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

D3 Core Components

Per STC's

Core Components		
	1. At least 1 higher intensity service: Intensive Outpatient (IOP), Partial Hospitalization (PH), Non-hospital based residential treatment services	• **Ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services, should be offered concurrent or in tandem, as indicated, with assisted treatment services (MAT) are also a critical component for effectively addressing substance use disorders** • **Providers will offer concurrent treatment for co-occurring tobacco use disorder**
	2. Ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services	• Should be offered concurrent or in tandem, as indicated, with assisted treatment services (MAT) are also a critical component for effectively addressing substance use disorders
	3. Regular outpatient counseling for substance use disorders or co-occurring disorders	• Provided by qualified practitioners, for individuals with lower levels of acuity broadly across the spectrum of health and social service programs within the IDN
	4. Coordination to Core Competencies as required as part of Project B1 Integrated Healthcare	• Including the use of screening, brief intervention, and referral to treatment (SBIRT)

		• See attached for full list of Core Competencies of B1
	5. Workforce requirements coordinated with and incorporated into IDN's Workforce Capacity Development plan	• Link to Project A1 Behavioral Health Workforce Capacity Development

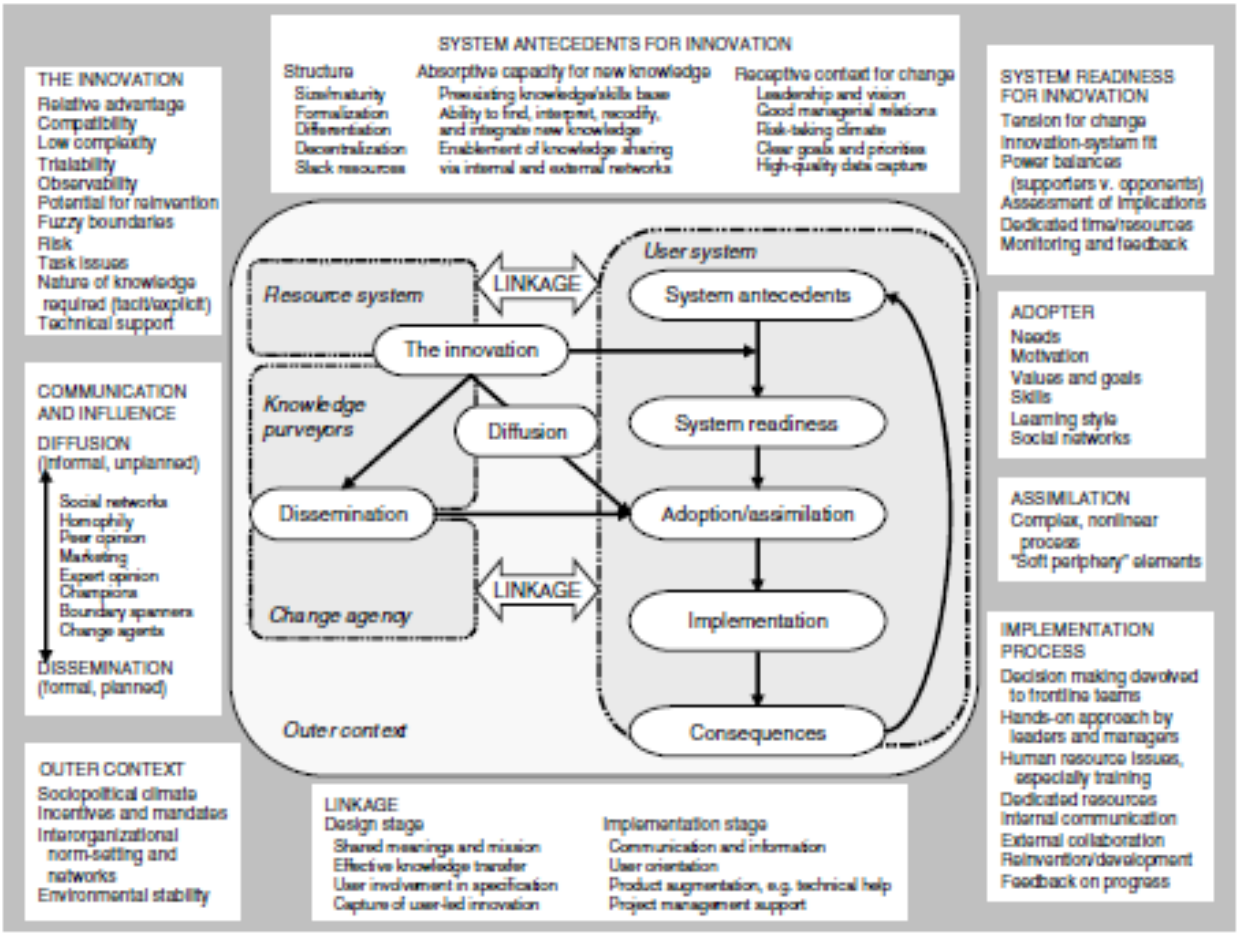
Region 1 D3 RFA Round 1:

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

1. Offers individual organizations a forum for collaborating with other organizations to propose, fund, and implement a tangible transformational project and to share findings openly with other interested organizations for dissemination.
2. Creates the collaborative conditions, inter-organizational trust, supporting resources, and funding for bottom up change.
3. Provides an open and transparent process for allocating 1115 Waiver funds supported by a multi-stakeholder / multi-disciplinary Independent Review Board and overseen by the multi-organizational governance body.

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

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



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

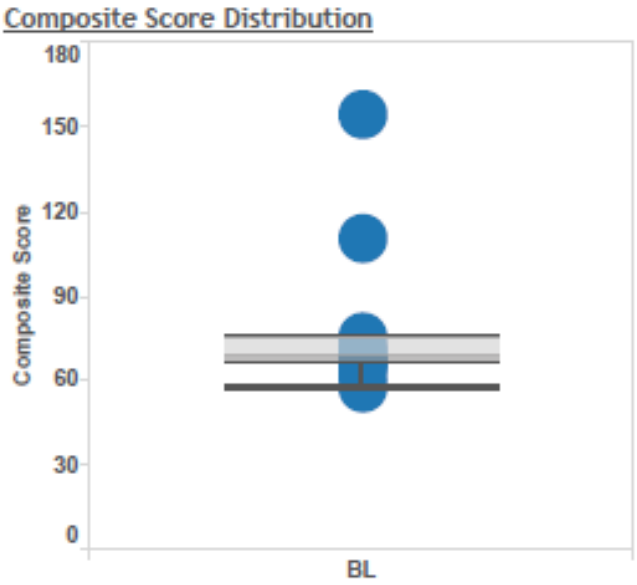
Region 1 leaders are committed to a strategy that would lead to transformative change that can be sustained even after DSRIP funding had ended. Leaders acknowledged that Region 1 is not a system, indeed there are at least 3 distinct regions within this region (Upper Valley, Sullivan County, Cheshire-Keene)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

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

- Variation in 'readiness for change';
- Variation in skills, knowledge, and/or resources for improvement or innovation work;

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

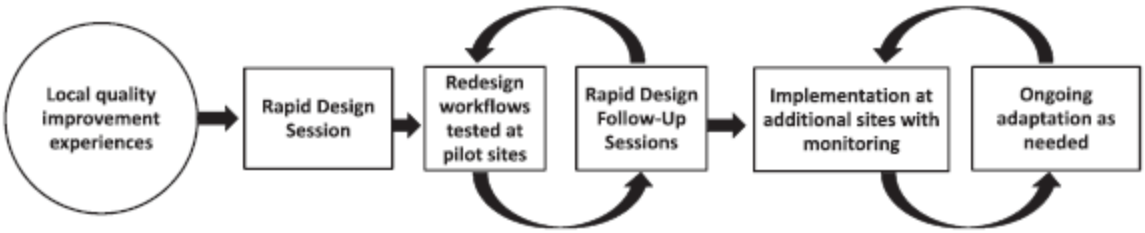
Results from the Region 1 integration assessment report reaffirmed the variation discovered during partner interviews. As described in the Region 1 IDN B1 Implementation Plan IDN partners completed the Maine Health Access Foundation Site Self-Assessment survey in May-June 2017. This validated tool scores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



Composite Scores by Practice

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

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



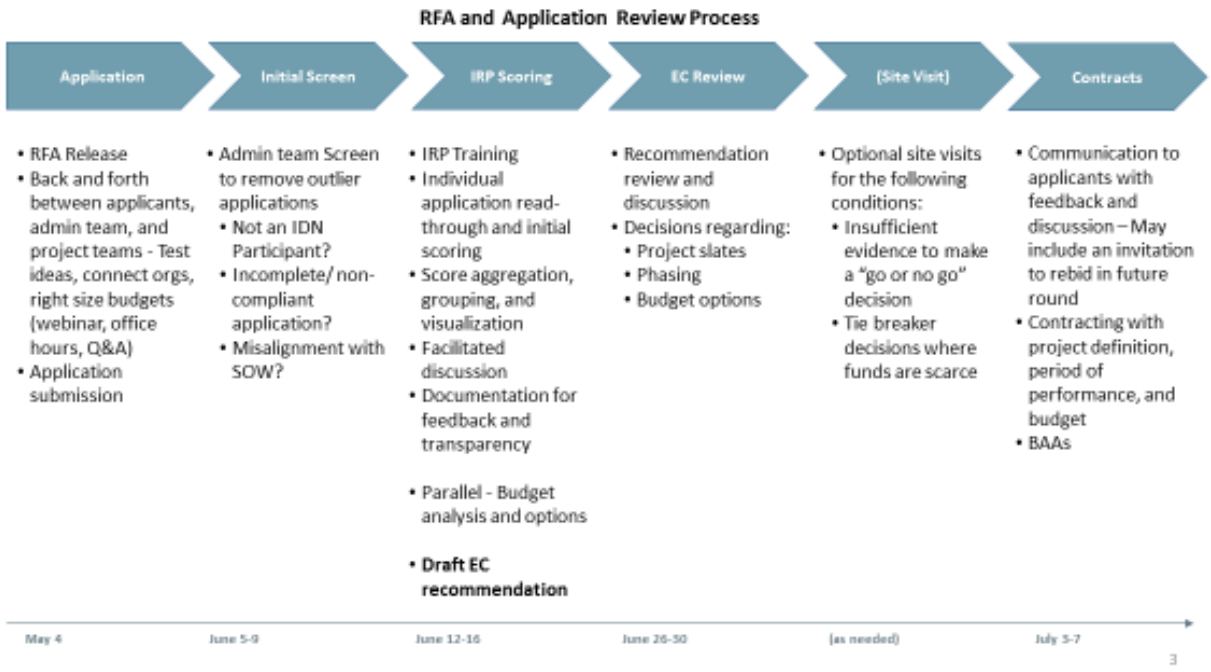
The RFA process was endorsed as the strategy with the greatest likelihood of creating lasting change in the IDN and the most fiscally responsible strategy, avoiding investments in processes or structures that had not been tested for feasibility in our region.

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

RFA Timeline Milestones	Date
RFP Process Shared with Region 1 IDN	Thursday, May 4th
Region 1 Admin. Leads hold "Office Hours" and Q&A Webinars for RFA Support	Weeks of May 8th and 15th
Application Deadline for Submission	Monday, June 5th
Application Review Period by • Admin. Leads • Project Teams • Independent Review Panel	Weeks of June 5th, 12th and 19th
Final Approval by Executive Committee	Week of June 26th
Funding Disbursed	Not later than Friday, July 17th

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

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



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

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

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

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

Tier	Committee Name	Committee Composition	Evaluation Criteria
1	Administrative Leaders	• Executive Director • Project Manager • Medical Director	• Is the application complete? • *Solicit any additional information needed to make application complete through an iterative process with applicant.* • Does this proposal align with the scope of work advanced by the project teams? • Is there a contract on file? • Are the necessary compliance and conflict of interest forms in place?

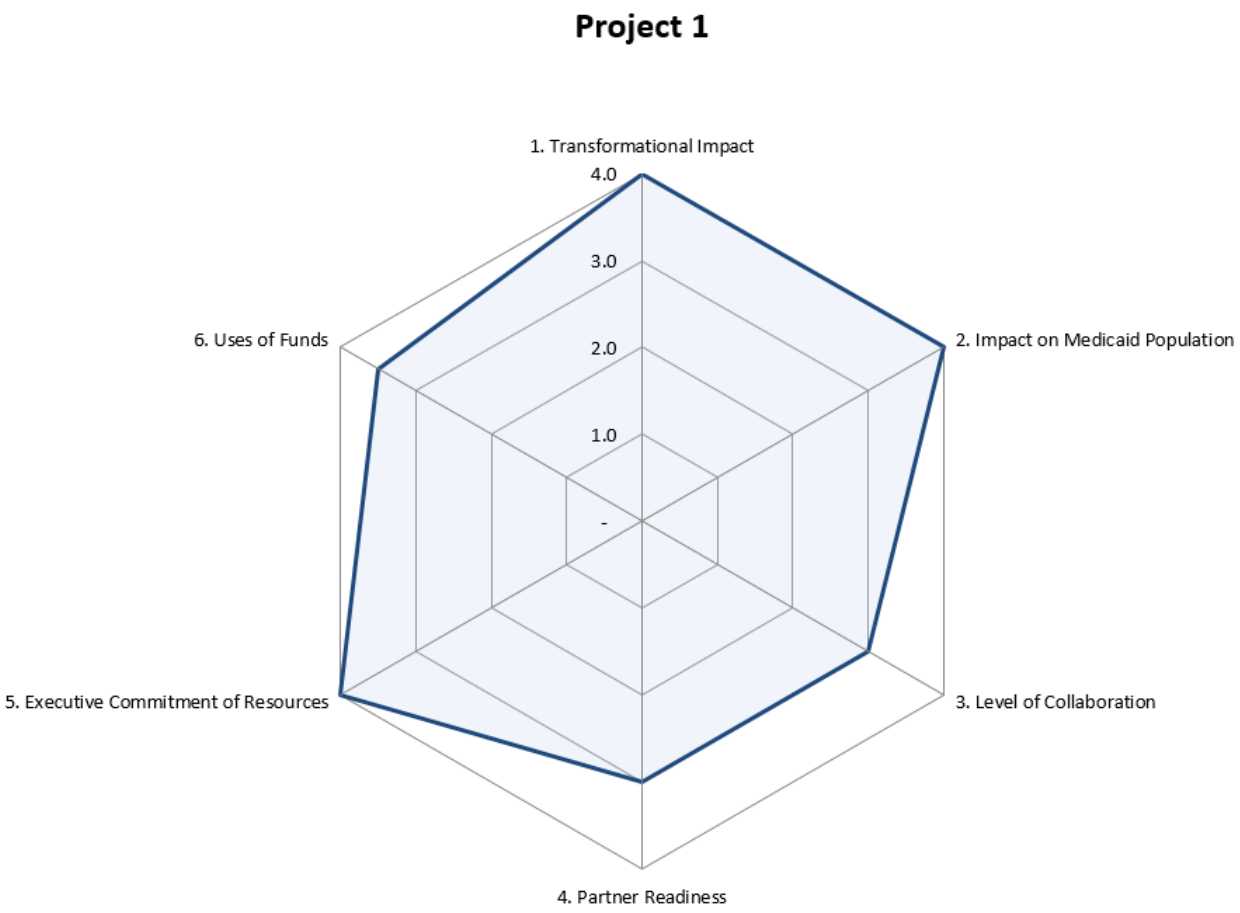
			• Recommend proposals as a slate for review by the Independent Review Panel.
2	Region 1 Independent Review Panel	• Finance Workgroup Member • HIT Workgroup Member • Clinical/Workforce Workgroup Member • Community Engagement Workgroup Member • Executive Committee Member • Administrative Lead Organization Representation • Executive Director (non-voting)	• Anticipated Transformational Impact • Anticipated Impact on Region 1 Medicaid Population • Levels of Collaboration • Partner Readiness • Level of Executive Commitment • Use of Funds • Recommend slate of proposals for final review by Executive Committee.
3	Executive Committee	• 7 voting members • 7 non-voting members (IDN Administrative Leadership Team)	• Review all criteria and recommendations of Region 1 Independent Review Panel. • Does the slate of proposals advance transformation of care in our regions toward integration? • Ensure the proposals/slate of proposals preclude biases and conflict of interests?

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

	Good (1 point)	Better (2 points)	Best (3 points)
Anticipated transformational impact	Proposed project shows promise for serving the needs of Medicaid members but is not designed to change the current care delivery system.	Proposed project shows some promise for positively transforming the way in which the health and wellbeing of Medicaid members is supported. Proposed approach is supported with some evidence of efficacy where available or demonstrates some ingenuity where evidence is scarce.	Proposed project shows great promise for positively transforming the way in which the health and wellbeing of Medicaid members is supported. Proposed approach is supported with significant evidence of efficacy where available or ingenuity where evidence is scarce.
Partner Readiness	"Ready Later:" Applicant is ready to start in 2018. Proposed project is formulated but requires significant additional planning prior to launch.	"Ready Soon:" Applicant is ready to start in late 2017. Proposed project is well formulated but requires additional detailed planning prior to launch.	"Ready Now:" Applicant is ready to start in July/Aug of 2017. Proposed project is already designed in detail and ready for immediate implementation.

Anticipated impact on Medicaid population	Proposed project is expected to impact a small portion of the Medicaid members in the region.	Proposed project is expected to impact a modest portion of the Medicaid members in the region. Alternatively, the proposed project is expected to impact a small number of Medicaid members with the most acute needs.	Proposed project is expected to impact a large portion of the Medicaid members in the region. Alternatively, the proposed project is expected to impact a modest number of Medicaid members with the most acute needs.
Level of Collaboration	Applicant proposes a single organization project. Applicant has not yet established working relationships with partners.	Applicant proposes to work with other organizations to implement the project. Applicant has established some working relationships with partners but requires additional connections and commitments to collaborate.	Applicant proposes to work deeply with other organizations to implement the project. Applicant has established deep working relationships with all partners. Partners have committed to collaborate with Applicant.
Level of Qualification	Applicant has little experience in implementing projects like the 1115 waiver.	Applicant has a positive record in implementing projects similar to the 1115 waiver but of smaller size and scope.	Applicant has a positive record in implementing projects of similar size and scope as the 1115 waiver.
Level of Executive Commitment	Top executive(s) of the applicant organization are absent from the project planning.	Top executive(s) of the applicant organization are involved in the project. The executive(s) see this project as important and have committed to devoting some of the organization's time, resources, and talent to the project.	Top executive(s) of the applicant organization are deeply involved in the project. The executive(s) have made the project a top priority and are committed to devoting a significant amount of the organization's time, resources, and talent to the project.

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



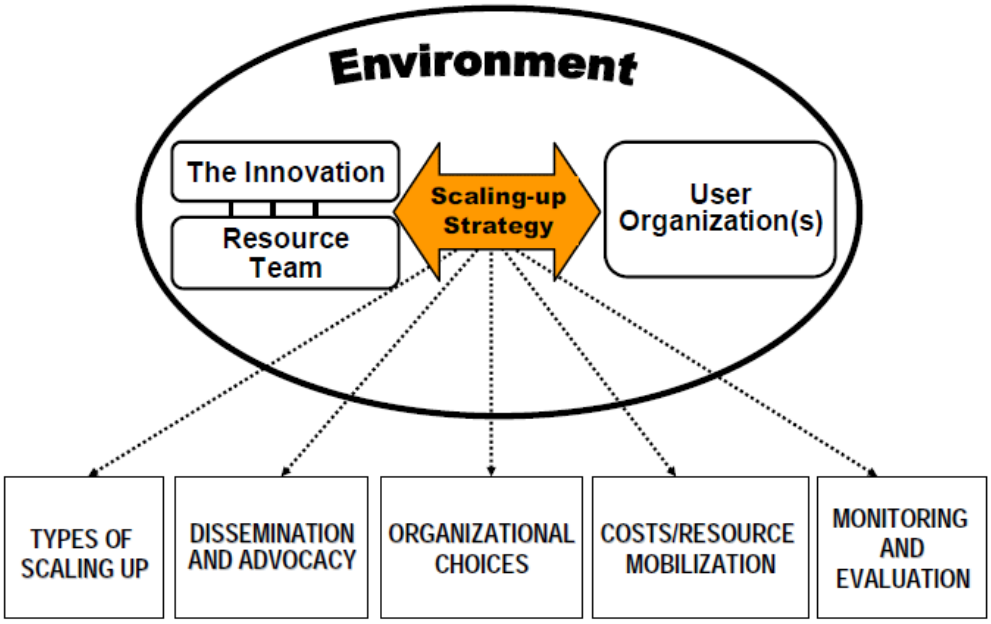
Information about RFA and details on the review process were shared with all IDN partners through written communications, webinars, postings on the Region 1 website, and verbal communications.

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

The goal of this iterative process is to develop a learning system; a system that capable of using data across the continuum of care to continuously improve performance. Each funded RFP team agrees to collect and report data and to share their experiences so all members of the IDN can learn best practices. Funded project teams also agree to serve as mentors to other IDN partners, sharing details of their work, hosting site visits and participating in knowledge exchanges. Funding for project teams requires

documentation that milestones have been met (see Appendix B- Use of Funds Section). Region 1 is committed to creating a sustainable system of learning capable of continuous improvement in the years to come.

Figure 1: The ExpandNet Framework for Scaling-up



WHO Nine Steps for Developing a Scaling Up Strategy

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

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

RFP Proposals Received in Round 1 RFP

Project Category	Organizational Applicants	Approved for Round 1 Funding
B1	West Central Behavioral Health, D-H Heater Road Primary Care, D-H Psychiatry	Yes
C1/E5	Monadnock Family Services, Cheshire Medical Center, Monadnock Collaborative	Yes

D3	Perinatal Addiction Treatment Program- D-H Psychiatry	Yes
	Mindful Balance Therapy Center	Not approved at this time
E5	Valley Regional Hospital	Yes
	NAMI	Not approved at this time
	TLC Family Resource Center	Not approved at this time

Moving forward it is anticipated that a Round 2 RFP will be opened using the same RFP process and criteria for the D3 project in the spring of 2018. The Region 1 team will be facilitating Knowledge Exchange meetings for all IDN partners potentially involved in the D3 project monthly from August, 2017- June, 2018. These meetings will continue to foster the open culture around project creation and relationships between the providers active in the D3 project in Round 1 and those that may be looking to move forward in subsequent waves. This process followed a formal review process and the target areas for proposal assessment (below) were outlined in the RFA documentation.

Scope of Work Development:

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

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

D3 Scope of Work

Medication Assisted Treatment Expanded IOP:

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

Medication assisted treatment (MAT) will be a component of the IOP program, and those clients diagnosed with opioid use disorder, who are evaluated as good candidates for MAT, will receive educational information on MAT and if willing, will be set up with the MAT healthcare provider for an assessment and for induction to take place. An additional follow up appointment with the MAT provider

will be scheduled within a few days following induction. All MAT clients in IOP will participate in at a minimum of one hour (of 9hrs a week) MAT specific group with a clinician and the MAT provider. Once they have completed IOP, or if they meet OP ASAM Level 1, clients will be enrolled in a weekly Ongoing Recovery Support group, which is a process group, as well as a one- hour MAT specific group. MAT patients can also request an individual session with the MAT provider.

Required Elements of MAT- IOP Framework:

- Potential IOP clients will complete a thorough bio-psychosocial assessment, utilizing the Comprehensive Intake Assessment, a clinical interview, and meet the ASAM 2.7 level, prior to starting the program to identify their individual problems, needs, assets and strengths and to determine if the IOP is the appropriate level of care to meet these needs
- Clients will complete an individualized treatment plan with their counselor within the first week of treatment. The IOP Treatment plan must include all 6 domains of the ASAM.
- Clients commit to a minimum of 3 group sessions weekly for at least 6 weeks (recommended 10-12 weeks) (Maximum of 8-10 clients per group) of curriculum based psycho-education and group therapy.
- All clients in the IOP must be provided with an option to pursue individual counseling and a connection to recovery support services either internal or external to the organization.
- All clients are required to submit random urinalysis screenings
- The IOP will include a component of family involvement and education.

Staff Required:

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

Suggested and Recommended-Evidence Based Treatment Methods:

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

Focus Area:

Pregnant Women

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

Specific Needs:

- Gender Specific
- Trauma Informed
- Parenting
- Life Skills

Region 1 IDN's Initial D3 Implementation Project

In response to our May 2017 RFP process, the Region 1 IDN Executive Committee selected a proposal from Dartmouth Hitchcock- PATP to Implement an Intensive Outpatient Program project starting July 1, 2017. This is consistent with our D3 Project Team's recommendation that our region start our work with one D3 project pilot then pursue additional Intensive SUD focused projects later in 2018. Below is application text from the DH-PATP proposal that provides a description of this planned project:

Perinatal Addiction Treatment Program Intensive Outpatient Project:

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

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

Currently the only gender-specific SUD treatment option in Region 1 is that provided by the Dartmouth-Hitchcock Perinatal Addiction Treatment Program (PATP) in Lebanon, a once weekly office-based

outpatient program. The proposed project builds on the existing infrastructure of the current program, which includes deep knowledge of the social and health needs of this population, medication assisted treatment, weekly group therapy, peer support, integrated psychiatric and reproductive health care, and case management for pregnant and parenting women.

Program components will include:

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

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

Childcare. A major barrier to treatment for this population is a lack of childcare. Typically, this population struggles with inadequate social supports: extended family and fathers of their children may also be

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

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

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

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

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

Implementation Timeline

*See the Region 1 Implementation Plan Timeline Appendix C

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

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

In regard to training, the current Masters Level Clinicians employed by the PATP completed the Circle of Security Training early in summer, 2017. All current staff are participating in Motivational Interviewing refresher trainings as well during summer, 2017. A number of treatment modalities and evidence based addiction treatments will be used for the PATP IOP program primarily:

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

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

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

July – August 2017:

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

August-September 2017:

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

September/October 2017:

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

October/November 2017:

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

November 2017- June 2018

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

January 2018-July 2018

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

April/June 2018

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

Budget

*Please see Budget Table in E5-4

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

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

Training Plan

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

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

These targeted population, in the case of the IOP, is mothers with SUD as well as challenges with emotional regulation, impulse control, aggression, detachment, and disruptive behavior patterns. The training requirements will be met by the identified IOP staff members and can be completed in a 4-day training with a total of 24 hours of training.

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

Pregnancy-focused

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

Not pregnancy-focused

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

Process Milestones:

*Please See attached Appendix D: D3 Evaluation Table

Y1Q1
PATP additional staff recruited and hired, including clinician, case manager and childcare provider
PATP-IOP schedule developed, including staffing schedule
PATP-IOP protocols developed including intake protocols, participation guidelines, family support (childcare) guidelines
PATP-IOP initial curriculum developed
Y1Q2
PATP fully staffed and oriented
Outreach to community agencies to inform about program and invite referrals
Intake provided to initial group participants
PATP outpatient program expanded to second day
Y1Q3
First cycle of PATP-IOP completed
PATP-IOP graduates transitioned, when appropriate, into PATP outpatient program
PATP-IOP curriculum and structure assessed and adjusted as needed
Y1Q4
Outcome data accumulated and reviewed
Curriculum and Program Structure Documented
PATP-IOP ongoing and fully integrated with PATP-outpatient program
Budget for 2018-19 developed and funding sources identified

Evaluation Plan

*See the attached Evaluation Plan Framework in Appendix E

Projected Improvement Outcomes

1) Improved access to care. Participating women will be provided with:

a. Comprehensive, intensive addiction treatment annually that they would not be able to access otherwise.
b. Treatment of co-occurring psychiatric disorders
c. Intensive support in accessing resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.

2) Improved outcomes for families in which DCYF has assumed custody of the children because of the impact of active addiction.
3) Improved health outcomes for enrolled women and children due to increased engagement in on-site medical services, including decreased morbidity and mortality related to injection drug use during and after program.

Indicators to be measured

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

D3-2. IDN Community Project: Evaluation Project Targets

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Medicaid women successfully completing the IOP program	Will be defined in Q2, Q3 – Dependent upon program enrollment			
Number of women engaged in continuing care one month following completion of IOP				
# of women whose UDS indicate abstinence from all substances not prescribed to them for 4 consecutive weeks prior to completion of the program				
Number of women receiving reproductive health services during program including recommended cervical cancer screening, testing for STIs, screening for HCV and HIV, and discussion of pregnancy intention/contraception				

Number of pregnant women who attend recommended prenatal visits during program				
Proportion of women with an established primary care provider at completion of program as compared to intake				
STC Defined Program Measures				
All performance measures identified within the evaluation plan milestones	100%			
Operationalization of Program	100%			
A. Implementation of Workforce Plan				
B. Deployment of Training Plan				
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures				
D. Use of assessment, treatment, management and referral protocols				
Initiation of Data Reporting	100%			
A. Number of individuals served vs. projected				
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected				
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements				