partners															
Other Potential Trainings															
Health Data Literacy															
Home Visiting & Safety															

The number of individuals to be trained at each practice site will be determined during the Assessment and Design Phases of each Wave of the Integrated Collaborative Design process. Completion of those phases is projected by:

- Wave 1: January 31, 2017
- Wave 2: March 31, 2018
- Wave 3: July 31, 2018
- Wave 4: October 15, 2018

Behavioral Health 101

Integrated health care requires that service providers understand the connection between behaviors and the health and well-being of the body, mind and spirit. This training provides a basic overview of Behavioral Health, which

Summary: includes both mental health and substance use, encompassing a continuum of prevention, intervention, treatment and recovery support services.

Learning Objectives: After completing this activity, participants will be able to:

1. Define behavioral health and its relationship with mental health, substance use, physical health and wellbeing.
2. Describe the social, emotional, cognitive and behavioral manifestations of health, which include occurrence or co-occurrence of those conditions traditionally under the umbrellas of mental health and/or substance use disorders.
3. Provide accurate, basic information about mental illness, the signs and symptoms of common disorders, treatments, medications and available community resources.
4. Provide accurate, basic information about the signs and symptoms of substance use disorders, and common treatments options and available community resources.
5. Describe how behavioral choices are enabled or constrained by environmental factors external to the individual
6. Describe common approaches to integrating behavioral health into the primary care setting

Format: Web Based
 In-Person
 Mixed Media
 Multi-session -In Person
 Multi-session - Web

Trainers	Price	Contract required?	Continuing Ed Provided?
IDN staff IDN Partner Agency AHEC NAMI other			

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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Core Standardized Assessment (CSA)

The Core Standardized Assessment (CSA) is a person centered, culturally competent approach to collect and share key information about the health and wellness needs and strengths of the “whole person” across multiple domains.

Summary: This training provides a comprehensive understanding of the CSA, including the background, context, characteristics, definitions, data elements and the adaptation and adoption of the CSA into practice.

Learning Objectives: After completing this activity, participants will be able to:

1. Describe the Core Standardized Assessment and it’s relationship to the aims of the IDN.
2. Demonstrate an understanding of the role and requirements of the CSA relative to Integrated Care.
3. Identify specific actions needed to adapt the CSA to existing tools in use.
4. Identify specific actions needed to adopt CSA into practice.
5. Describe the value of CSA uniformity in Process, Purpose and Data collection.
6. Describe use of the CSA to assess the needs of the “whole person” and translate into appropriate referrals.

Format: Web Based
 In-Person
 Mixed Media
 Multi-session -In Person
 Multi-session - Web

Trainers	Price	Contract required?	Continuing Ed Provided?
IDN staff			
IDN Partner Agency			
AHEC			
NAMI			
other			

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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Integration

Learn about the nature and implications of integrated care, and the paradigm shift from disease-oriented to recovery-oriented service delivery, resulting in new opportunities and challenges, and direct implications for

Summary: consumers and their families. Topics will include successful models of integrated care; population health management and health disparities; and ethical challenges and opportunities in integrated care.

Learning Objectives: After completing this activity, participants will be able to:

1. Explain the difference between colocation and integration.
2. Compare and contrast interdisciplinary and multidisciplinary teams.
3. Identify level of integration based on standard model that is used in current workplace and determine what changes can further integrate practice.
4. Identify at least three social determinants of health.
5. Identify at least two ethical challenges to integrated health practice.
6. Address/resolve common ethical challenges in integrated health practice.

Format: Web Based
 In-Person
 Mixed Media
 Multi-session -In Person
 Multi-session - Web

Trainers	Price	Contract required?	Continuing Ed Provided?
IDN staff IDN Partner Agency AHEC NAMI other			

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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Mental Health First Aid

Summary:

Mental Health First Aid is an 8-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Just as CPR training helps a layperson without medical training assist an individual following a heart attack, Mental Health First Aid training helps a layperson assist someone experiencing a mental health crisis.

Learning Objectives: After completing this activity, participants will be able to:

1. Recognize the potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, psychosis and psychotic disorders, substance use disorders, and self-injury.
2. Use a 5-step action plan to help an individual in crisis connect with appropriate professional help.
3. Interpret the prevalence of various mental health disorders in the U.S. and the need for reduced negative attitudes in their communities.
4. Apply knowledge of the appropriate professional, peer, social, and self-help resources available to help someone with a mental health problem treat and manage the problem and achieve recovery.
5. Assess their own views and feelings about mental health problems and disorders.

Format: Web Based

In-Person

Mixed Media

Multi-session -In Person

Multi-session - Web

Trainers

IDN staff

IDN Partner Agency

AHEC

NAMI

other

Price

Contract required?

Continuing Ed Provided?

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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SBIRT

Summary:

Learning Objectives: After completing this activity, participants will be able to:

1. Select and utilize tobacco, alcohol, and substance use screening tools with patients.
2. Perform brief interventions for tobacco and substance use problems with patients.
3. Refer patients to the appropriate type of substance use treatment center and/or specialist.
4. Follow-up with and reassess patients who receive treatment for substance abuse or tobacco use.
5. Apply the SBIRT approach to substance use problems at a comprehensive and integrated level by individualizing screening, brief interventions, and referral for different patients.

Format: Web Based
 In-Person
 Mixed Media
 Multi-session -In Person
 Multi-session - Web

Trainers	Price	Contract required?	Continuing Ed Provided?
IDN staff			
IDN Partner Agency			
AHEC			
NAMI			
other			

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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CTI Series

Summary: All five regions that are implementing CTI are executing a shared contract with CACTI to provide a series of trainings to CTI staff. Enrollment will likely be limited to CTI Staff.

Training Series Topics:

- 1) Two Day Face-to-Face CTI Training for Supervisors
- 2) Two Day Face-to-Face CTI Training for All CTI Staff
- 3) Two Day Face-to-Face Train-the-Trainer
- 4) Web-based training on Program Fidelity Assessment
- 5) Ongoing Coaching and Implementation Support (Community of Practice and Individual TA)

Trainers	Price	Contract required?	Continuing Ed Provided?
CACTI Staff			

Trainings Scheduled:

Date	Topic	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
Late October 2017	Training for Supervisors	CACTI			
Late October 2017	All CTI Staff	CACTI			
	Train-the-Trainer	CACTI			
	Program Fidelity	CACTI			
	Community of Practice	CACTI			
	Technical Assistance	CACTI			

Resiliency & Retention

Summary: A training that is modified for specific service provider populations to build Staff Resiliency. The training covers Individual and Agency strategies to address: Self Care; Burnout Prevention; Compassion Fatigue

- Learning Objectives:** After completing this activity, participants will be able to:
1. List risk factors and early warning signs for burnout
 2. List the factors that contribute to service provider wellness & resiliency
 3. Practice one type of wellness promotion skill
 4. Describe the components of one program's burnout prevention and wellness promotion curriculum

Format: Web Based
 In-Person
 Mixed Media
 Multi-session -In Person
 Multi-session - Web

Trainers	Price	Contract required?	Continuing Ed Provided?
IDN staff IDN Partner Agency AHEC NAMI other			

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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CulturalCompetency

Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of health disparities.

Learning Objectives: After completing this activity, participants will be able to:

1. Demonstrate an understanding of cultural diversity and the importance of cultural competence..
2. Be able to assess one's own biases, stereotypes, and level of cultural competence.
3. Discuss how cultural beliefs shape patients' interpretation and experience of health, wellness, and medicine.
4. Demonstrate an understanding of health care needs and health disparities of diverse populations and seek to develop practices that take cultural diversity into account.
5. Use effective cultural communication strategies when interacting with others.
6. Understand and utilize strategies and resources to instill cultural competence as a life-long learning process.

Format: Web Based
 In-Person
 Mixed Media
 Multi-session -In Person
 Multi-session - Web

Trainers	Price	Contract required?	Continuing Ed Provided?
IDN staff IDN Partner Agency AHEC NAMI other			

Evaluation

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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Motivational Interviewing

Summary:

Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client’s belief s/he can successfully make a change).

Learning Objectives: After completing this activity, participants will be able to:

1. Define MI as a counseling style
2. Define the 4 principles of MI
3. Demonstrate skill with OARS
4. Demonstrate at least 2 methods to elicit change talk

Format: Web Based

In-Person

Mixed Media

Multi-session -In Person

Multi-session - Web

Trainers

IDN staff

IDN Partner Agency

AHEC

NAMI

other

Price

Contract required?

Continuing Ed Provided?

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
------	--------------	------------	------------------------------------	-------------------------------------	----------------

Trauma Informed Care

Summary: Trauma Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma - that emphasizes physical, psychological and emotional safety for both survivors and providers, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

Learning Objectives: After completing this activity, participants will be able to:

1. Improve ability recognize the prevalence of trauma
2. Improve ability to define trauma and identify types of trauma, including ACEs
3. Identify Key Steps to TIC
4. Identify the characteristics of a Trauma-Informed Organization
5. Identify the 3 R's of TIC

Format: Web Based

In-Person

Mixed Media

Multi-session-In Person

Multi-session - Web

Trainers

IDN staff

IDN Partner Agency

AHEC

NAMI

other

Price

Contract required?

Continuing Ed Provided?

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
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Diabetes/Hyperglycemia

Summary: Individuals with diabetes are at higher risk of mental health disorders — including depression and psychotic disorders — than the general population. Likewise, those with mental health disorders are at higher risk of developing diabetes. People with such comorbidity are frequently under-recognized and undertreated, meaning that the risk of long-term complications from either type of disorder is high. This training provides an overview of the diabetes disease process, increases awareness of the impact of co-occurring disorders, and offers strategies to support integrated care for those with co-occurring conditions.

Learning Objectives:

1. Define the basic disease processes of Type 1 and Type 2 Diabetes
2. Describe potential impacts of mental health conditions on diabetes
3. Describe potential impacts of diabetes on mental health conditions
4. Identify strategies to support clients with co-occurring conditions

Format: Web Based

In-Person

Mixed Media

Multi-session -In Person

Multi-session - Web

Trainers

IDN staff

IDN Partner Agency

AHEC

NAMI

other

Price

Contract required?

Continuing Ed Provided?

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
------	--------------	------------	------------------------------------	-------------------------------------	----------------

Dyslipidemia

Summary:

Dyslipidemia is very common in the general population. The CDC estimates that one third of the U.S. population has high LDL (bad) cholesterol. In addition, certain medications taken by clients to treat serious mental conditions can raise cholesterol levels. This training provides an overview of dyslipidemia and the risks and management strategies that can encourage heart health in individuals at risk for dyslipidemia and heart disease as a result of behavioral health conditions.

Learning Objectives:

1. Define the basic disease process of dyslipidemia
2. Describe the ways mental health conditions can impact cholesterol and heart health
3. Discuss the importance of monitoring heart health for people with mental health conditions

Format: Web Based

In-Person

Mixed Media

Multi-session -In Person

Multi-session - Web

Trainers

IDN staff

IDN Partner Agency

AHEC

NAMI

other

Price

Contract required?

Continuing Ed Provided?

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
------	--------------	------------	------------------------------------	-------------------------------------	----------------

Hypertension

Summary: Patients with chronic conditions like hypertension may experience many negative emotions which increase their risk for the development of mental health disorders particularly anxiety and depression. Mental health disorders can decrease an individuals ability to manage their chronic physical illness and impact ability to adopt and maintain self-care strategies. This training provides an overview of the relationship between mental health and hypertension and offers strategies to support individuals experiencing co-occurring conditions.

Learning Objectives:

1. Describe the disease process of hypertension and the impact of hypertension on health status.
2. Discuss the impact of mental health conditions on chronic diseases like hypertension.
3. Discuss the impact of chronic disease conditions on mental health conditions.
4. Demonstrate strategies to support clients at-risk for or experiencing co-occurring mental health and chronic disease conditions.

Format: Web Based

In-Person

Mixed Media

Multi-session -In Person

Multi-session - Web

Trainers

IDN staff

IDN Partner Agency

AHEC

NAMI

other

Price

Contract required?

Continuing Ed Provided?

Evaluation

Incentive Plan

Trainings Scheduled:

Date	Organization	Trainer(s)	Evals collected (*if indicated)	CEUs distributed (*if indicated)	# of Attendees
------	--------------	------------	------------------------------------	-------------------------------------	----------------

B1-8D Training for non-clinical staff is highlighted in yellow

TRAININGS		B1: Core Series										Chronic Disease Series		
		Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	CTI Series	Resiliency & Retention Series	Cultural Competence	Withdrawal Management	Motivational Interviewing	Traum Informed Care	Diabetes/Hyperglyc	Dyslipidemia
REQUIRED	OPTIONAL	<i>includes substance use overview</i>		<i>includes data analytics & pop health & 42 CFR (Part 2)</i>										
Region Wide (Open to all partners by probable provider type)														
	PCP - clinical													
	Mental Health													
	SUD													
	All Practices - Nonclinical													
	Social Services													
	Case Management													
Project Specific (available to all partners, prioritized for project participating partners)														
B1: Integration														
	PCP - clinical													
	Mental Health													
	SUD													
	All Practices - Nonclinical													
	Social Services													
	Case Management													
C1: Care Transitions														
	CTI Supervisors													
	CTI Workers													
	Community Health Workers													
	Affiliate Providers/Services													
D3: SUD Expansion														
	PCP - Clinical													
	Navigator													
	Case Management													
E5: Enhanced Care Coord														
	Clinical Care Coordinator													
	Case Management													
	Nonclinical Partners													
Other Potential Trainings														
	Health Data Literacy													
	Home Visiting & Safety													

The number of individuals to be trained at each practice site will be determined during the Assessment and Design Phases of each Wave of the Integrated Collaborative Design process. Completion of those phases is projected by:

- Wave 1: January 31, 2017
- Wave 2: March 31, 2018
- Wave 3: July 31, 2018
- Wave 4: October 15, 2018

Attachment_B1.8e

COMMUNITY CARE TEAM	2017						2018				2019	2020
	JULY	AUG	SEPT	OCT	NOV	DEC	Q1	Q2	Q3	Q4		
Eastern Rockingham County Portsmouth Regional Hospital Classroom 3 or 4 2nd Monday of each month 10:30 to 11:30 AM	July 10	Aug 14	Sept 11	Oct 9	Nov 13	Dec 11	Bi-weekly meetings					
				Plan to move to bi-weekly meetings in 2017 Q3								
Strafford County Frisbie Memorial Hospital Belknap Room, Education & Conference Center 3rd Monday of each month 9:00-10:30 AM	July 17	Aug 21	Sept 18	Oct 16	Nov 20	Dec 18	Bi-weekly meetings					
				Plan to move to bi-weekly meetings in 2017 Q3								

Eastern Rockingham County CCT

- Amedisys
- Beacon Health Strategies
- Community Action Partnership of Strafford County
- Cornerstone VNA
- Cross Roads House
- Crotched Mountain Community Care
- Exeter Health Resources
- Families First of the Greater Seacoast
- Granite State Independent Living
- Greater Seacoast Coalition to End Homelessness
- Haven
- Hope on Haven Hill
- NH DHHS Bureau of Elderly and Adult Services
- NH Healthy Families
- Portsmouth Housing Authority
- Portsmouth Regional Hospital
- Region 6 Integrated Delivery Network
- Rockingham Community Action
- Rockingham VNA
- Safe Harbor Recovery Center
- Salvation Army, Portsmouth
- Seacoast Mental Health Center
- Seacoast Pathways (Granite Pathways)
- ServiceLink of Rockingham County
- St. Vincent dePaul Society
- Veterans, Inc.
- Welfare Department, City of Portsmouth
- WellSense Healthplan

Strafford County CCT

- Beacon Health Strategies
- Community Action Partnership of Strafford County
- Community Partners
- Cornerstone VNA
- Cross Roads House
- Dover Housing Authority
- Families First of the Greater Seacoast
- Frisbie Memorial Hospital
- Goodwin Community Health
- Granite State Independent Living
- Greater Seacoast Coalition to End Homelessness
- Haven
- Homeless Center for Strafford County
- Hope on Haven Hill
- The Homemakers Services
- My Friend's Place
- NH DHHS Bureau of Elderly and Adult Services NH
- Healthy Families
- Region 6 Integrated Delivery Network
- Rochester Community Recovery Center Rochester
- Housing Authority
- ServiceLink of Strafford County
- Somersworth Housing Authority
- SOS Recovery Community Organization
- Southeastern NH Services
- Tri-City Consumers' Action Co-operative Veterans, Inc.
- Welfare Department, City of Dover
- Welfare Department, City of Rochester
- Welfare Department, City of Somersworth
- WellSense Healthplan
- Wentworth-Douglass Hospital
- Wentworth Home Care and Hospice - Amedisys

Attachment_B1.8f

The Region 6 IDN is exploring the use of secure messaging as a stand-alone product (like Kno2), as a standalone option and as a component of a statewide minimum standard (Event Notification/Shared Care Plan solution) and as part of a yet-to be procured Care Coordination solution that, while not initially statewide, may be multi-region. Additional assessment of current partner capacity, development of project based use cases, and performance evaluation of the suite of statewide minimum standard HIT solutions will inform any additional requirement setting and procurement processes for this standard.

Attachment_B1.8g

The Region 6 IDN is exploring the use of closed loop referrals within a Care Coordination solution. Performance evaluation of the suite of statewide minimum standard HIT solutions will inform Care Coordination requirement setting and any additional procurement process for this Optional standard.

Region 6 IDN Work Flow/Protocol Tracking	
Documented work flows and/or protocols that include, at minimum:	<u>Status Update</u>
<ul style="list-style-type: none"> Interactions between providers and community based organizations 	To be fully assessed during B1: Collaborative Design Planning and Community Project Discovery
<ul style="list-style-type: none"> Timely communication 	To be fully assessed during B1: Collaborative Design Planning and Community Project Discovery
<ul style="list-style-type: none"> Privacy, including limitations on information for communications with treating provider and community based organizations 	In support of the development of confidentiality tools related to substance use disorder services projects, all members of the Region Six Operations Team attended the SUD Treatment Confidentiality Boot Camp conducted by the University of New Hampshire, Health Law and Policy Program at UNH School of Law, the Institute for Health Policy and Practice, and the NH Citizens Health Initiative. The “boot camp” consisted of three guided “Boot Camp” sessions (each 4 hours in duration) with assigned home work between meetings, aimed at the ultimate development of policies, processes and plans to implement Part 2 confidentiality throughout IDN project protocols. The UNH Team provided an educational summary of federal and state confidentiality requirements, focusing on 42 CFR Part 2, providing technical assistance to assist each IDN partner with their SUD confidentiality project goals.
<ul style="list-style-type: none"> Coordination among case managers (internal and external to IDN) 	To be fully assessed during B1: Collaborative Design Planning and Community Project Discovery and Implementation of C1: Care Transitions
<ul style="list-style-type: none"> Safe transitions from institutional settings back to primary care, behavioral health and social support service providers 	To be fully assessed during B1: Collaborative Design Planning and Community Project Discovery
<ul style="list-style-type: none"> Intake procedures that include systematically soliciting patient consent to confidentially share information among providers 	To be fully assessed during B1: Collaborative Design Planning and Community Project Discovery
<ul style="list-style-type: none"> Adherence to NH Board of Medicine guidelines on opioid prescribing 	To be fully assessed during B1: Collaborative Design Planning

B1: Collaborative Design Planning projected to be complete for

Wave 1 partners by March 31, 2018

Wave 2 partners by May 31, 2018

Wave 3 partners by August 31, 2018

Wave 4 partners by October 15, 2018

C1: Care Transitions Discovery & Implementation projected to be complete by June 30, 2018

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-1	IDN Integrated Healthcare: Assessment and Ongoing Reporting of Current State of Practice Against SAMHSA Framework for Integrated Levels of Care and Gap Analysis	Narrative				
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: <ul style="list-style-type: none"> Demographic information Physical health review Substance use review Housing assessment Family and support services Educational attainment Employment or entitlement Access to legal services Suicide risk assessment Functional status assessment Universal screening using depression screening 	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	(PHQ 2 & 9) and <ul style="list-style-type: none"> Universal screening using SBIRT 					
	For pediatric providers, the CCSA must also include: <ul style="list-style-type: none"> Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool 	Table listing all providers by domain indicating Y/N on progress for each process detail				
B1-8b	List of multi-disciplinary core team members that includes, at minimum: <ul style="list-style-type: none"> PCPs Behavioral health providers (including a psychiatrist) Assigned care managers or community health worker 	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: <ul style="list-style-type: none"> Diabetes hyperglycemia Dyslipidemia Hypertension Mental health topics (multiple) SUD topics (multiple) 	Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support service providers • Intake procedures that include systematically soliciting patient consent 	Work flows and/or Protocols (submit all in use)				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	to confidentially share information among providers <ul style="list-style-type: none"> Adherence to NH Board of Medicine guidelines on opioid prescribing 					

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

B1-9a: During this reporting period, the Region 6 IDN made progress toward supporting all partners to achieve Coordinated Care Practice status by developing relationships with partners to allow continued assessment of levels of practice and system integration. The IDN also initiated a process that includes self-assessment by survey to determine baseline level of integration and includes protocols for re-evaluating self-reported level of integration at 12-18 months in the future to assess impact of IDN efforts.

B1-9b: The Region 6 IDN made efforts to ready partners to adopt Medication-Assisted Treatment (MAT) and evidence based treatment of mild-to-moderate depression during this reporting period. The IDN identified those partners currently providing MAT to ensure they were included in self-assessment survey process and continued to explore and begin assessment of current workflow protocols currently in use. The use of or need for protocols to guide the use of MAT and evidence based treatment of mild-to-moderate depression will be assessed during the Assessment Phase for each wave of Project B1. When indicated, the protocol development will be supported during the Design Phase for each wave of Project B1. Projected dates for completion of the Assessment/Design phases are as follows: Wave 1: Jan 31, 2017; Wave 2: March 31, 2018; Wave 3: August 31, 2018; and Wave 4: October 31, 2018.

B1-9c: The Region 6 IDN is leading statewide HIT Taskforce efforts to develop an HIT Roadmap that will guide the use of technology to identify at-risk patients, help partners and members plan care, monitor/manage patient progress towards goals, and ensure closed loop referral. During this reporting period, the Region 6 IDN entered an alliance with 2 other regions to discuss collaboration on care coordination solution procurement and participated in initial requirement scoping sessions and demonstrations with vendors to inform planning for the B1.9c goals. See Table B1.9c on page 116a for additional information on the R6 IDN plan to monitor partner use of technology to identify at risk clients, plan care, monitor and manage patient care goals, and ensure closed loop referral.

B1-9d: During this reporting period, the Region 6 IDN began to identify key service providers and communication channels across the region. Insights into both key providers and key communication channels were gained through facilitated discussion at All-Partner meetings, key informant interviews, and project planning meetings with workgroups. Further understanding of these resources will be developed during the upcoming environmental scans and collaborative integrated design assessments identified in the implementation timeline in Attachment_B1.3.

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

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: <ul style="list-style-type: none"> • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model 	Protocols (Submit all in use)				
B1-9c		<ul style="list-style-type: none"> • Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral 	Table listing all providers indicating progress on each process detail. See Table B1.9c on page 116a.				
B1-9d		Documented work flows with community based social support service providers including, at minimum: <ul style="list-style-type: none"> • Joint service protocols • Communication channels 	Work flows (Submit all in use)				

B1-9c

Partner Use of Technology to Monitor/Manage Care

Region 6 IDN
as of 10/2017

		Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Care Coord Element									
Frisbie Hospital and PCP Affiliates	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Wentworth Douglass Hospital & PCP affiliates	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Portsmouth Hospital & PCP affiliates	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Families First Health & Support Center	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Goodwin Health Center	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Lamprey Health Center	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Southeastern NH Services	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Community Partners	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						
Seacoast Mental Health Center	Identification of at-risk clients	EHR	EHR						
	Provide/Participate in Care Planning	CC/SDM	CC/SDM						
	Monitor/Manage Patient Care to goals	CC/DA	CC/DA						
	Initiate Closed Loop Referral	EHR/CC	EHR/CC						
	Manage Closed Loop Referral	CC	CC						

Primary Technology Anticipated to meet Care Coordination Element

EHR = Electronic Health Record
 DA = Data Aggregator/QCI pop health tool
 CC = Care Coordination Solution
 SDM = Secure Direct Messaging

 = not yet in use
 = in use, not yet DSRIP integrated
 = in use, DSRIP integrated

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

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

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	14	0			
Integrated Care Practice	Minimum of three (3)	0			

The Region 6 IDN anticipates serving a minimum of 16 practices in the B1 Project including 2 Community Mental Health Centers, 4 FQHC sites, and 10 Primary Care sites (hospital based and/or independent). The 10 Primary Care Sites selected/designated for participation will be identified through attribution/utilization analysis, CHI Self-Assessment survey results and Partner Reviews to identify readiness for integration. The Region 6 IDN anticipates that at least 14 of those 16 will achieve Coordinated Care Practice status.

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

Once the IDN has identified a comprehensive list of participating providers, efforts to balance the distribution of partner practices across 4 Waves will begin. Some early adopters for the Wave 1 cohort have already been identified as a result of extensive DSRIP planning. Probable Wave 1 partners include Lamprey Health Care, Seacoast Mental Health Center, Community Partners, one Primary Care practice within the Frisbie Hospital system, and one Primary Care practice within the Wentworth Douglass Hospital system.

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

The Region 6 IDN will identify providers/practices anticipated to make progress toward Integrated Care Practice designation during the Integrated Collaborative Assessment & Design Planning Phases of each of the 4 proposed waves of the B1 project.

Community Projects

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs are required to complete an IDN Community Project Implementation Plan including design and development of clinical services infrastructure plan for each selected community project. Using Microsoft Project or similar platform, provide a project plan that includes required activities, timelines, milestones, and progress assessment checkpoints for implementing the IDN's community project.

Include a detailed narrative to complement the project plan or provide further explanation.

The project implementation and infrastructure plans must include Project Core Components and Process Milestones outlined in the process specifications for the following timeframes:

- 6/30/17
- 12/31/17
- 6/30/18
- 12/31/18

Provide a training plan, curricula, and schedule that identify the types and numbers of individuals by organization that will be targeted for training. Ongoing reporting for each training should include the staff name, job title, and organization for which the individual is employed.

Provide an evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The plan will at minimum include a description of performance measures that address:

- Program impact including individuals served by the program and project adherence rates, and
- Fidelity to evidence-supported project elements.

Project Goals

To support the New Hampshire Department of Health and Human Services (DHHS) Delivery System Reform Incentive Payment (DSRIP) Building Capacity for Transformation, Section 1115 Medicaid demonstration waiver, IDN Region 6 is designing and implementing Community Project option C.1: Care Transitions.

DSRIP guidance specifies that the Care Transition program adopt a service model led by a multi-disciplinary team that follows the 'Critical Time Intervention' (CTI) approach to providing care at time-limited, staged levels of intensity to support patients with serious mental illness during transitions from the hospital setting to the community.

Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults age 18 years and older with mental illness, with or without co-occurring disorders who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. CTI promotes a focus on recovery, psychiatric rehabilitation, and bridges the gap between institutional living and community services. CTI differs from traditional case management because it is time limited, focused, and follows a three-phased approach. Unlike some other models, timing of movement through the phases is defined by the program model, not the readiness of the individual.

This C.1 Implementation Plan is the product of a dedicated IDN Work Group comprised of representatives from ten organizations that met 8 times between January and July 2017. Building on rationale described in our initial Project Plans, the Work Group further assessed needs and opportunities in our region that produced our initial plan. The Work Group identified key partners, tools, and protocols to be employed in C.1. The Work Group also benefitted from our cross-regional engagement with IDNs that are also implementing C.1. Of note, our cross-regional planning calls and shared contract with the Center for Advancement of Critical Time Intervention (CACTI) to provide training and technical assistance to all CTI teams being deployed. A kickoff event held on June 1, 2017 served to affirm the value of cross-regional collaboration as well as the considered expertise and guidance from the CACTI Team.

Community Care Teams

A unique feature of our Care Transitions project will be our strategic integration with the existing and functioning Community Care Teams (CCTs) in our region. The CCTs begin with a data driven approach to identifying highest need participants as indicated by their patterns of utilization of crisis/emergency services, typically emergency departments. Comprised of decision-making representatives from a wide range of service providers—typically hospitals, community health centers, mental/behavioral health services and an array of non-clinical social service agencies—CCTs are a particularly effective approach to serving a population for whom traditional models of services, support, and care delivery have not been effective to meet their complex needs. The CCT model helps to overcome typical barriers of communication between agencies, reduces the likelihood of client's "bouncing" between agencies, and provides a structure for conducting more thorough follow-ups to plans created among and between agencies.

CCTs meet face-to-face at regular intervals to review newly identified cases and create individualized plans that move beyond addressing discrete urgent needs, integrating the assets of partners from multiple sectors to address the social determinants of a given person's health and wellness, and to monitor progress and make any needed adjustments to active cases. The CCT aligns medical and/or behavioral treatment plans with non-clinical resources and supports, seeking to create a holistic and comprehensive plan to address complex behavioral and/or chronic health conditions, as well as other important factors that may enable or constrain an individual's capacity to achieve their goals (e.g. housing, transportation, legal, domestic violence, children and family issues, etc.) .

A key need and marker of collaboration is the combined and unified release of information (ROI) that prospective clients must sign authorizing all represented agencies to discuss their case. The two CCTs that are in full operation in Region 6 employ one ROI that includes forty-seven (47) agencies and organizations. One CCT operates out of Portsmouth Regional Hospital and one out of Frisbie Memorial Hospital. Most of the required IDN participating agencies are among those on the Release of Information documents presented to potential CCT clients.

It is not possible to implement the Care Transitions project across the entire IDN at once, but rather pilot the intervention with a subset of key partners, demonstrate capacity for best practices and fidelity to the model, then replicate and expand throughout the region. The Work Group identified two primary institutional settings as our initial referral sources, one clinical and one non-clinical: Frisbie Memorial Hospital and Crossroads House Shelter. Both organizations serve high rates of individuals who are candidates for the intervention, and both are able to commit to the initial data and staffing needs of the initiative. Once established and operational we will seek to expand capacity by adding the other three hospitals in our region, as well as jail and inpatient SUD treatment partners.

DSRIP Aims Alignment

The Care Transitions Project is highly aligned with our IDN aims to improve access to and the quality of behavioral health services and physical health care.

The Region 6 IDN seeks to create a system that delivers holistic care by integrating social, physical and behavioral health services that are accessible and valued by all consumers and providers. To meet our aim of cultivating individual and community resiliency in a system where prevention, treatment and recovery are mutually reinforcing, the IDN must:

- Ensure the delivery of the right clinical and non-clinical services that people need or value at the most efficient time and place
- Develop nimble models of service delivery that are responsive to patients' changing needs and priorities, and reward improved outcomes
- Redirect resources into services and partnerships that have the most positive impact on individual, community and population health
- Create services payment models that can be adopted, adapted and sustained across populations, providers and payers

The Care Transitions Project directly addresses each of these IDN 6 Objectives as a highly responsive, flexible, functionally needs and strengths-based model that seeks to remove barriers to, and enhance coordination of clinical and non-clinical services and resources. The IDN 6 Operations Team will closely monitor utilization and outcomes in support of establishing the business case for a reimbursable CTI service. The Care Transitions Project is highly integrated across IDN 6 DSRIP projects, including A.1, A.2, B.1.

Future Vision

The Care Transitions community project holds great potential to be brought to region-wide scale in our IDN and directly build our systems transformation capacity. In conjunction with CCTs, the Care Transitions effort will serve as a catalyst for creating the connective tissue that comprises the IDN. A robust workforce that operates across clinical and non-clinical stakeholders and sectors throughout the region will be the eyes, ears and facilitators of coordination and integration of services and supports across domains. A central resource to meeting B1 objectives – improved efficiencies, responsive models and earlier identification, engagement and response that results in improved prevention, quality of treatment and reduced cost.

Establishing CTI as a Medicaid reimbursed service package is key to sustainability. The Care Transitions Project also has potential to improve CMHC coordination across county catchment areas.

Project Core Components

DSRIP guidance specifies that the Core Components of the Care Transition program is the adoption of a service model led by a multi-disciplinary team that follows the 'Critical Time Intervention' (CTI) approach to providing care at time-limited, staged levels of intensity to support patients with serious mental

illness during transitions from the hospital setting to the community. The following is a brief overview of those phases, followed by a table that contains slightly more detail.

Phase 1: The case worker provides support and begins to connect client to providers and agencies that will gradually assume the primary support role. During Phase 1, the case worker:

- Meets client prior to discharge (Pre-CTI): Relationship-building; Screening; Enrollment verification
- Collaborates with the mental health professional and primary care provider on client assessment(s) and, with client, develop and document a care transition plan
- Strengths-based and prioritized by client
- Makes frequent home visits to meet with client and caregivers, teach conflict resolution skills, and provide support as needed
- Identifies and meets with existing supports and introduces the client to new supports as needed.

Phase 2: The caseworker monitors and strengthens support network and client's self-management skills, assesses support network effectiveness and helps client to make changes as needed. The caseworker monitors client progress and encourages client to increase levels of responsibility and encouragement to manage problems independently after connecting clients to supportive services.

Phase 3: Transfer of Care - 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.

The CTI Team in Region Six will all be employed by the Administrative Lead, Strafford County. The CTI Team will share office space as a home base, but each CTI worker will also be co-located in our primary partner agencies to promote visibility, engagement, communication and knowledge transfer within and among staff.

The CTI Team will meet for Weekly Case Conference to be facilitated and supported by the Operations Team. CTI Team members will also be expected to attend Community Care Team meetings in both Rochester and Portsmouth locations. Case Conferencing will serve dual purposes:

- Enhancing Team-based approach to meet client objectives
- Continuous Tool/Protocol Refinement and Development

Standard Case Conferencing Agenda items:

- Report on previous week's activities, starting with the to do list from the last supervision meeting
- Review any new cases/individuals referred to the CTI team
- Reinforcement of CTI principles and practices
- In depth discussion of high priority cases, usually between 4-8 individuals. Additionally, each individual should be discussed at minimum once a month
- Plan for resolving barriers to implementation of CTI
- Make a "To Do List" for upcoming week.

Table C1: CTI Process

Phase	Transition	Try-out	Transfer of Care
Timing	Months 1-3	Months 4-6	Months 7-9
Purpose	CTI provides assessment of social and health needs and develops and implements an individualized service plan to address immediate needs related to critical transition	CTI supports an individual's engagement and effective participation in their own support system. Facilitates and tests the individual's new problem solving skills	CTI remains available to solve problems in collaboration with the individual, and his/her providers and natural supports prior to discharge
Activities	<p>CTI worker engages the individual. This includes making home visits or visits in the community including in shelters or on the street, introducing the individual to providers, and meeting with caregivers, helping the individual negotiate ground rules for relationships, mediating conflicts, and assess the potential of the individual's support system.</p> <p>Focus on urgent/basic needs such as food, immediate medical care, shelter, warm clothing or blankets, access to essential medications;</p> <p>Accompanies individuals to community providers; Forges connections to social service systems, and assists the individual to apply for available benefits as indicated (phone, food and nutrition benefits, Medicaid, Disability, etc.);</p> <p>Introduces the individual to vocational services.</p>	<p>CTI worker monitors the effectiveness of the support network; Helps to modify network as necessary;</p> <p>Continues case management activities as necessary; Continues community based visits;</p> <p>Provides psychoeducation about self- management and successful navigation of the service systems and</p> <p>Completes any Phase I activities that still need resolutions.</p> <p>Less frequent meetings, and provides social crisis interventions and troubleshooting.</p>	<p>CTI worker provides consultation but little direct service. The worker lets the individual solve their own problems.</p> <p>The worker ensures key caregivers or providers meet and agree on long term support system. Reinforces the roles of support network members; Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification);</p> <p>May hold a party or some other ceremonial recognition of successful transition out of CTI services. A final meeting is held to formally recognize the end of interventions and relationship.</p>

As defined in Evaluation Design Section of Table/Attachment C.1.1, we will work closely with project partners to finalize Clinical Protocols in accordance with the following timeline: Protocol Draft to be completed by Oct 31, 2018, Staff to be trained and protocol to be pilot-tested by project partners by Nov 30, 2018, and final protocol projected to be fully adopted with fidelity monitoring standards created by Dec 31, 2017.

Additional detail is available in the project timeline in Attachment_C1.1.

Attachment C1.1

Project Implementation Plan		Resp	6/30/2017	12/31/2017	6/30/2018	12/30/2018	6/30/2019	12/31/2019	6/30/2020	12/30/2020
C.1 Care Transitions										
Workforce										
Objective	Recruit and hire new CTI Staff						As Needed	→		
Task	Job Postings (Supervisor and CTI Staff)	Ops		30-Sep		31-Jul				
Task	Interviewing/Hiring	Ops		31-Oct		31-Aug				
Task	Orientation and Onboarding	Ops		30-Nov		30-Sep				
Objective	Training for CTI Staff						As Needed	→		
Task	CACTI Supervisor Training	CACTI		30-Nov		30-Nov				
Task	CACTI Staff Training	CACTI		30-Nov		30-Nov				
Task	CACTI Community of Practice	CACTI			Begins Jan and is ongoing through 2020					
Task	CACTI TA	CACTI		Begins Nov and is ongoing through 2018						
Task	CACTI Train-the-Trainer	CACTI				31-Oct				
Task	Required Trainings (BH 101; CSA; Integration; MH 1st Aid; Cult Comp; Mot Int	Ops		31-Dec						
Task	Orientation and Protocol Training for Frisbie Staff	Ops		30-Nov						
Task	Orientation and Protocol Training for Crossroads House Staff	Ops		30-Nov						
Task	Supplemental Trainings Offered	Ops		Begin Dec 2017 and is ongoing through 2020						
Evaluation Design										
Objective	Establish Project-specific Metrics									
Task	Source/Analyze Partner Agency Data (Hospital & Homeless Shelter)	Ops		30-Nov						
Task	Source/Analyze Systems Data (Encounters/Claims)	Ops		30-Nov						
Task	Create Database integrating all sources (including project tools)	Ops			Mar-18					
Task	Create Dashboard	Ops			Mar-18					
Objective	Refine Data Collection Instruments									
Task	Finalize Internal Clinical Protocols with Partners as required	Ops		31-Oct						
Task	Final Draft Tools	Ops		31-Oct						
Task	Pilot Test Tools	Full Team		30-Nov						
Task	Final Tools	Ops		31-Dec						
Objective	Develop Service Definition and Standards for Reimbursement									
Task	Review of existing CTI Service Reimbursement Models	Ops		30-Sep						
Task	Establish Standard Required Program Components	Ops		31-Oct						
Task	Establish Utilization Management Specifications and Tracking	Ops		30-Nov						
Task	Establish Fidelity Monitoring Standards and Protocol	Ops		31-Dec						
Administration										
Objective	Execute Contracts and Agreements									
Task	Budget and Plan Approval by EC	Ops		30-Sep						
Task	Finalize Required MOUs, BAAs	Ops		30-Nov						
Task	Finalize Contracts	Ops		31-Oct						
Task	Finalize Consent Forms and Privacy Agreements (including 42-CFR Part 2)	Ops		30-Nov						
Task	Clinical Advisory Team Review	Ops		30-Nov						

Start-up									
Objective	Formal Launch of Project								
Task	Kickoff Event	Full Team		31-Dec					
Task	Enrollment	Full Team		Begin Dec					
Task	Case Conferencing Begins	Full Team		Begin Dec					
Progress Reporting									
Objective	Semi Annual Reporting and document progress								
	Period Ending 12/31/17	Ops		31-Jan					
	Period Ending 6/30/18	Ops			31-Jul				
	Period Ending 12/31/18	Ops				31-Jan			

C-2. IDN Community Project: Evaluation Project Targets

From the Evaluation Project Plan, use the format below to provide a list 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.

***In the absence of Medicaid case data availability from DHHS or NH MCOs', we are currently reliant on partner agency level data to determine baseline measures to be used for progress. The sourcing of these data are underway, however this approach introduces significant challenges and limitations as we add more referral sources. Baselines for the population will be calculated by aggregating enrollee case data. Targets will be determined upon baseline calculations.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Total # clients served	70 per CTI team	10 (10 total)	35 (45 total)	45 (90 total)
ED Admissions	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
ED Utilization for PC treatable conditions	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
Hospitalization Frequency & Duration	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
Psych Hospitalization Freq. & Duration	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
Incarceration Nights	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
Increase enrollment for eligible benefits	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
Reduce Crisis Response Services	Baseline TBD	Baseline Dependent	Base Depend	Base Depend
Improve Independent Living Skills	Baseline TBD	Baseline Dependent	Base Depend	Base Depend

C-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the workforce targets and timeline milestones specifically related to this project using the format below.

- Project will hire and onboard one Full CTI Team comprised of:
 - Masters level Team Leader
 - 3 FTE CTI Workers (competencies composite)
- Team located in space secured by Strafford County, with half-time co-location of each CTI worker at each of the following partner agencies:
 - One CTI Worker at Crossroads House
 - One CTI Workers at Frisbie Memorial Hospital
 - One CTI Worker at Community Partners CMHC

Our objective is to hire, onboard and deploy a second full CTI Team before the end of 2018. This goal will be dependent upon the successful full staffing and implementation of the first team.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Team Leader (Masters Clinician)	2	0	1	1	2
CTI Worker (Case Manager)	6	0	3	3	6

Recruiting and Hiring: All CTI staff will be employees of the IDN (in this case, Strafford County). First will systematically conduct outreach to the Human Resources departments of each of our partner agencies. Our objectives are three-fold: 1) to keep our partners informed of our workforce needs, strategies and potential competition for current or future staff, 2) to share job descriptions and position announcements with each key partner, and 3) to solicit any recommended candidates from the partners' applicant pool in advance of public posting of positions.

After solicitation of Human Resources Departments from our IDN partners, we will circulate job announcements throughout our e-mail listservs and post announcements on popular and commonly used web-based job boards (Indeed; NH NonProfits; Idealist, etc.). As CTI workers will need and benefit from a wide range of competencies, we plan to assemble a full menu of those competencies and fulfill as many as possible across our three eventual hires.

See Attachment C1.1 for specific tasks and hiring/training milestones.

C-4. IDN Community Project: Budget

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

Budget C.1 Care Transitions	Q3-Q4 2017	Q1-Q2 2018	Q3- Q4 2018	2019	2020	TOTAL
C1 Workforce Expenses						
Recruitment (with bonuses)	5,000	10,000	10,000	10,000	10,000	45,000
Retention	5,000	10,000	10,000	20,000	20,000	65,000
Training/Education	10,000	10,000	5,000	10,000	10,000	45,000
Workforce Staffing						
LCMHC (2)						
CTI Case Managers (6)						
Section Subtotal	65,000	135,000	235,000	460,000	460,000	1,355,000
C1 Project Expenses						
Lease: Office	4,500	4,500	4,500	18,000	18,000	49,500
Furniture	4,000		4,000			8,000
Supplies; Technology; Equip	5,000	5,000	15,000	20,000	20,000	65,000
Travel	2,000	3,000	6,000	15,000	15,000	41,000
Enabling Technology		20,000	20,000	40,000	40,000	120,000
Section Subtotal	15,500	32,500	49,500	93,000	93,000	283,500
TOTALS	80,500	167,500	284,500	553,000	553,000	1,638,500

Budget Narrative: The C.1 budget is based on the projected recruitment, hiring, onboarding, training and deployment of one full CTI Team (1 Masters-level Clinician; 3 CTI CMs) in October 2017, with a

second full team added by the end of 2018. The core CTI Team will be employees of the IDN. The Workforce budget also includes the resources to hire a full time dedicated Mental Health provider in the CMHC partner setting to be dedicated to ensuring the minimum wait time for engagement with referred services. We anticipate the payment of modest sign-on bonuses for Masters-level professionals and other costs associated with recruitment (advertising, staff time, etc.). We will invest in resources specifically intended to improve Retention, to include enhanced coaching, mentoring, continuing education incentives, team-building time and resources, recognition, and other investments that reside outside standard training. The Training budget in C.1 is primarily associated with the contractual agreement with CACTI to be shared across five IDNs.

The CTI Team will require dedicated office space to be leased and furnished and outfitted with basic supplies. Each team member will also require standard electronic devices (laptop, mobile phone, etc.), and mileage reimbursement for considerable local travel between and among partner agencies and community settings. We anticipate the deployment and testing of novel Enabling Technologies to enhance the delivery, coordination and impact of services.

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

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

Organization/Provider	Agreement Executed (Y/N)
Frisbie Memorial Hospital, Rochester, NH (*host org)	In Process- Expected 15-Dec
Crossroads House Shelter, Portsmouth, NH (*host org)	In Process- Expected 15-Dec
Community Partners CMHC, Rochester, NH (*host org)	In Process- Expected 15-Dec
Potential Partners to be added as identified	
Seacoast Mental Health - CMHC	Aiming for 6/30/18 Reporting Period
Goodwin Community Health (FQHC)	Aiming for 6/30/18 Reporting Period
Families First (FQHC)	Aiming for 6/30/18 Reporting Period
Cornerstone VNA	Aiming for 6/30/18 Reporting Period
SOS Recovery Community Organization	Aiming for 6/30/18 Reporting Period
Rochester Community Recovery	Aiming for 6/30/18 Reporting Period
Safe Harbor Recovery Center	Aiming for 6/30/18 Reporting Period
Tri-City Consumers' Action Cooperative	Aiming for 6/30/18 Reporting Period

C-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project. NOTE: Project C1: Care Transitions does not *require* the use of standardized assessment tools. If the IDN chooses to use any standardized assessment tools, please list them.

Screening and assessment tools are under review and being developed by the Project Work Group. The group is considering a number of existing tools from the field in relation to those that are already being used by partner agencies. Screening and assessment objectives will be aimed at identifying our Target Population:

- Current or Medicaid Eligible

- >18yo Individuals/Head of Household
- Primary or co-occurring disorders SMI/SPMI; SUD; TBI
 - Risk Factors (2-3):
 - 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
 - Unemployment/underemployed/lack of employment skills
 - Probation/Parole

Standard Assessment Tool Name	Brief Description
Health Related Social Needs	To be adapted from several tools, including CMS, Core Standardized Assessment, etc.
Functional Assessment	Reviewing several functional assessment tools being used across partner organizations
Arizona Self Sufficiency Matrix	To be used as a case management tool

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

The Critical Time Intervention is not intended to be a clinical care protocol, but rather is focused on supporting clients to align clinical and non-clinical care and support services on their own behalf.

- Eligibility Screening (Described in C.6)
- Needs Assessment and CTI Phase Planning
- Case Utilization Management

As defined in the Evaluation Design Section of Table/Attachment C.1.1, we will work closely with project partners to finalize Clinical Protocols in accordance with the following timeline:: Protocol Draft to be completed by Oct 31, 2017. Staff to be trained and protocol to be pilot-tested by project partners by Nov 30, 2017. Final protocol fully adopted and fidelity monitoring standards created by Dec 31, 2017.

Protocol Name	Brief Description	Use (Current/Under development)
Screening Protocol	For use in each setting to determine initial eligibility	Under Development
Referral Protocol	For use in referral of positively screened patients to CTI Team	Under Development
CTI Assessment	For use in each setting to determine confirm eligibility and initiate care planning	Under Development
Case Utilization Management	To establish evidence base for case rate and model fidelity	Under Development

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

Use the format below to identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and li documents used by the IDNs.

Project Team Member	Roles and Responsibilities
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
CTI Team Supervisor	See C.1: Core Components
CTI Worker 1	See C.1: Core Components
CTI Worker 2	See C.1: Core Components
CTI Worker 3	See C.1: Core Components

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

The Region Six IDN has entered into an agreement with the four other IDNs implementing CTI to secure the training and technical assistance services of the Center for the Advancement of Critical Time Intervention (CACTI), housed at Hunter College.

New Project Staff:

CACTI delivered trainings

- Two Day Face-to-Face CTI Training for Supervisors
- Two Day Face-to-Face CTI Training for All CTI Staff
- Train-the-Trainer
- Ongoing Coaching and Implementation Support (Community of Practice and Individual TA)
- Web-based training on Program Fidelity Assessment

The CTI Team will also receive a set of required core trainings through the Region 6 Workforce Capacity Building initiative. The required and supplemental trainings are detailed in Section B1-8c. Scheduling of trainings are to be aligned with the needs, demand and delivery of trainings across IDN projects. We have provided Training Descriptions and Learning Objectives for each training in B1-8c, however until contracts with trainers have been executed we cannot provide a fully developed curriculum for each.

IDN-delivered Trainings

- Core Series (BH 101; CSA; Integration)
- Mental Health First Aid
- Cultural Competence
- Motivational Interviewing

Partner Agency Staff:

C.1 Training Schedule	6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
CACTI Delivered								
Two Day F2F CTI Training for Supervisors		Nov 30			Apr 30		Apr 30	
Two Day F2F CTI Training - All CTI Staff		Nov 30			Apr 30		Apr 30	
CTITrain-the-Trainer			Mar 30					
Ongoing Coaching & Imp Support		Begins Nov and ongoing through 2020						
Web-based: Program Fidelity Assmt			Mar 30					
Core Trainings								
Behavioral Health 101		Dec 31		Dec 31		Dec 31		Dec 31
Core Standardized Assessment		Dec 31		Dec 31		Dec 31		Dec 31
Integration in Practice		Dec 31		Dec 31		Dec 31		Dec 31
Supplemental Trainings								
Mental Health First Aid			Mar 30		Mar 30		Mar 30	
Cultural Competence			Mar 30		Mar 30		Mar 30	
Motivational Interviewing			Mar 30		Mar 30		Mar 30	

****All Key Agencies and CCT partner agencies will be invited to participate in Core Series and Supplemental Trainings**

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

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

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

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs are required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Using Microsoft Project or similar platform, provide a project plan that includes required activities, timelines, process milestones, and progress assessment checkpoints for implementing the IDN's community project.

Provide a detailed narrative to complement the project plan or provide further explanation.

The project plan must include Process Milestones for the following timeframes:

- 6/30/17
- 12/31/17
- 6/30/18
- 12/31/18

Provide a training plan, curricula, and schedule that identify the types and numbers of individuals by organization that will be targeted for training. Ongoing reporting for each training should include the staff name, job title, and organization for which the individual is employed.

Provide an evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The plan will, at minimum, include a description of performance measures that address:

- Program impact including individuals served by the program and project adherence rates, and
- Fidelity to evidence-supported project elements.

Project Goals

To develop and expand integrated withdrawal management services (ambulatory detoxification) for substance use disorders (SUD) among Primary Care providers in the IDN. The service model provides medical supervision to complement simultaneous or rapid transfer of stabilized patients into the associated SUD services, and provides/links with care management services that will assist the stabilizing patient to address the life disruption related to the complications of SUD. The project aims are to expand the capacity of Primary Care practices throughout the IDN to

1. Screen and assess for SUD
2. Provide Ambulatory Detoxification and Withdrawal Management services
3. Build a sustainable workforce to provide clinical and case management support services to patients who are candidates for, and choose ambulatory withdrawal management and integration with appropriate modalities of SUD treatment.
4. Build systems capacity for delivery of Intensive SUD Treatment by improving overall SUD related care transitions, coordination and quality of services.

A key to building a sustainable support services workforce (3.) is to invest in resources specifically intended to improve Retention, to include enhanced coaching, mentoring, continuing education incentives, team-building time and resources, recognition, and other investments that reside outside standard training.

SUD Work Group:

An IDN Work Group was created specifically tasked with designing the D.3 Community Project. The Work Group was comprised of representatives from every primary agency providing Intensive SUD treatment services in Region Six, including IOP, MAT, and residential treatment services. The Work Group met eight (8) times to work through four general phases of project development:

1. To review the objectives and standards contemplated in the DSRIP Project Description.
2. Completed an exercise to conceptualize and systematically review ten (10) possible project models that would meet the aims of the D.3 Project guidance.
3. Scored each project option using these criteria: feasibility; potential for population impact; potential to support systems transformation; and potential cost/benefit
4. Selected and conceptualized a project that has the greatest potential to meet these objectives.

There was broad and strong agreement among the experts in Region 6 that that the primary deficits being experienced in the provision of intensive SUD treatment in the region are related to systems efficiency. The group concluded that:

- The funds available through DSRIP are not adequate to meaningfully expand inpatient or partial hospitalization “beds” in the system.
- There has been rapid expansion of MAT and IOP options in our region.
- The greatest challenge to system capacity to deliver Intensive SUD treatment is poor efficiency and coordination that results in: 1) patients occupying treatment beds who are not appropriate candidates for the level of intensive care; and 2) lack of coordination and critical support between providers, resulting in poor outcomes.
- The greatest need and opportunity to improve systems capacity, quality and cost efficiency is through the provision of Ambulatory Detoxification and support services.

Interest and Readiness: To confirm the potential for adoption and delivery of Ambulatory Detoxification and Support Services in Region Six, the Operations Team conducted a brief survey among IDN Primary Care Practices to assess estimated panel demand, and practice interest, readiness and likelihood of receiving training and delivering Ambulatory Detoxification services. More than half of respondents indicated significant unmet need in their patient panels and “high or very high” interest in project participation.

Background:

It has been estimated that nearly one half of the patients who visit a primary care provider have some type of problem related to substance use (Miller and Gold 1998). As a general rule, outpatient treatment is just as effective as inpatient treatment for patients with mild to moderate withdrawal symptoms (Hayashida 1998). A primary objective of Outpatient Detoxification and linkage to appropriate treatment modalities is reducing barriers to care through the least restrictive means possible.

The majority of patients seeking inpatient detoxification services do not require the intensive monitoring and medication management available in the inpatient setting. These patients can be monitored in an outpatient program until stability is assured and then rapidly integrated into a co-located outpatient SUD program with a PCP integrated team. Additionally, patients will be provided with care management services that will assist the stabilizing patient to organize medical, educational, legal, financial, social, family and childcare services in support of abstinence and improved function within the community. Care management can be provided as part of the SUD program or through a Health Home strongly linked to the SUD program if qualified for Health Home Services. Such programs can address

alcohol, sedative and opioid dependency as well as provide access to ongoing medication management treatment.

There are two levels of Outpatient Detoxification:

1. Level I-D: Ambulatory Detoxification Without Extended Onsite Monitoring (e.g., physician's office, home health care agency). This level of care is an organized outpatient service monitored at predetermined intervals.

At the most basic level this project will focus on building the capacity of the Primary Care Workforce to deliver Level I services through the following:

- Primary Care providers and their support staff receive training in SBIRT
- Primary Care Providers and their support staff receive training in Withdrawal Management
- MLADC Clinical Support and Navigation to each identified/enrolled patient
- Case Manager Support (minimum CRSW) to each identified/enrolled patient

Through the four phases to OP Detox:

- Screening and Referrals
- Detoxification and Readiness
- Appropriate linkage to treatment
- Ongoing Support

DSRIP Aims Alignment

The Region Six Ambulatory Detoxification Community Project aims to directly address our aims to integrate SUD services into Primary Care. The project extends well beyond the scope of individual practices to directly address and build SUD services capacity and quality at the IDN systems level.

The Region 6 IDN seeks to create a system that delivers holistic care by integrating social, physical and behavioral health services that are accessible and valued by all consumers and providers. To meet our aim of cultivating individual and community resiliency in a system where prevention, treatment and recovery are mutually reinforcing, the IDN must:

- Ensure the delivery of the right clinical and non-clinical services that people need or value at the most efficient time and place
- Develop nimble models of service delivery that are responsive to patients' changing needs and priorities, and reward improved outcomes
- Redirect resources into services and partnerships that have the most positive impact on individual, community and population health
- Create services payment models that can be adopted, adapted and sustained across populations, providers and payers

The SUD Capacity Building Project directly addresses each of these IDN 6 Objectives to integrate evidence-based behavioral health services into primary care, lower the threshold of access to appropriate modalities of treatment and care, and remove barriers to, and enhance coordination of clinical and non-clinical services and resources. The IDN 6 Operations Team will closely monitor utilization and outcomes in support of establishing the business case for a reimbursable Ambulatory Detoxification and Treatment Navigation service. The SUD Project is highly integrated across IDN 6 DSRIP projects, including A.1, A.2, B.1.

Future Vision

The Region Six SUD Community Project holds great potential to be brought to region-wide scale in our IDN and directly build our systems integration capacity. Building core competencies and services availability for the screening, brief intervention, referral to appropriate modalities of treatment, integration with complementary and supportive services, and enhanced systems navigation and support through transitions of SUD and associated care will directly build systems capacity to remove barriers, enhance the availability and improve the accessibility to evidence-based SUD services for the IDN attributed population and other IDN residents.

These efforts are directly aligned with our B1 objectives build services integration capacity that results in improved prevention, early identification and intervention, improved systems efficiency, enhanced quality of care, and reduced cost. We envision a future in which SBIRT is as common as taking vital signs, and Primary Care practices are key and integral partners in a robust SUD services continuum.

Project Core Components

The DSRIP contemplates that IDNs implementing this project will expand capacity to deliver at least one of the following three types of higher intensity SUD treatment/recovery services: Intensive Outpatient (IOP); Partial Hospitalization (PH); or Non-hospital based residential treatment services. The Work Group determined that Region Six has recently increased the availability of each of these modalities of service, however the capacity to deliver these services can be best expanded through the building systems efficiencies and quality concurrent, or in tandem, as indicated, with treatment services for mental health (MH), substance use (SUD) and co-occurring (COD) disorders.

The Work Group determined that the most effective current strategy needed to have meaningful impact on the Region's capacity to lower the threshold to, and improve provider capacity deliver high quality intensive SUD treatment, is to improve screening and appropriate referral processes, and to infuse clinical care and recovery support services into referral, transition, coordination and ongoing care. This model includes **regular outpatient counseling for substance use disorders** (and/or co-occurring disorders) provided by qualified practitioners for individuals with varied levels of acuity broadly across the spectrum of health and social service programs within the IDN.

Additional detail is available in the project timeline in Attachment_D3.1

The Operations Team will work closely with the D.3 Work Group in the development of an Evaluation Plan for the community project. The Plan will evaluate the project impact at two levels, as illustrated in section D2 on page 141. Evaluation includes: 1) measures on system capacity enhancement, such as increase in the number of Providers and staff trained in SBIRT and withdrawal management who are; employing SBIRT, # providing ambulatory detox and withdrawal management; and the # of patients receiving previously unavailable services, and 2) measures on system utilization, including the number of referrals made and completed, # of patients receiving ambulatory detox, # ;engaged with a Navigator, # who complete a defined treatment program, # who leave treatment in the first 7 days,, # in supportive services 30 days after completion,, # employed or attending school 6 months after discharge from the program.

Our Training Plan for this project includes the three core series trainings to be offered by IDN 6 (BH 101, Core Standardized Assessment, and Integration)) with an additional series of trainings offered to and by partner agency staff (including Mental Health First Aid, SBIRT, Resiliency and Retention, Cultural Competency, Motivational Interviewing, Withdrawal Management, Trauma Informed Care). A key component of all Region 6 training efforts is the development of efforts to operationalize and continuously improve practice after participation in trainings. We will work closely with partners to offer continuous learning and competencies-building opportunities, such as coaching, communities of practice, case conferencing, etc.

Attachment D3.1

Project Implementation Plan		Resp	6/30/2017	12/31/2017	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020	12/31/2020
D.3 SUD Treatment Capacity Building										
Workforce										
Objective	Recruit and hire new SUD Project Staff									
Task	Job Postings (MLADC and CM Staff)	Ops		15-Oct			15-Jan			
Task	Interviewing/Hiring	Ops		31-Oct			15-Feb			
Task	Orientation and Onboarding	Ops		30-Nov			28-Feb			
Objective	Training for SUD Project Staff									
Task	Withdrawal Management Training	Ops		30-Nov			28-Feb			
Task	Staff Training in Comprehensive Assessment	SENHS		30-Nov			28-Feb			
Task	Required Trainings (BH 101; CSA; Integration; MH 1st Aid; Cult Comp;	Ops		31-Dec			31-Mar			
Objective	Training for Primary Care Providers and Staff									
Task	Training: SBIRT	Ops		Begins in October and is ongoing through 2020			→	→		
Task	Training: Withdrawal Management for Prescribers	Ops		Begins in October and is ongoing through 2020			→	→		
Task	Training: Withdrawal Management and Ambulatory Detox for Staff	Ops		Begins in October and is ongoing through 2020			→	→		
Task	Orientation and Protocol Training for Participating Practice Staff	Ops		Begins in October and is ongoing through 2020			→	→		
Task	Supplemental Trainings Offered	Ops		Begins in November and is ongoing through 2020			ongoing	→	→	→
Evaluation Design										
Objective	Establish Project-specific Metrics									
Task	Source/Analyze Partner Agency Data (as available)	Ops		31-Oct						
Task	Source/Analyze Systems Data (Encounters/Claims, RAPS, 211, Crisis	Ops		31-Oct						
Task	Create Database integrating all sources (including project tools)	Ops		30-Nov						
Task	Create Dashboard	Ops		31-Dec						
Objective	Refine Data Collection Instruments									
Task	Finalize Clinical Protocols with Partners as required	Ops/SENHS		31-Oct						
Task	Final Draft Tools	Ops/SENHS		31-Oct						
Task	Pilot Test Tools	Ops/SENHS		30-Nov						
Task	Final Tools	Ops/SENHS		30-Nov						
Objective	Develop Service Definition and Standards for Reimbursement									
Task	Review Current Payor Environment (bundled/unbundled)	Ops/SENHS		31-Oct						
Task	Review Limits imposed by 3rd party payors	Ops/SENHS		31-Oct						
Task	Review of existing Service Reimbursement Models	Ops/SENHS		31-Oct						
Task	Establish Standard Required Program Components	Ops/SENHS		30-Nov						
Task	Establish Utilization Management Specifications and Tracking	Ops/SENHS		30-Nov						
Task	Establish Fidelity Monitoring Standards and Protocol	Ops/SENHS		30-Nov						
Administration										
Objective	Execute Contracts and Agreements									
Task	Budget and Plan Approval by EC	Ops		30-Sep						
Task	Finalize Required MOUs, BAAs	Ops/SENHS		31-Oct						
Task	Finalize Contracts	Ops/SENHS		31-Oct						
Task	Finalize Consent Forms and Privacy Agreements (including 42-CFR Part 2)	Ops/SENHS		30-Nov						
Task	Clinical Advisory Team Review	Full Team		30-Nov						

Start-up									
Objective	Formal Launch of Project								
Task	Kickoff Event per Practice/Group	Full Team		31-Oct					
Task	Enrollment	Full Team		30-Nov					
Task	Case Conferencing Begins	Full Team		30-Nov					
Progress Reporting									
Objective	Semi Annual Reporting and document progress								
	Period Ending 12/31/17	Ops		31-Jan		31-Jan			
	Period Ending 6/30/18	Ops			31-Jul			31-Jul	

D-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list of 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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Providers trained in SBIRT	In Process - TBD	TBD	TBD	TBD
# Providers employing SBIRT	In Process – TBD	TBD	TBD	TBD
# Providers providing ambulatory detox	In Process – TBD	TBD	TBD	TBD
# patients receiving ambulatory detox	In Process – TBD	TBD	TBD	TBD
# patients engaged with Navigator	In Process – TBD	TBD	TBD	TBD
# referrals made and completed	In Process – TBD	TBD	TBD	TBD
# clients who complete a defined treatment program	In Process – TBD	TBD	TBD	TBD
# clients who leave treatment in the first 7 days	In Process – TBD	TBD	TBD	TBD
# clients in supportive services 30 days after completion	In Process – TBD	TBD	TBD	TBD
# clients who are employed or attending school 6 months after discharge from the program	In Process - TBD	TBD	TBD	TBD

***TBD: Baseline measures cannot be determined until we know the number of providers who formally agree to adopt the project/protocol (training and support in SBIRT; provision of Ambulatory Detox; Referral protocol). Then, target measures will be determined by aggregation of participating providers eligible panel member estimates. Baseline enrollment/participation data (or projections) will be collected for 12/31/17 SAR, but are unknown at this time.

D-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the workforce targets and timeline milestones specifically related to this project using the format below.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
MLADC Navigator	2	0	1	1	2
Case Manager	6	0	3	3	6
Prescribers trained in Withdrawal Management	TBD	0	TBD	TBD	TBD
Clinical Support Staff trained in Withdrawal Management	TBD	0	TBD	TBD	TBD

New Staff Recruiting and Hiring: First will systematically conduct outreach to the Human Resources departments of each of our partner agencies. Our objectives are three-fold: 1) to keep our partners informed of our workforce needs, strategies and potential competition for current or future staff, 2) to share job descriptions and position announcements with each key partner, and 3) to solicit any recommended candidates from the partners' applicant pool in advance of public posting of positions.

After solicitation of Human Resources Departments from our IDN partners, we will circulate job announcements throughout our e-mail listservs and post announcements on popular and commonly used web-based job boards (Indeed; NH NonProfits; Idealist, etc.).

Existing Staff Recruitment and Training: We will conduct outreach throughout our Primary Care Partners in our Network to offer the opportunity to receive training and support to offer Ambulatory Detoxification Services to Prescribers and their Clinical Support Staff. Outreach will include a full description of the protocol, training and support, and expectations of participation. Outreach will be conducted through multiple means, including direct telephone and in-person visits, IDN listservs and other electronic communication platforms, and through the key partners in our multiple Workgroups and Committees (i.e. Executive Committee, Clinical Advisory Team, C1, D3 and E5 Workgroups, etc.). Recruitment, training and support of existing staff to provide Ambulatory Detoxification Services will be continuous throughout the entirety of the DSRIP.

New Staff Recruiting and Hiring, Partner outreach, public job postings and recruitment screening will commence in October 2017, per the Implementation Timeline for this project. We anticipate recruiting up to one MLADC and up to three case managers, with subsequent hiring, onboarding and training occurring in November 2017. Outreach to our Primary Care partner staff will commence in October 2017. Initial trainings described in the Implementation Plan will commence in November and December of 2017 depending on staff and trainer availability and schedule alignment.

D-4. IDN Community Project: Budget

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

Budget Narrative: The D.3 budget is based on the projected recruitment, hiring, onboarding, training and deployment of one full D.3 Team (1 MLADC; 3 CMs) in October 2017, with a second full team added by the end of 2018. The core D.3 Team will be employees of Southeastern NH Services. The Workforce budget also includes the resources to offset clinical supervision time to be provided by SENHS staff. We anticipate the payment of modest sign-on bonuses for Masters-level professionals and other costs associated with recruitment (advertising, staff time, etc.). We will invest in resources specifically intended to improve Retention, to include enhanced coaching, mentoring, continuing education incentives, team-building time and resources, recognition, and other investments that reside outside standard training. The Training budget contemplates additional intensive training for D.3 staff.

The D.3 Team will require dedicated office space to be provided by SENHS outfitted with basic supplies. The Lease line represents an allocated cost offset for that space. Each team member will also require standard electronic devices (laptop, mobile phone, etc.), and mileage reimbursement for considerable local travel between and among partner agencies and community settings. We anticipate the deployment and testing of novel Enabling Technologies to enhance the delivery, coordination and impact of services.

Budget D.3SUD Capacity	Q3-Q4 2017	Q1-Q2 2018	Q3- Q4 2018	2019	2020	TOTAL
D3 Workforce Expenses						
Recruitment (with bonuses)	5,000	10,000	10,000	10,000	10,000	45,000
Retention	5,000	5,000	5,000	10,000	10,000	35,000
Training/Education	10,000	10,000	5,000	10,000	10,000	45,000
Workforce Staffing (Contracts)						
MLADC (2)						
Case Managers (6)						
Clinical Supervision						
Administrative Support						
Section Subtotal	72,000	123,000	208,000	406,200	406,200	1,215,400
D3 Project Expenses						
Lease: Office	3,000	3,000	6,000	12,000	12,000	36,000
Supplies; Technology; Equip	5,000	5,000	15,000	20,000	20,000	65,000
Travel	2,000	3,000	6,000	15,000	15,000	41,000
Enabling Technology	0	20,000	20,000	40,000	40,000	120,000
Section Subtotal	10,000	31,000	47,000	87,000	87,000	262,000
TOTALS	82,000	154,000	25,000	493,200	493,200	1,477,400

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

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

Staff for the SUD Community Project will be hired through contractual agreements with SENHS, housed at SENHS, and clinical supervision will be provided by senior clinical staff at SENHS. The IDN Operations Team will provide additional administrative, program development and implementation, and evaluation support to the partners in the project.

Despite the location of SUD Community Project staff at SENHS, clients who are identified will be referred to the most appropriate modality of currently available SUD treatment among the large network of SUD participating providers in Region Six.

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

Organization/Provider	Agreement Executed (Y/N)
Southeastern New Hampshire Services (host agency)	In Process – Expected 15-Dec
Goodwin Community Health	In Process – Expected 15-Dec
Families First Health & Support Center	In Process – Expected 15-Dec
Seacoast Mental Health Center	In Process – Expected 15-Dec
ROAD to Recovery	In Process – Expected 30-Jun-18
Wentworth Douglass Hospital	In Process – Expected 15-Dec
Frisbie Memorial Hospital	In Process – Expected 15-Dec
Portsmouth Regional Hospital	In Process – Expected 30-Jun-18
Hope on Haven Hill	In Process – Expected 15-Dec

Additional Organizations/Providers	Agreement Executed (Y/N)
SOS Recovery Community Organization	In Process – Expected 15-Dec
Safe Harbor Recovery Community Organization	In Process – Expected 15-Dec
Potential Partners to be added as identified	
Merrimack	Aiming for 6/30/18 Reporting Period

D-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
SBIRT	Standard Tool
Core Standardized Assessment	Via B1.
Comprehensive SUD Assessment	Designed and Employed by SENHS
Case Management Program	TBD in conjunction with HIT platform

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

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

The Work Group has been compiling a menu of existing protocols for Assessment, Treatment, Management and Referrals already being employed by key partners in the Region. Based on the current status of the field locally, the Project Team is crafting a full set of protocols and Work Flow to be adopted by participating agencies across the initiative.

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

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

Using the format below, identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

Project Team Member	Roles and Responsibilities
[REDACTED]	[REDACTED]

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

The D.3 Project Training Plan is comprised of a combination of Core and Supplemental Trainings for new project staff, as well as those offered to staff of all partner agencies. The specific curricula for trainings are still in development, as some will be delivered through contracted providers, while some may be delivered through IDN Operations staff. Whenever possible we will recruit IDN Partner agency staff to participate in the design and delivery of trainings in an effort to build partner relationships and cultivate an environment and processes for knowledge transfer within the IDN.

The B.3 Core Team core trainings through the Region 6 Workforce Capacity Building initiative. The required and supplemental trainings are detailed in Section B1-8c. Scheduling of trainings are to be aligned with the needs, demand and delivery of trainings across IDN projects. We have provided Training Descriptions and Learning Objectives for each training in B1-8c, however until contracts with trainers have been executed we cannot provide a fully developed curriculum for each.

Core Project Staff:

- Core Series (BH 101; CSA; Integration)
- Mental Health First Aid
- SBIRT
- Resiliency and Retention
- Cultural Competency
- Motivational Interviewing
- Withdrawal Management
- Trauma Informed Care

Partner Agency Staff:

At a minimum Partner agencies will be required to participate in:

- Core Standardized Assessment
- SBIRT
- Withdrawal Management

All participating Agencies will be invited to participate in Core Series and Supplemental Trainings offered through the IDN 6 Workforce Initiative.

D.3 Training Plan Schedule	6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
Core Trainings - Project Staff								
Behavioral Health 101		Nov 30		Dec 31		Dec 31		Dec 31
Core Standardized Assessment		Nov 30		Dec 31		Dec 31		Dec 31
Integration in Practice		Dec 31	Mar 31	Dec 31		Dec 31		Dec 31
Mental Health First Aid		Dec 31		Dec 31		Dec 31		Dec 31
SBIRT		Dec 31	Mar 31	Dec 31		Dec 31		Dec 31
Resiliency & Retention			Mar 31	Dec 31		Dec 31		Dec 31
Cultural Competence			Mar 31	Dec 31		Dec 31		Dec 31
Withdrawal Management		Dec 31		Dec 31		Dec 31		Dec 31
Motivational Interviewing		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Trauma Informed Care		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Core Trainings - Partner Staff								
Core Standardized Assessment			Mar 31	Dec 31				
SBIRT		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Withdrawal Management		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

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

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

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

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs are required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Using Microsoft Project or similar platform, provide a project plan that includes required activities, timelines, process milestones, and progress assessment checkpoints for implementing the IDN's community project.

Provide a detailed narrative to complement the project plan or provide further explanation.

The project plan must include Process Milestones for the following timeframes:

- 6/30/17
- 12/31/17
- 6/30/18
- 12/31/18

Provide a training plan, curricula, and schedule that identify the types and numbers of individuals by organization that will be targeted for training. Ongoing reporting for each training should include the staff name, job title, and organization for which the individual is employed.

Provide an evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The plan will, at minimum, include a description of performance measures that address:

- Program impact including individuals served by the program and project adherence rates, and
- Fidelity to evidence-supported project elements.

Project Goals

The Enhanced Care Coordination (ECC) project aims to develop comprehensive care coordination/management services for high need populations with multiple physical health and behavioral health chronic conditions. These services are intended to maintain or improve an individual's functional status, increase that individual's capacity to self-manage their condition, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

An IDN Work Group was created specifically tasked with designing the E.5 Community Project. The Work Group was comprised of representatives from several primary agencies providing services to transition-aged youth primarily in the Rockingham County segment of Region Six. The Work Group, and subsets of the Work Group, met five (5) times to work through four general phases of project development

- To review the objectives and standards contemplated in the DSRIP Project Description.
- Completed an exercise to systematically review existing available services project models that would that are aligned with the aims of the E.5 Project guidance.
- Selected and conceptualized a project that has the greatest potential to meet these objectives.

IDN Operations Team members also met with representatives from five partner agencies (CMHC, FQHC, Area Agency, School, Youth Services) and attended numerous meetings of existing teams (internal to agencies, as well as multi-agency) that are focused on the coordination of services for our target population. In total, input from experts in the Region concurred on the following points:

There are excellent, evidence-based programs in place such as RENEW and the SAMHSA System of Care model for children and youth with serious emotional disturbance, there is a lack of coordination and communication with and among youth-serving agencies, particularly schools.

While there are a number of high need and vulnerable populations that the ECC project could serve, and while an argument could be made to justify the targeting of each, experts agreed on rationale to initially target transition-aged youth from <18y/o to 18+y/o with behavioral health disorders (specifically, serious mental illness or Substance Use Disorders, including opioid addiction) with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors (such as homelessness) that are barriers to community living and well-being. The project will also serve transition-aged youth from <18y/o to 18+y/o with chronic serious emotional disturbance or a developmental disability. Among the observations of experts in the field:

- Excellent, evidence-based models for children and youth already exist (like RENEW, Partners in Health, etc.) but availability, accessibility and efficient enrollment and retention in existing programs is a considerable challenge.
- The rapid rise in incidence and prevalence of conditions and associated behaviors means that the most acute cases receive the majority of attention and resources.
- There are significant numbers of eligible youth who are candidates for services yet unenrolled for a variety of reasons.
- There is especially poor integration between the Mental Health, Developmental Disability, Primary Care and school-based sectors in serving this population, and significant opportunities to strengthen coordination, improve outcomes, and strengthen processes for earlier identification.
- There is difficulty in maintaining meeting schedules with regularity
- Youth receiving intensive services face significant challenges when they hit the age of 18 years old due to shifting of eligibility and administrative programming.

Currently two youth-focused “resource connection” teams meet in Region 6’s portion of Rockingham County; one in Portsmouth and one in the Hampton/Seabrook area. Their purpose is to assist families and children, often who are in crisis, by bringing together youth-serving agencies including Seacoast Mental Health Center, DCYF, Juvenile Justice, Chase Home for Children, Portsmouth Police Department and Families First. Together these agencies work with the family to set goals and coordinate and connect them to services. Though these teams have been in place for several years, their activity has been sporadic and they have served a limited number of youth.

This project will create and continually develop an ECC model that combines the development and deployment of Clinical Care Coordinators with Team-based care coordination. The initial target population will be specifically focus on transition-aged youth with an aim to develop a model for serving other age groups and extend the model to serve highly complex populations across the region.

For Team-based coordination we will establish and support a Community Care Team (CCT) model comprised of key agencies of which the existing teams as a foundation (including but not limited to the appropriate school personnel (Nurse and/or Guidance and/or Homeless Liaison, etc.), One Sky Services, Families First, Seacoast Community Mental Health, Child and Family Services of NH). In this model, dedicated Clinical Care Coordinator/Case Managers will support children and families referred to the project by

It is not possible to implement the Enhanced Care Coordination project across the entire IDN at once, but rather pilot the intervention with a subset of key partners, demonstrate capacity for best practices

and fidelity to the model, then replicate and expand throughout the region. Our ECC Project will begin partner development, enrollment and model development with schools and services partners serving the Greater Exeter area and expand throughout the Region Six Rockingham County Districts, and eventually Strafford County. We aim to develop a model that can be adapted for different age groups, including the eventual prospect of serving CCT adults who's needs are too acute and/or complex for the CTI model being used in our Care Transitions project.

DSRIP Aims Alignment

The Region Six Enhanced Care Coordination Project aims to directly address our aims to integrate services into Primary Care. The project extends well beyond the scope of individual practices to directly address and build services capacity and quality at the IDN systems level. The Region 6 IDN seeks to create a system that delivers holistic care by integrating social, physical and behavioral health services that are accessible and valued by all consumers and providers. To meet our aim of cultivating individual and community resiliency in a system where prevention, treatment and recovery are mutually reinforcing, the IDN must:

- Ensure the delivery of the right clinical and non-clinical services that people need or value at the most efficient time and place
- Develop nimble models of service delivery that are responsive to patients' changing needs and priorities, and reward improved outcomes
- Redirect resources into services and partnerships that have the most positive impact on individual, community and population health
- Create services payment models that can be adopted, adapted and sustained across populations, providers and payers

The Enhanced Care Coordination Project directly addresses each of these IDN 6 Objectives to integrate evidence-based behavioral health services into primary care, lower the threshold of access to appropriate modalities of treatment and care, and remove barriers to, and enhance coordination of clinical and non-clinical services and resources. The IDN 6 Operations Team will closely monitor utilization and outcomes in support of establishing the business case for a reimbursable Enhanced Care Coordination service. The ECC Project is highly integrated across IDN 6 projects, including A1,A2, B1.

Future Vision

The Region Six Enhanced Care Coordination Project holds great potential to be brought to region-wide scale in our IDN and directly build our systems integration capacity. Building core competencies and services availability for the screening, intervention, referral to, and coordination of appropriate modalities of treatment, integration with complementary and supportive services, and enhanced systems navigation and support through program and age-related transitions of care will directly build systems capacity to remove barriers, enhance the availability and improve the accessibility to evidence-based services for the IDN attributed population and other IDN residents. These efforts are directly aligned with our B1 objectives; build services integration capacity that results in improved prevention, early identification and intervention, improved systems efficiency, enhanced quality of care, and reduced cost.

The Operations Team meets weekly to review the progress on each task defined in the Implementation Plan. Progress is monitored by the team by assigning a current status code (Green = Complete, Yellow = in Progress, Red=Target Date Missed and/or needs attention) in each of the tasks throughout the Workforce, Evaluation Design, Administration and Start-Up sections of the Plan. Any tasks, steps, or deliverables designated as *missed* and/or *needs attention* will be referred to the appropriate responsible party for follow-up, with Operations Team support, if necessary.

Attachment E5.1

Project Implementation Plan		Resp	6/30/2017	12/31/2017	6/30/2018	12/31/2018	6/30/2019	12/31/2019	6/30/2020	12/31/2020	Milestone/Deliverable
E.5 Enhanced Care Coordination											
Workforce											
Objective	Recruit and hire new ECC Project Staff										
Task	Job Postings (CCC Staff)	Ops/SMHC		30-Sep							Two case managers are hired
Task	Interviewing/Hiring	Ops/SMHC		31-Oct							
Task	Orientation and Onboarding	Ops/SMHC		30-Nov							
Objective	Training for ECC Project Staff										
Task	Staff Training in Comprehensive Assessment	Ops		30-Nov							Project staff complete required trainings
Task	Required Trainings (BH 101; CSA; Integration; MH 1st Aid; Cult Comp; Mot Int)			30-Nov							
Objective	Training for Core ECC Staff										
Task	Training: Core Training Series	Ops		Begins in October and continues through 2018			ongoing	→	→	→	Project staff complete required trainings
Task	Training: CCC Protocol, Data Collection, management, Reporting	Ops		Begins in November and continues through 2018			ongoing	→	→	→	
Task	Orientation and Protocol Training for Participating Practice Staff	Ops		Begins in November and continues through 2018			ongoing	→	→	→	
Task	Supplemental Trainings Offered	Ops		Begins in December and continues through 2018			ongoing	→	→	→	
Evaluation Design											
Objective	Establish Project-specific Metrics										
Task	Source/Analyze Partner Agency Data (as available)	Ops		31-Oct							Project-specific metrics are established
Task	Source/Analyze Systems Data (Encounters/Claims, RAPS, 211, Crisis Hotline)	Ops		31-Oct							
Task	Create Database integrating all sources (including project tools)	Ops		30-Nov							Database is created and operational
Task	Create Dashboard	Ops		30-Nov							Dashboard is created and operational
Objective	Refine Data Collection Instruments										
Task	Finalize Clinical Protocols with Partners as required	Ops/SMHC		31-Oct							Tools accepted. Dissemination Plan created
Task	Final Draft Tools	Ops/SMHC		31-Oct							
Task	Pilot Test Tools	Ops/SMHC		30-Nov							
Task	Final Tools	Ops/SMHC		30-Nov							
Objective	Develop Service Definition and Standards for Reimbursement										
Task	Crosswalk/Review Current Service Reimbursement Models	Ops		31-Oct							Crosswalk created
Task	Establish Standard Required Program Components	Ops		15-Nov							
Task	Establish Utilization Management Specifications and Tracking	Ops		30-Nov							
Task	Establish Fidelity Monitoring Standards and Protocol	Ops		30-Nov							Standards & Protocols created
Administration											
Objective	Execute Contracts and Agreements										
Task	Budget and Plan Approval by EC	Ops		30-Sep							Approved budget and staffing plan
Task	Finalize Required MOUs, BAAs	Ops/SMHC		31-Oct							Contracts and Agreements are signed and in place
Task	Finalize Contracts	Ops		31-Oct							
Task	Finalize Consent Forms and Privacy Agreements (including 42-CFR Part 2)	Ops		30-Nov							Consent Forms and Privacy Agreements are approved and operational
Task	Clinical Advisory Team Review	Ops		30-Nov							
Start-up											
Objective	Formal Launch of Project										
Task	Kickoff Event per Care Team	Ops/SMHC			31-Jan						Kick-Off Event held
Task	Enrollment initiated	Ops/SMHC			15-Jan						
Task	Case Conferencing Begins	Ops/SMHC			28-Feb						Case Conferencing started
Progress Reporting											
Objective	Semi Annual Reporting and document progress										
	Period Ending 12/31/17	Ops/SMHC			31-Jan						
	Period Ending 6/30/18	Ops/SMHC				31-Jul					
	Period Ending 12/31/18	Ops/SMHC					31-Jan				

Project Core Components

Region Six IDN ECC Work Group is currently engaged in creating project standards and processes in our care coordination model that will include all of the core required elements:

- Identified care teams that include care coordinator/managers, primary care providers, behavioral health providers
- Systematic strategies to identify and intervene with target population
- A comprehensive core assessment and a care plan for each enrolled patient, updated on a regular basis
- Care coordination services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources
- Transitional care coordination across settings, including from the hospital to the community
- Technology-based systems to track and share care plans and to measure and document selected impact measures
- Robust patient engagement process around information sharing consent
- Coordination with other care coordination/management programs or resources that may be following the same patient so that to the extent possible, only one care coordinator/manager is playing a lead role in managing the patient’s care plan

E-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list all of the measurable 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.

We are conducting an up-to-date follow-up, full scale survey of partners in the network to assess measures currently in place, the availability of registry data, and establish standards for baseline performance measures. Standards will be informed by those established by the National Quality Forum Preferred Practices and Performance Measures.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# individuals served	TBD	TBD	TBD	TBD
# referrals and continued participation in care	TBD	TBD	TBD	TBD
# client generated goals met	TBD	TBD	TBD	TBD
Adherence to care plan	TBD	TBD	TBD	TBD
Preventive screening and immunization	TBD	TBD	TBD	TBD
Disease/Condition-specific Measures	TBD	TBD	TBD	TBD
Functional status	TBD	TBD	TBD	TBD
Crisis services utilization	TBD	TBD	TBD	TBD
School attendance/truancy	TBD	TBD	TBD	TBD
Medication adherence	TBD	TBD	TBD	TBD
Care Continuum Alliance or other Provider Tool	TBD	TBD	TBD	TBD

***TBD: Baseline measures cannot be determined until we know the number of school-based partners who formally agree to adopt the project/protocol . Then, target measures will be determined by aggregation of participating partners estimates of eligible enrollees. Will have reportable numbers for 12/31/17 SAR, but unknown at this time.

E-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the workforce targets and timeline milestones specifically related to this project using the format below.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Clinical Care Coordinator	6	0			
Clinical Supervision (3 hrs/week per CCC)	Up to .5FTE	0			

Recruiting and Hiring: First will systematically conduct outreach to the Human Resources departments of each of our partner agencies. Our objectives are three-fold: 1) to keep our partners informed of our workforce needs, strategies and potential competition for current or future staff, 2) to share job descriptions and position announcements with each key partner, and 3) to solicit any recommended candidates from the partners' applicant pool in advance of public posting of positions. After solicitation of Human Resources Departments from our IDN partners, we will circulate job announcements throughout our e-mail listservs and post announcements on popular and commonly used web-based job boards (Indeed; NH NonProfits; Idealist, etc.).

E-4. IDN Community Project: Budget

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

Budget	<u>Q3-Q4</u> <u>2017</u>	<u>Q1-Q2</u> <u>2018</u>	<u>Q3- Q4</u> <u>2018</u>	<u>2019</u>	<u>2020</u>	<u>TOTAL</u>
E.5 Enhanced Care Coordination						
E5 Workforce Expenses						
Recruitment (with bonuses)	5,000	10,000	10,000	10,000	10,000	45,000
Retention	5,000	5,000	5,000	15,000	15,000	45,000
Training/Education	10,000	15,000	25,000	15,000	15,000	80,000
Workforce Staffing						
Clinical Care Coordinators (6)						
Clinical Supervision						
Section Subtotal	70,000	120,000	210,000	405,000	405,000	1,130,300
E5 Project Expenses						
Lease: Office	3,000	3,000	6,000	12,000	12,000	36,000
Supplies; Technology; Equip	5,000	5,000	15,000	20,000	20,000	65,000
Travel	2,000	3,000	6,000	15,000	15,000	41,000
Enabling Technology	0	0	20,000	40,000	40,000	100,000
Section Subtotal	10,000	11,000	47,000	87,000	87,000	242,000
TOTALS	80,000	131,000	257,000	492,000	492,000	1,372,300

Budget Narrative: The E.5 budget is based on the projected recruitment, hiring, onboarding, training and deployment of two Clinical Care Coordinators in October 2017, with two more pairs of CCCs added in Q3 and Q 4 of 2018. The core E.5 Team will be employees of Seacoast Mental Health Center (SMHC). The Workforce budget also includes the resources to offset clinical supervision time to be provided by SMHC staff, estimated at 3 hours per CCC per week. We anticipate the payment of modest sign-on bonuses for new staff (due to very high cost-of-living in Seacoast Region) and other costs associated with recruitment (advertising, staff time, etc.). We will invest in resources specifically intended to improve Retention, to include enhanced coaching, mentoring, continuing education incentives, team-building time and resources, recognition, and other investments that reside outside standard training. The Training budget contemplates additional intensive training for E.5 staff.

The E.5 Team will require dedicated office space to be provided by SMHC outfitted with basic supplies. The Lease line represents an allocated cost offset for that space. Each team member will also require standard electronic devices (laptop, mobile phone, etc.), and mileage reimbursement for considerable local travel between and among partner agencies and community settings. We anticipate the deployment and testing of novel Enabling Technologies to enhance the delivery, coordination and impact of services.

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

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

Organization/Provider	Agreement Executed (Y/N)
Families First Health and Support Center	In Process – Expected Dec 31
OneSky Services	In Process – Expected Dec 31
Seacoast Mental Health	In Process – Expected Nov 30
Potential Partners to be added as identified	
Chase Home for Children	Pending Verbal Commitment
Winnacunnet High School	Pending Verbal Commitment
Seacoast Youth Services	Pending Verbal Commitment
Exeter Hospital and Core Physicians	Pending Verbal Commitment
Division of Children, Youth and Families, NH DHHS	Pending Verbal Commitment
Bureau of Juvenile Justice Services, DCYF, NH DHHS	Pending Verbal Commitment
Krempels Center	Pending Verbal Commitment
Portsmouth Regional Hospital	Pending Verbal Commitment
Community Partners	Pending Verbal Commitment
Lamprey Health	Pending Verbal Commitment
Goodwin Community Health	Pending Verbal Commitment
Wentworth Douglass Hospital and Partners	Pending Verbal Commitment

The table represents the many community partners have been engaged in, and contributing to the development of our E.5 Enhanced Care Coordination Project. At this writing, three key partners have agreed to execute Memoranda of Commitment. We expect a number of these organizations to also sign MOC's before 6/30/17 as implementation unfolds, although due to the nature of this project's implementation it is premature to commit to a subset of specific agencies.

E-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
Community Supports Inventory	Systems-level Assessment
Functional Needs Assessment	Under Development
Arizona Self Sufficiency Matrix	Multi-domain Evidence-based Tool (considering)
Fidelity Monitoring	Designed from existing tools (e.g. Wraparound)

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

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

There are several service delivery models currently in operation in our region that serve smaller segments of the target population. This project does not seek to duplicate or supplant any of these existing services or alter their protocols, but rather enhance capacity for appropriate referral and participation in these protocols, enhance the coordination of services among and between IDN providers as indicated and appropriate in care plans, and improve engagement with and completion of existing protocols. The following are examples of the program protocols in place with which our Enhanced Care Coordination Model will partner.

Protocol Name	Brief Description	Use (Current/Under Development)
RENEW	Strengths-based strategies for setting and obtaining life goals	In use by SMHC
Partners in Health	Home visiting for conditions of 12 months or more (up to 21y/o)	In use by Families First
Wraparound	Intensive Family Systems of Care Coordination Model	Modest use in Strafford County

The Region Six Enhanced Care Coordination project is focused first on improving the coordination and alignment of existing programs and services that each have their own assessment, treatment and referral protocols. The ECC Work Group of experts strongly advised against the development of a new assessment, treatment or referral protocol in advance of establishing a comprehensive understanding of the many existing programs and initiatives already being offered in varying degrees of availability and accessibility across the region.

As boundary-spanners who are coordinating existing assessments and treatment services, it is the job of the ECC Team is to learn about existing gaps and opportunities in assessment, treatment and referral protocols that serve the target population. While we do not anticipate offering treatment services in the context of Enhanced Care Coordination, we do anticipate developing a protocol for screening and referral to ECC staff to be employed by partners (primarily for schools) by March 31, 2018.

E-8. IDN Community Project Member Roles and Responsibilities

Use the format below to identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

Project Team Member	Roles and Responsibilities
[REDACTED]	[REDACTED]

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

The E.5 Project Training Plan is comprised of a combination of Core and Supplemental Trainings for new project staff, as well as those offered to staff of all partner agencies. The specific curricula for trainings are still in development, as some will be delivered through contracted providers, while some may be delivered through IDN Operations staff. Whenever possible we will recruit IDN Partner agency staff to participate in the design and delivery of trainings in an effort to build partner relationships and cultivate an environment and processes for knowledge transfer within the IDN. The E.5 Core Team core trainings through the Region 6 Workforce Capacity Building initiative. The required and supplemental trainings are detailed in Section B1-8c. Scheduling of trainings are to be aligned with the needs, demand and delivery of trainings across IDN projects. We have provided Training Descriptions and Learning Objectives for each training in B1-8c, however until contracts with trainers have been executed we cannot provide a fully developed curriculum for each.

Core Project Staff:

- Core Series (BH 101; CSA; Integration)
- Mental Health First Aid
- Resiliency and Retention
- Cultural Competency
- Motivational Interviewing
- Trauma
- will also receive ongoing training and coaching through Project RENEW

Partner Agency Staff:

E.5 Training Schedule	6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
Core Trainings - Project Staff								
Behavioral Health 101		Nov 30		Dec 31		Dec 31		Dec 31
Core Standardized Assessment		Nov 30		Dec 31		Dec 31		Dec 31
Integration in Practice		Dec 31	Mar 31	Dec 31		Dec 31		Dec 31
Mental Health First Aid		Dec 31		Dec 31		Dec 31		Dec 31
Resiliency & Retention			Mar 31	Dec 31	Jun30	Dec 31	Jun30	Dec 31
Cultural Competence			Mar 31	Dec 31	Jun30	Dec 31	Jun30	Dec 31
Motivational Interviewing		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Trauma Informed Care		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Core Trainings - Partner Staff								
Behavioral Health 101		Dec 31		Dec 31		Dec 31		Dec 31
Core Standardized Assessment		Dec 31		Dec 31		Dec 31		Dec 31
Motivational Interviewing		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Trauma Informed Care		Dec 31	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

All participating Agencies will be invited to participate in Core Series and Supplemental Trainings. The long term schedule of Core Staff Trainings anticipates either potential turnover or added growth that cannot be accurately predicted at this time.

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

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

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

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

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap, a “plan to plan”, currently under CMS review, articulates the process by which the state will work with the IDNs, Medicaid managed care organizations (MCO), and other Medicaid services stakeholders, develop a statewide APM workgroup and develop the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020. IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics. Each IDN will be required to develop an IDN-specific APM Implementation Plan. Once finalized and CMS approved, the DSRIP APM Roadmap will be posted to eStudio.

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

Use the format below to identify the IDN’s participation in Statewide APM Taskforce activities, completion of a Statewide APM Implementation Plan, and completion of the IDN APM Implementation Plan. Of note, *all* IDNs must participate in the development and writing of a Statewide Implementation Plan. Should the Statewide APM Implementation Plan not be completed, *all* IDNs will receive a “no” for this effort.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners			
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings			
Completion of the Statewide APM Implementation Plan			
Participation in the creation of the IDN APM Implementation Plan			

DSRIP Outcome Measures for Years 2 and 3

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

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

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

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
		Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose