New Hampshire
Department of Health and Human Services

Building Capacity for Transformation Waiver

Integrated Delivery Network

Semi-Annual Report

(January – June 2017)

Network4Health (IDN 4)

October 3, 2017

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Project Plan Implementation Narrative

Network4Health has made significant progress in the last year – beginning with our application to serve as the Region IV Integrated Delivery Network (IDN) to where we are today --- an organization of providers that stands ready to implement six projects aimed at improving the health of our patients by implementing innovations in workforce, infrastructure and behavioral health integration. This section of our project plan submission provides an overview of Network4Health's progress towards meeting requirements related to soliciting community input, network development, addressing the opioid crisis, governance and budget.

Soliciting Community Input

Network4Health believes its success requires a strong relationship with the communities we serve and our leadership is keenly aware of the need to both be involved in the community and solicit their input. Since our formation, we have made a concerted effort to reach out to community groups and organizations, and have had several interactions across the region. Over the past several months, Network4Health has engaged in the community in several ways including:

- Co-sponsoring a public forum entitled "Connect The Dots: Mental Health & The Opioid Crisis" on May 30, 2017 at the Manchester Health Department. Network4Health partners participated in a panel discussion as part of the forum, which was attended by over 75 community members were.
- Meeting with and presenting to the Rockingham County Delegation Executive Committee and County staff on April 21, 2017. Presentations by [redacted] the Network4Health executive director and the Region VI executive director focused on an overview of the waiver and the goals and objectives of the two IDN's serving Rockingham County.

In addition, Network4Health is in the process of creating a Patient Family Advisory Council (PFAC) and Regional Stakeholders Advisory Council. which will begin meeting in December 2017. Both of these groups will meet quarterly. Nominations for membership were requested from Network4Health partner organizations in September 2017. Meetings will be held in various locations throughout the region. To provide incentive to participate, Network4Health will offer gas/gift cards to patients and families who attend the PFAC meeting.

Network4Health's Executive Director meets twice monthly with other IDN leads to discuss challenges that are common to all regions, including best practices in soliciting community input.

Network Development

Network4Health partner organizations remain stable. There have been no changes in network partners since the beginning of 2017 and no new network partners have been proposed. Network4Health will continue to monitor activities within the region and will consider adding new partners as needs arise that will benefit the residents of Region IV.

To keep partners engaged within Network4Health, the Executive Director continues to meet with partner organization representatives either individually or within the context of project planning meetings to strengthen identification with and support of N4H goals and objectives. Quarterly all partner meetings are critical to continuing development of the network.

Due to the intensity of project implementation planning over the course of the last six months, much of the network development has occurred as an outgrowth of the collaborative efforts of the project planning teams.

Addressing the Opioid Crisis

Network4Health recognizes the depth of the opioid crisis in the greater Manchester area and is committed to make a different to better the life of our residents. In particular, one of our projects is focused squarely on addressing the opioid crisis by developing and implementing new treatment capacity with the development of a partial hospitalization program; similarly, the Critical Time Intervention (CTI) initiative is an important evidence based practice to use with individuals with addiction issues. Likewise, our focus on integrated treatment for co-occurring disorders also brings focus to those with opioid addiction. In addition to these projects, and our overall focus on improved behavioral health integration, Network4Health has participated in several specific activities across the region and the state to address the opioid crisis., including:

- Co-sponsoring a public forum entitled "Connect The Dots: Mental Health & The Opioid Crisis" on May 30, 2017 at the Manchester Health Department, as described above.
- Participating on a monthly basis in meetings of the Continuum of Care, chaired by [redacted], of Network4Health partner organization Makin It Happen. These meetings are well attended by Network4Health Executive Director and representatives of several partner organizations.
- Participating in a public meeting in Manchester, hosted by the Mayor, on the community's response to the substance misuse. [redacted] prepared a community report summarizing all of the ongoing and planned initiatives including Network4Health programming.

Governance

Network4Health maintains a Steering Committee of 12 members to provide governance to the network. The Steering Committee continues to meet monthly, provides oversight of project plan development and budgeting as well as develops policies and procedures for Network4Health. Membership in the Steering Committee has remained relatively stable and had not changed since [redacted] left that organization. Network4Health recently replaced a Steering Committee member, [redacted] from the Elliot Health System in early July. In accordance with our Steering Committee charter, the group voted on a new member at its next Steering Committee meeting and filled the spot with [redacted] who is also from the Elliot Health System.

Monitoring Progress

Network4Health will continue to monitor our progress on meeting our and the Department's goals on a regular basis. The table below provides implementation activities and milestones, the responsible party within Network4Health, the timeframe for the activity and progress measures. Each of the activities delineated below will be ongoing throughout the course of the demonstration. As noted above, Network4Health is working to engage a Patient Family Advisory Council and a Regional Stakeholders Advisory Council. The first meeting for both of the groups is planned for December 2017, and the groups will meet on a quarterly basis throughout the demonstration. In terms of Network Development, Network4Health will monitor its membership on a regular basis and quarterly will report on the potential for new members to join Network4Health. To retain our current membership and keep them engaged throughout the project, Network4Health will hold a quarterly partnership meeting. The steering committee will meet on a monthly basis and will be more involved in the daily activities of Network4Health.

Network4Health will continue to be engaged in efforts to combat the opiate crisis in New Hampshire. As part of this effort, Network4Health will be represented monthly at the Continuum of Care Meetings, and will continue to participate in, and sponsor where appropriate, community events and forums to address the opioid crisis.

Implementation Activity/ Milestone: Community Input	**Responsible Party/ Organization**	**Timeline**	**Progress Measure / Notes**
Establish and meet on a regular basis with Patient Family Advisory Council	N4H Executive Director	Quarterly, beginning in December 2017.	Group will be established and meet on a quarterly basis beginning in December 2017.
Establish and meet on a regular basis with the Regional Stakeholders Advisory Council	N4H Executive Director	Quarterly, beginning no later than Q4 2017.	Group will be established and meet on a quarterly basis beginning no later than Q4 2017.
Implementation Activity/Milestone: Network Development	**Responsible Party/ Organization**	**Timeline**	**Progress Measure**
Continue to consider whether any new partners should be invited to join Network4Health	N4H Executive Director	Quarterly	Quarterly review of partners and potential for new members (Note that Network4Health does not expect to add new members)
Hold quarterly all partner meetings	N4H Executive Director	Quarterly	Quarterly all partner meetings are held.

			Agendas are designed to update partners on N4H progress and gain input, as appropriate.
Implementation Activity/Milestone: Addressing the Opioid Crisis	**Responsible Party/ Organization**	**Timeline**	**Progress Measure**
Participate in ongoing community activities and presentations focused on the Opioid crisis.	N4H Executive Director; N4H partner organizations	Quarterly	Actively participate in at least on one community-based activity focused on the opioid crisis each quarter.
Participate in monthly Continuum of Care Meetings.	N4H Executive Director; N4H partner organizations	Monthly	N4H is represented at each monthly meeting by one or more representatives.
Implementation Activity/Milestone: Governance	**Responsible Party/ Organization**	**Timeline**	**Progress Measure**
Hold monthly meetings of the N4H Steering Committee	N4H Executive Director	Monthly	Monthly meetings of N4H Steering Committee are held.

Budget

Network4Health has adopted a fiscally conservative approach to utilization of Project Design and Capacity Building funds. These funds support the salary and benefits of the Executive Director, a Financial Manager (.5 FTE), Project Management (1.6 FTE) and a recently added a Population Health Data Analyst (1.0 FTE). The Steering Committee has also authorized the use of these funds to support three project directors- Care Transitions Director/Clinical Supervisor; SUD Intensive Out Patient Program Director and Director of Integrated Treatment of Co-Occurring Disorders. By funding these positions through the Project Design and Capacity Building fund, Network4Heatlh can hire for these positions well in in advance of approval and the release of transformation funding. This project "start-up" funding will be replenished when transformation funding is received in the fall.

Project plan funding has been developed with an emphasis on limited administrative overhead and maximum funding directed to impacting patient care. However, there are remaining administrative expenses to be planned, budgeted and approved by the Steering Committee. These include but are not limited to: administrative support for Executive Director, implementation expenses associated with the planned Patient Family Advisory and Stakeholder Advisory Councils, web site and other promotional development for the network, among others.

The budget below provides a detailed description of how Network4Health plans to utilize its Project Design and Capacity Building Funds over the course of the demonstration. The majority of funding is focused on employees and general consulting, and miscellaneous administrative and other costs

associated with operating the IDN and obtaining community input. Salary and benefits account for a 3% increase in years 3-5.

PROJECT DESIGN AND CAPACITY BUILDING	CY 2016 (Yr1)	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
Total Revenue (received in two payments to CMC)	$ 5,216,890				
Rollover		$ 5,048,734	$ 4,400,937	$ 2,958,089	$ 1,491,136
Total Revenue	$ 5,216,890	$ 5,048,734	$ 4,400,937	$ 2,958,089	$ 1,491,136
Salary & Benefits 1 FT	$ 79,620	$ 159,240	$ 164,017	$ 168,937	$ 174,005
Salary & Benefits .2 FTE 1.4 FTE	$ 10,500	$ 176,878	$ 178,091	$ 182,424	$ 186,756
Salary & Benefits-	$ 2,917	$ 36,279	$ 37,367	$ 38,488	$ 39,643
Salary & Benefits (including technology requirements)- 1 FTE		$ 75,000	$ 136,525	$ 140,621	$ 144,839
Consulting	$ 68,619	$ 42,000	$ 40,000	$ 40,000	$ 40,000
Salary & Benefits- 3 FTE		$ 150,000	$ 304,500	$ 313,635	$ 323,044
Steering Committee Project Team Support and other N4H administrative support.			$ 573,348	$ 573,348	$ 573,348
UNH Law Health Practice & Policy Institute Privacy Consult	$ 6,500				
Quarterly Partner Meetings- refreshments		$ 6,000	$ 6,000	$ 6,000	$ 6,000
Miscellaneous Office Supplies		$ 2,400	$ 3,000	$ 3,500	$ 3,500
Subtotal	$ 168,156	$ 647,797	$ 1,442,848	$ 1,466,953	$ 1,491,135
Variation to Budget (Transfer Funds to Subsequent Year)	$ 5,048,734	$ 4,400,937	$ 2,958,089	$ 1,491,136	$ 1

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

Use the format below to identify the IDN's participation in Statewide Workforce Taskforce activities and completion of a Statewide Workforce Capacity Strategic Plan. Of note, *all* IDNs must participate in the development and writing of the Statewide Workforce Capacity Strategic Plan. Should the Statewide Workforce Capacity Strategic Plan not be received by DHHS, *all* IDNs will receive a "No" for this effort.

Statewide BH Workforce Capacity Taskforce Strategic Plan Activity	Yes/No
Participation in taskforce meetings - 1 BH representative	Yes; [redacted]
Participation in taskforce meetings - 1 SUD representative	Yes; [redacted]
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; [redacted] attend monthly statewide taskforce meetings to participate in the development of the Statewide Workforce Capacity Strategic Plan.
Completion of the Statewide Workforce Strategic Plan	Yes; The statewide plan was finalized and voted on 6/28/17

A1-2. IDN-level Workforce: Gap Analysis

Provide a narrative summarizing the results of your IDN's analysis of workforce gaps in your region informed by the Statewide Behavioral Health Workforce Capacity Development Strategic Plan, the IDN's community needs assessment, and selected community-driven projects. The narrative should include identified workforce gaps in education, recruitment, training, and retention of specific behavioral health providers to include but not be limited to:

- *Master Licensed Alcohol and Drug Counselors (MLADC);*
- *Licensed Mental Health Professionals;*
- *Peer Recovery Coaches; and*
- *Other Front Line Providers.*

Gaps In Workforce

Although Region 4 has a significant number of behavioral health providers, as well as organizations providing physical health care, behavioral care, and social supports to address social determinants of health, there remain significant barriers to accessing care. We have identified a number of gaps in workforce. These gaps were identified by Network4Health's Behavioral Health Workforce team through our region's Gap Analysis and also is informed by the Statewide Behavioral Workforce Capacity

Development Strategic Plan. In addition, workforce needs identified across other Network4Health projects being implemented as part of the state's DSRIP activities (including Integrated Healthcare, Care Transitions, Integrated Treatment of Co-occurring Disorders and Expansion of SUD Services and HIT) helped inform this summary.

The gaps in workforce lead to care transition risks and problems. Many individuals find it difficult to access services upon their discharge from a medical or other institution.[1] These are in part linked to wait times for care, as well as a lack of communication and collaboration during a number of transition periods, including discharges from acute-care hospitals, rehabilitation and nursing home stays, mental health inpatient stays, the criminal justice system, and different levels of substance use treatment (detox, IOP, residential, etc.). This lack of communication can lead to missing or delayed referrals, as well as difficulty accessing necessary medications. Care transitions also are difficult for individuals transitioning from youth treatment to adult treatment providers and for individuals transitioning from homelessness to housing. Individuals with SMI frequently experience difficulty in navigating systems, and negotiating transitions in care. Too often such individuals fall through the cracks because their illness interferes with their ability to make and keep appointments and follow through with a provider's aftercare instructions. The vulnerabilities of the population compound the issues of the system.

As reported recently and described in our response to Question 10 in our October 2016 project plan submission, workforce shortages in the mental health system are problematic across the State and pose significant access issues including increased wait times, reduced continuity and quality of care for our most vulnerable population. These shortages in particular affect substance use disorder treatment programs. Even more challenging is recruiting clinicians licensed in both mental health (LICSW, LCMHC, etc.) and drug and alcohol counseling to treat members with co-occurring disorders. Addressing workforce issues is a critical component of our community-based projects (expanding treatment options for substance use disorders integrated care for co-occurring disorders, and community transitions Critical Time Intervention).

The chart below provides the results of Network4Health's workforce survey which were shared with the statewide workforce group. As detailed below, there is a significant need with open positions for LICSW, LMHCs, LADCs, Clinical Psychologists, Psychiatrists, Psychiatric Advanced Practice Nurses, MSWs and nurses. There is not sufficient funding through the IDN to focus on all of these open positions. Instead, of the open positions, the BH Workforce Team finds that the 28 open positions for LICSW, LADC, and MLADC are the most significant gaps and as described below, will focus our funding resources on recruiting for these 28 positions in the first year (year 2). LMHPs were not identified as a significant workforce gap under this analysis, but Network4Health will continue to monitor the need for LMHPs during our annual workforce gap analysis.

In general, these open positions likely understate the need as organizations may not otherwise have capacity to fully expand behavioral health services. Limited use of peer supports, recovery specialists and outreach workers is also an issue. If these workers were available, they may free up time for other

[1] Information gathered in Network4Health Focus Groups held prior to project plan submission in October 2016.

professionals in the workforce to practice more efficiently. Network4Health believes in the importance of peer supports and will try to utilize these specialists as much as possible for the benefit of our patients. To that end, Network4Health job descriptions will include "lived experience" to meet experience requirements, where appropriate.

Results of Network4Health Gaps in Workforce Survey – Open Positions				
Role	**Title**	**License**	**Current Staff**	**Open Positions**
BH (MH & SUD) Clinician	Social Worker	LICSW	89	15
	Counselor	LMHC, LFMT	59	6
	Social Worker Under Supervision		43	0
	Counselor Under Supervision		25	0
	Substance Use Disorder Counselor	LADC, MLADC	37	13
	Substance Use Disorder Counselor		19	0
	Clinical Psychologist	MA, PsyD, PhD	36	11
Psychiatric Clinician	Psychiatrist	MD	12	3
	Psychiatric Advanced Practice Nurse	APRN	21	5
	Psychiatric Physician Assistant	PA	1	0
Care Coordinator	Social Worker	MSW	1	0
	Social Worker	BSW	127	17
	Nurse	NA, LPN, RN	728	112
	Medical Assistant		33	9
	Care Coordinator		82	5
	Nurse (or other) Navigator		8	0
Care Enhancer	Health Coach		3	1
	Community Health Worker		22	1
	Direct Support Worker		370.5	11
	Patient Advocate		0	0
	Patient Educator		2	0
	Health (or other) Navigator		7.5	0
	Personal Care Service Provider		330	24
	Residential Assistant		32	4
	Peer (MH/SUD)	None/CRSW	38.5	9
	Peer (Family/Parent)		4	0
Primary Care Clinician	Physician	MD, OD	17	0

Results of Network4Health Gaps in Workforce Survey – Open Positions				
Role	**Title**	**License**	**Current Staff**	**Open Positions**
	Advance Practice Nurse	APRN	9	0
	Physician's Assistant	PA	5	0
Other	MSW Social Worker or Advanced Degree		6	3
	Interpreter	Internal certification	215	30

Specifically in regards to LADCs, there is an inadequate supply of providers. There are 114 LADC/MLADC providers who are working in the region out of the 456 total across the state.[2] While Network4Health's region has the highest number of providers in the state, the region also has the highest need for services and treatment. Both qualitative data from focus group participants and providers as well as quantitative data on inpatient and ED utilization provide evidence that the region has significant unmet need. This finding is linked to wait times for care, and many focus group participants observed that the problems were most acute with specialty providers, particularly those offering BH care. A 2014 DHHS study of service providers found that many providers did not have the capacity to service people with co-occurring illness including severe and persistent mental illness. In addition, many focus group participants noted that available BH providers did not participate in their health insurance plan.

Issues Leading to Gaps in Workforce

There are many factors that lead to gaps in workforce, including lack of specific education and training, difficulty with recruitment due a limited supply of professionals and low salaries; and difficulties retaining the workforce.

Education and Training: Specifically, there are limited professionals trained to work with individuals who have a co-occurring illness. Many workers have been trained to work with either clients with mental health issues or substance use issues. This results in a large gap because we know that at least 10.9% of the target population has a co-occurring disorder. There is also a lack of consistent and attainable certification standards across the continuum of care.

Gaps in training also persist across the region. Training programs are not keeping pace with changes in demand or current best practices for treating co-occurring disorders. This is one area in which the DSRIP projects will be particularly helpful in providing training for areas identified as needs through the projects. Integrating behavioral health and primary care will require a workforce with the skills and training to address the population's continuum of needs, as well as the knowledge and understanding of the various treatment options available to individuals with complex needs. Finally, new practitioners

[2] Information provided by the New Hampshire Board of Licensing for Alcohol and Other Drug Use Professionals.

require additional training regarding how to navigate potentially complex administrative and operational processes.

Recruitment: Another issue that impacts the workforce is the ability of organizations to recruit individuals meeting the job requirements. Not only is there a dearth of individuals with the appropriate training but low wages and other policy and legislative barriers, such as reciprocity with neighboring states, make it difficult for organizations to recruit highly skilled staff, including APRNs and MDs. The gaps are even greater for Master Licensed Therapists.

Retention: Once an individual is hired, it is important for New Hampshire organizations to learn strategies and have resources available to retain the talent. This can be difficult due to intensity of the direct-care jobs and burn-out rate, as well as the potential for higher wages in the neighboring state of Massachusetts.

Addressing the Gaps

To address the gaps, Network4Health will put specific strategies in place to educate, recruit, train and retain the workforce, particularly MLADCs, LMHPs, Peer Recovery Coaches and other front line providers:

<u>Master Licensed Alcohol and Drug Counselors (MLADC)</u>

Education

- Loan Repayment/ Tuition reimbursement
- Collaboration with institutes for higher education to ensure that training programs are keeping the pace with changes in demand or current best practices

Recruitment

- Indeed (**Indeed** is a website that includes all job listings from major job boards, newspapers, associations, and company career pages. Employers can even post jobs directly to **Indeed** that may not be available anywhere else. **Indeed** is an American worldwide employment-related search engine for job listings)
- National recruitment through Bi-State Recruitment
- Loan Repayment/ Tuition reimbursement
- Sign-on bonuses

Training

- Off set productivity funds budgeted to allow N4H partners to send employees to attend trainings
- Up to 300 trainings will be made available over the course of the waiver to N4H participants and their employees around the SAMHSA Core Competencies and supporting individuals that suffer from behavioral health and substance misuse
- Planned efforts to support organizations in offering supervision to MLADAC candidates. This could be in the form of financial support to pay for the supervisor (or off set an organizations lost revenue if using an existing staff member). We could also explore creating a team of supervisors who could be made available to organizations. This one could be tricky due to

supervisor rules requiring the supervisor to work within the same organization but there may be ways to overcome that challenge.

Retention

- Decreasing the number of open positions is expected to decrease the burn-out rate of behavioral health practitioners and increase job satisfaction
- The significant increase in training opportunities, especially in areas of evidence based and advanced practice, could be effective in retaining staff.

Licensed Mental Health Professionals

Education

- Loan Repayment/ Tuition reimbursement to encourage employees of N4H partners to further education in positions identified as a significant need on the gap analysis
- Collaboration with institutes for higher education to ensure that training programs are keeping the pace with changes in demand or current best practices

Recruitment

- Indeed (**Indeed** is a website that includes all job listings from major job boards, newspapers, associations, and company career pages. Employers can even post jobs directly to **Indeed** that may not be available anywhere else. **Indeed** is an American worldwide employment-related search engine for job listings)
- Bi-State Recruitment
- Loan Repayment/ Tuition reimbursement
- Sign-on bonuses

Training

- Off set productivity funds budgeted to allow N4H partners to send employees to attend trainings
- Up to 300 trainings will be made available over the course of the waiver to N4H participants and their employees around the SAMHSA Core Competencies and supporting individuals that suffer from behavioral health and substance misuse
- Planned efforts to support organizations in offering supervision to MLADAC candidates. This could be in the form of financial support to pay for the supervisor (or off set an organizations lost revenue if using an existing staff member). We could also explore creating a team of supervisors who could be made available to organizations. This one could be tricky due to supervisor rules requiring the supervisor to work within the same organization but there may be ways to overcome that challenge.

Retention

- Decreasing the number of open positions is expected to decrease the burn-out rate of behavioral health practitioners and increase job satisfaction
- The significant increase in training opportunities, especially in areas of evidence based and advanced practice, could be effective in retaining staff.

Peer Recovery Coaches

Education

- Loan Repayment/ Tuition reimbursement to encourage employees of N4H partners to further education in positions identified as a significant need on the gap analysis
- We will support education and training efforts that increase opportunities to obtain certification as a certified peer support worker or recovery coach for example the recently announced grant to Manchester Community College in which we are a partner.

Recruitment

- Region 4 is home to a culturally diverse community which is why we plan to invest funds into providing trainings for these communities on the American culture and English language that would extend the pool of potential applicants

Training

- Off set productivity funds budgeted to allow N4H partners to send employees to attend trainings
- Up to 300 trainings will be made available over the course of the waiver to N4H participants and their employees around the SAMHSA Core Competencies and supporting individuals that suffer from behavioral health and substance misuse
- Region 4 is home to a culturally diverse community which is why we plan to invest funds into providing trainings for these communities on the American culture and English language that would extend the pool of potential applicants

Retention

- Educating partners on how to utilize peer support workers and recovery coaches or individuals with lived experience.
- Decreasing the number of open positions is expected to decrease the burn-out rate of behavioral health practitioners and increase job satisfaction

<u>Other Front Line Providers (to include Community Health Workers, Receptionists and emergency services</u>

Education

- Loan Repayment/ Tuition reimbursement to encourage employees of N4H partners to further education in positions identified as a significant need on the gap analysis
- Collaboration with institutes for higher education to ensure that training programs are keeping the pace with changes in demand or current best practices

Recruitment

- Sign-on bonuses for all N4H Director level positions, Mental Health Clinician, Substance Use Disorder Clinician, Case Manager, Nurse Practitioner or Psychiatrist and Nurse.
- Indeed (**Indeed** is a website that includes all job listings from major job boards, newspapers, associations, and company career pages. Employers can even post jobs directly to **Indeed** that may not be available anywhere else. **Indeed** is an American worldwide employment-related search engine for job listings)
- Bi-State recruitment
- Region 4 is home to a culturally diverse community which is why we plan to invest funds into providing trainings for these communities on the American culture and English language that would extend the pool of potential applicants

Training

- Off set productivity funds budgeted to allow N4H partners to send employees to attend trainings
- Up to 300 trainings will be made available over the course of the waiver to N4H participants and their employees around the SAMHSA Core Competencies and supporting individuals that suffer from behavioral health and substance misuse. Trainings provided will include Mental Health First Aide.
- Region 4 is home to a culturally diverse community which is why we plan to invest funds into providing trainings for these communities on the American culture and English language that would extend the pool of potential applicants

Retention

- Decreasing the number of open positions is expected to decrease the burn-out rate of behavioral health practitioners and increase job satisfaction

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

Each IDN is required to complete an IDN-level Workforce Capacity Development Implementation Plan, inclusive of the workforce needed to complete projects A1, A2, B1, and the IDN selected Projects C, D, and E.

Using Microsoft Project or similar platform, provide a Workforce Capacity Development Implementation Plan that includes required activities, timelines, milestones, progress assessment check points, and evaluation metrics for implementing the IDN's Workforce Capacity Development Implementation Plan, addressing areas of workforce capacity, including training, identified in the IDN's Workforce Gap Analysis aligned to goals established in the Statewide Workforce Capacity Development Strategic Plan. Include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects.

Include a narrative as needed to complement the Workforce Capacity Development Implementation plan or provide further explanation.

The Workforce Capacity Development Implementation Plan should include the IDN's strategies to address identified workforce gaps in:

- *Educating and training, including gaps in educational preparation of behavioral health providers' workforce readiness upon graduation;*
- *Recruitment of new providers and staff; and*
- *Retention of existing staff, including the IDN's targeted retention rates; and address:*
    - *Strategies to support training of non-clinical IDN staff in Mental Health First Aid;*
    - *Strategies for utilizing and connecting existing SUD and BH resources;*
    - *Additional strategies identified in the Statewide Workforce Capacity Strategic Plan; and*
    - *Any special considerations for workforce development related to the IDN's Community-Driven Projects, including unique training curricula and plans.*

The Workforce Capacity Development Implementation Plan must include Milestones for the following timeframes:

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

Network4Health is pleased to provide DHHS with its Workforce Capacity Development Implementation Plan, included as Attachment_A1.3. As required, our Workforce Capacity Development Information Plan includes all required activities, timelines, milestones for 2017 and 2018, progress assessment check points, and evaluation metrics. The Plan addresses areas impacting workforce capacity as identified in Network4Health's Workforce Gap Analysis as well as workforce needs related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects.

The Implementation Plan includes Network4Health's strategies to address identified workforce gaps in:

- Educating and training, including gaps in educational preparation of behavioral health providers' workforce readiness upon graduation;
- Recruitment of new providers and staff; and
- Retention of existing staff, including Network4Health's targeted retention rates; and addresses
    - Strategies to support training of non-clinical IDN staff in Mental Health First Aid
    - Strategies for utilizing and connecting existing SUD and BH resources
    - Strategies to improve career growth through professional training and tuition reimbursement opportunities for specific positions as identified through the gap analysis

Recruitment

Through the BH Workforce team, Network4Health will support the recruitment of positions identified in the attached project plan (which includes both positions needed for projects being completed through the DSRIP waiver as well as positions identified through Network4Health's gap analysis) through:

- Providing feedback to network providers on recruitment strategies such as setting sign-on bonuses and salaries
- Allocating funds for sign-on bonuses
- Allocating funds to recruitment resources such as Indeed and Bi-State Recruitment

Region 4 is home to a culturally diverse community and we plan to invest funds into providing trainings for these communities on the American culture and English language that would extend the pool of available potential applicants for positions within Network4Health partner organizations.

Trainings

Because we recognize that training is an essential part of securing and maintaining a skilled workforce, Network4Health will fund specialized trainings needed for the DSRIP projects, as described in detail in the budget and accompanying narrative, as well as training in mental health first aid. Given that co-occurring disorders is a key gap, trainings will focus on this issue. The Dual Diagnosis Capability Quality Improvement Plans (DDC QIP) developed under project E4 are focused on improving partner organizations ability to serve those with co-occurring disorders. The DDC QIP will include co-occurring training as recommended from the Case Western Reserve team in serving this population.

Prioritized Recruitment Assistance Based on Gap Analysis Assessment

The Implementation Plan includes prioritized recruitment for a number of positions related to significant gaps identified as part of the gap analysis survey, including 28 open positions for LICSW, LADC, and MLADC which were found to be the most critical. In part, Network4Health will do this by allocating funds for tuition reimbursement for employees of network providers that are currently enrolled in an

educational program of a targeted position. In addition, Network4Health will provide for professional development through tuition reimbursement. We expect that this investment will assist with the retention of employees who attain a higher level of education in prioritized areas. Network4Health will do this through:

- Loan repayment for new hires recruited by N4H partners for targeted positions
- Recruitment for positions utilizing Indeed
- Broader recruitment efforts via Bi-State Recruitment

In order to evaluate the success of these efforts in decreasing the number of open positions, the BH Workforce Team will perform an updated gap analysis yearly to evaluate progress and revise targeted positions, if necessary, based on progress.

Ongoing Work with the Statewide BH Workforce Taskforce

Network4Health will continue to be an active ongoing participant in the statewide BH Workforce Taskforce. Until Network4Health hires a Workforce Director, [redacted] will serve as the co-chair of the Recruitment/Hiring Committee for the Statewide Taskforce. When the Workforce Director is hired, he/she will take over this activity. In addition, Network4Health representatives will be participating in each of the other committees. Specifically, [redacted] will serve as a team member on the Education/Training workgroup; [redacted] will serve as a team member on the Retention/Sustainability workgroup and [redacted] will serve as a team member on the Policy workgroup.

Network4Health's Executive Director, [redacted] and Project Manager [redacted], as well as Network Provider representatives [redacted] will attend the quarterly statewide Behavioral Health Workforce Taskforce meetings, and will delegate responsibilities, as needed, to Network4Health partners. The BH Workforce Director will also attend these meetings once hired. Network4Health will also participate in joint recruitment and training efforts as appropriate for the needs of the region.

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

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

The table below identifies the performance measures and targets for this project.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Recruit N4H Workforce positions	Up to 37 positions	Up to 28.5	Up to 37	Up to 37
Offer a variety of different trainings across the projects to maintain/ improve skills	Up to 144	Up to 48	Up to 96	Up to 144

Decrease the 28 open positions for LICSW, LADC, and MLADC identified in 2017 gap analysis	Add up to 14 staff	Add up to 2 staff	Add up to 8 staff	Add up to 14 staff

A1-5. IDN-level Workforce: Staffing Targets

From the IDN-level Workforce Capacity Development Implementation Plan, use the format below to provide the IDN's targeted number of full-time equivalent (FTE) staff needed to address the gaps identified in the IDN's Workforce Capacity Development Implementation Plan and the number of staff hired and trained by the date indicated. Include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare and the IDN selected community-driven projects.

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**
Application Analyst	Up to 2	0	Up to 1	Up to 1	Up to 2
Integrated Healthcare Clinical Director	Up to 1	0	Up to 1	Up to 1	Up to 1
Innovation Consultant	Up to 2	0	Up to 1.5	Up to 2	Up to 2
Community Health Workers	Up to 10	0	Up to 5	Up to 10	Up to 10
Co-Occurring Disorders Clinical Director	Up to 1	0	Up to 1	Up to 1	Up to 1
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	Up to 4 x .2 FTE	Up to 4 x .2 FTE	Up to 4 x .2 FTE
Program Coordinator	Up to 1	0	Up to 1	Up to 1	Up to 1
Mental Health Clinician	Up to 1	0	Up to 1	Up to 1	Up to 1
Substance Use Disorder Clinician	Up to 1	0	Up to 1	Up to 1	Up to 1
Clinical Case Manager, BSW, LMA, RN	Up to 1	0	Up to 1	Up to 1	Up to 1
Peer Support Specialist	Up to 1	0	0	UP to 1	UP to 1
Nurse	Up to 1	0	UP to 1	Up to 1	Up to 1
Psychiatric Nurse Practitioner or Psychiatrist	Up to .06	0	Up to .06	Up to .06	Up to .06
Outreach Worker	Up to 1	0	0	Up to 1	Up to 1
Critical Time Intervention Director/Supervisor	Up to 1	0	Up to 1	Up to 1	Up to 1
Critical Time Intervention Coach	Up to 6	0	Up to 6	Up to 6	Up to 6
Care Transitions Administrative Support Worker	Up to 1	0	Up to 1	Up to 1	Up to 1
Behavioral Health Workforce Director	Up to 1	0	Up to 1	Up to 1	Up to 1
Behavioral Health Workforce Administrative Support Worker	Up to 1	0	Up to 1	Up to 1	Up to 1
Program Coordinator	Up to 1	0	Up to 1	Up to 1	Up to 1

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

Provide a brief project budget outlining projected costs to support the workforce capacity development implementation plan. After 6/30/17, updates must include financial reporting on actual spending to recruit, hire, train, and retain the workforce.

The budget provided below outlines the projected costs, at a high level, to support the Workforce Capacity Development Implementation Plan. The numbers included are estimates, actual spending will be reported in future plan submissions. The budget focuses on workforce recruitment – both for the DSRIP projects and the most significant gaps as found in our 2017 gap analysis – and training and development. Below the chart is a high level narrative description of how funding will be spent.

TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
A1: BH Workforce (New)	$ 1,693,350	$ 1,693,350	$ 1,073,520	$ 715,680
A1: BH Workforce (Rollover)		$ 533,578	$ 697,816	$ 285,807
Total Revenue	$ 1,693,350	$ 2,226,928	$ 1,771,336	$ 1,001,487
Recruit	$ 549,500	$ 474,000	$ 474,000	$ 257,000
Training/Development	$ 515,712	$ 872,292	$ 823,301	$ 550,689
Salaries (Salary, benefits, and travel)	$ 87,500	$ 180,250	$ 185,658	$ 191,228
Technology (Computer, phone, software)	$ 7,060	$ 2,570	$ 2,570	$ 2,570
Subtotal	$ 1,159,772	$ 1,529,112	$ 1,485,529	$ 1,001,487
Variation to Budget (Transfer Funds to Proceeding Year)	$ 533,578	$ 697,816	$ 285,807	$ -

Recruitment

Recruitment dollars include funding for sign-on bonuses for Network4Heatlh project positions, including project director level positions as well as Mental Health Clinician, Substance Use Disorder Clinician, Case Manager, Nurse Practitioner or Psychiatrist, and Nurse. As recommended by the BH Workforce Team, sign-on bonuses will be offered at up to 10% of annual salary. Funding will also be allocated for use of Indeed and Bi-State Recruitment to advertise positions.

The budget also devotes significant funding towards loan repayment and tuition reimbursement, aimed at filling 28 open positions for LICSW, LADC, and MLADC which have been identified as the most significant gaps. By dedicating funding for loan repayment and tuition reimbursement, Network4Health

aims to assist employees of Network4Health partners with the completion of educational programs. The sign-on bonuses described above will also be available to assist partners in recruiting for LICSW, LADC and MLADC staff.

Training/Development

The Workforce budget also includes training funds to allow other N4H project teams to stand up their projects related to the Waiver by funding specific trainings needed to successfully complete those projects, including:

- Critical Time Intervention (C1)
- Case Western Reserve - Treatment for Co-Occurring Disorders (E4)
- CMT training (A2)

The budget will support up to an additional 96 trainings a year, including up to 48 within a 6-month reporting period. These trainings may include:

- Specialized trainings received by the individual N4H teams
- Conferences
- Trainings related to the 9 Core Competencies referenced in the Statewide BH Workforce Implementation Plan
- Trainings on Mental Health First Aid for non-clinical IDN staff
- SAMHSA-identified evidence-based trainings
- Training on co-occurring disorders

Network4Health has also included funding in its budget to pay project partners to offset productivity losses that occur when staff are at training. The budget will allow Network4Health to offset up to 48 4-hour trainings in the 2nd year, and 96 4-hour trainings in the 3rd year for approximately 20 participants each.

Training funds also include funding to allow the BH Workforce Director to attend ongoing training and development conferences pertinent to the Network4Health efforts.

Network4Health BH Workforce Staff

The Workforce budget includes salaries for the BH Workforce Director and his or her administrative support, as well as to support technology needs for these positions. Funding is also included to pay for the cost of a trainer for each class.

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

Use the format below to provide an updated list of key organizations and providers participating in the IDN to support workforce development. Include and note workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community projects.

The table below includes all Network4Health partners and indicates that all partners will have the opportunity to participate in projects A1 (workforce) and A2 (HIT). Some partners are also listed as participating in B1, C1, D3 and/or E4, depending on their involvement today. Please note that as implementation of these projects occur and as specific assessments are done, it is likely that additional Network4Health partners will also participate in these projects.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Catholic Medical Center (Lead) including Health Care for The Homeless.	Hospital	A1, A2, B1, E4
American Medical Response of MA	Other	A1, A2
Ascentria Care Alliance	Community-Based Organization providing social and support services	A1, A2
Bhutanese Community of NH	Community-Based Organization providing social and support services	A1, A2
NH Catholic Charities	Other	A1, A2
Center for Life Management	MHC	A1, A2, B1, E4
Child and Family Services	Social Services	A1, B1, E4
City of Manchester Health Department	Public Health Organization	A1, A2
Community Crossroads	Home and Community Based Care Provider	A1, A2
Crotched Mountain	Community-Based Organization providing social and support services	A1, A2
Dartmouth Hitchcock Manchester/Bedford	Medical Center	A1, A2, B1
Derry Friendship Center	Other	A1, A2
Easter Seals NH, including Farnhum Center	Community-Based Organization providing social and support services and SUD Treatment	A1, A2, B1, E4
Elliot Health System	Hospital	A1, A2, B1, E4, D3
Families in Transition	Community-Based Organization providing social and support services	A1, A2, B1, E4
Goodwill Industries of Northern New England	Community-Based Organization providing social and support services	A1, A2
Granite Pathways	Community Based Organization providing social services and supports	A1, A2, E4

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Granite State Independent Living	Home and Community Based Care Provider	A1, A2
Granite United Way	Host Agency for the South Central Public Health Network, Administrative Lead for 211-NH	A1, A2
Greater Derry Community Health Services, Inc.	Non Profit H&HS	A1, A2
Hillsborough County	County Corrections; Nursing Facility	A1, A2
Home Health and Hospice Care	Home and Community Based Care Provider	A1, A2, B1
Hope for NH Recovery	Community Based Organization providing social and support services	A1, A2
International Institute of New England	Other	A1, A2
Life Coping Inc.	Home and Community Based Care Provider	A1, A2
Makin' It Happen	Public Health Organization	A1, A2
Manchester Community Health Center	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Housing and Redevelopment Authority	Other	A1, A2
Manchester School District	Other	A1, A2
NAMI NH	Community Based Organization providing social services and supports	A1, A2
New Hampshire Hospital*	Hospital	A1, A2
New Horizons for NH	Community Based Organization providing social services and supports	A1, A2
NH Legal Assistance/NH Medical Legal Partnership	Other	A1, A2
On the Road to Wellness	Non-CMHC Mental Health Provider	A1, A2, B1
Parkland Medical Center	Hospital	A1, A2, B1
Pastoral Counseling Services	Other	A1, A2
Rockingham County	County Corrections; Nursing Facility	A1, A2
Serenity Place	SUD Treatment	A1, A2, B1, D3, E4
ServiceLink Aging and Disability Resource Center of Rockingham County	Community Based Organization providing social services and supports	A1, A2
Southern New Hampshire Services	Community Based Organization providing social services and supports	A1, A2, E4
St. Joseph Community Services, Inc.	Other	A1, A2

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
The Mental Health Center of Greater Manchester	MHC	A1, A2, B1, E4, C1
The Moore Center	Community Based Organization providing social services and supports	A1, A2
The Upper Room	Community Based Organization providing social services and supports	A1, A2

* New Hampshire Hospital is not an official partner of Network4Health, but will be invited to participate in all trainings offered through the IDN, and will be included in individual projects as appropriate. For example, within CTI, Network4Health will receive referrals from the NHH to the program.

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

Submit a signed attestation of the IDN's review and acceptance of the statewide workforce capacity development strategic plan.

A signed attestation of Network4Health's review and acceptance of the Statewide Workforce Capacity Development Strategic Plan is included as Attachment_A1.8 to this submission.

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
1		**BH Workforce**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
2		**Recruit**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
3		Recruit 1 BH Workforce Director	132 days	Sat 7/1/17	Mon 1/1/18	BH Workforce Team,Catholic Medica
4		Recruit 1 BH Workforce Administrative Support Worker	132 days	Sat 7/1/17	Mon 1/1/18	BH Workforce Team,Catholic Medical Center
5		Recruit 1 HIT Analyst/Trainer	132 days	Sat 7/1/17	Mon 1/1/18	HIT Team,Catholic Medical Center
6		Recruit 1 Integrated Healthcare Clinical Director	132 days	Sat 7/1/17	Mon 1/1/18	Integrated Healthcare Team,Catholi
7		Recruit 1 Critical Time Intervention Director	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
8		Recruit 1 Care Transitions Administrative Support Worker	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
9		Recruit 6 Critical Time Intervention Coaches	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
10		Recruit 1.5 Innovation Consultants	132 days	Sat 7/1/17	Mon 1/1/18	Integrated Healthcare Team
11		Recruit 5 Community Health Workers	132 days	Sat 7/1/17	Mon 1/1/18	Integrated Healthcare Team
12		Recruit 1 Co-occurring Disorders Clinical Director	132 days	Sat 7/1/17	Mon 1/1/18	Integrated TX COD Team,MHCGM
13		Recruit 3 Dual Diagnosis Capability Assessors	132 days	Sat 7/1/17	Mon 1/1/18	Integrated TX COD Team,MHCGM
14		Recruit Program Coordinator (D3)	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Serenity Plac

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Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	
Split	External Tasks	Inactive Summary	Manual Summary	Progress	
Milestone	External Milestone	Manual Task	Start-only		
Summary	Inactive Task	Duration-only	Finish-only		

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
15		Recruit Mental Health Clinician	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Elliot Hospita
16		Recruit Substance Use Disorder Clinician	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Serenity Plac
17		Recruit Clinical Case Manager	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Serenity Plac
18		Recruit Nurse	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Elliot Hospita
19		Recruit Nurse Practitioner or Psychiatrist	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Elliot Hospita
20		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
21		Assess and evaluate recruitment plan for N4H positions	131 days	Mon 1/1/18	Sat 6/30/18	
22		Recruit 1 additional HIT Analyst/Trainer	130 days	Mon 1/1/18	Sat 6/30/18	HIT Team
23		Recruit .5 additional Innovation Consultant	130 days	Mon 1/1/18	Sat 6/30/18	Integrated Healthcare Team
24		Recruit 5 additional Community Health Workers	130 days	Mon 1/1/18	Sat 6/30/18	Integrated Healthcare Team
25		Recruit Peer Support Specialist	130 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
26		Recruit Outreach Worker	130 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
27		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
28		Assess turnover and additonal recruitment needs of N4H teams	132 days	Sun 7/1/18	Mon 12/31/18	

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Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline			
Split	External Tasks	Inactive Summary	Manual Summary	Progress			
Milestone	External Milestone	Manual Task	Start-only				
Summary	Inactive Task	Duration-only	Finish-only				

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
29		Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Sun 7/1/18	Mon 12/31/18	[redacted]
30		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
31		Assess turnover and additonal recruitment needs of N4H teams	130 days	Tue 1/1/19	Sun 6/30/19	[redacted]
32		Revise recruitment plan to include additonal positions needed based on most current assessment	130 days	Tue 1/1/19	Sun 6/30/19	[redacted]
33		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
34		Assess turnover and additonal recruitment needs of N4H teams	132 days	Mon 7/1/19	Tue 12/31/19	[redacted]
35		Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Mon 7/1/19	Tue 12/31/19	[redacted]
36		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
37		Assess turnover and additonal recruitment needs of N4H teams	130 days	Wed 1/1/20	Tue 6/30/20	[redacted]
38		Revise recruitment plan to include additonal positions needed based on most current assessment	130 days	Wed 1/1/20	Tue 6/30/20	Wed 7/1/20
39		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
40		Assess turnover and additonal recruitment needs of N4H teams	132 days	Wed 7/1/20	Thu 12/31/20	Wed 7/1/20
41		Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Wed 7/1/20	Thu 12/31/20	Wed 7/1/20
42		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	
43		**Trainings**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	

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Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
44		Confirm training needs of N4H teams	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
45		Survey N4H partners to idenify which partners currently offer trainings needed	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
46		Develop training plan based on needs, requests and retention efforts	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
47		Begin implementation of training plan	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
48		Critical Time Intervention worker training for Coaches	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
49		Critical Time Intervention training for Director	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
50		Critical Time Intervention Community of Practice meetings	131 days	Sat 7/1/17	Sun 12/31/17	[redacted]
51		HIT training in CMT & Eccovia	131 days	Sat 7/1/17	Sun 12/31/17	HIT Team
52		Case Western Reserve training	131 days	Sat 7/1/17	Sun 12/31/17	Integrated TX COD Team
53		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
54		Critical Time Intervention Worker training for Coaches	131 days	Mon 1/1/18	Sat 6/30/18	Care Transitions Team
55		Critical Time Intervention Community of Practice meetings	131 days	Mon 1/1/18	Sat 6/30/18	Care Transitions Team
56		HIT training in CMT & Eccovia	131 days	Mon 1/1/18	Sat 6/30/18	HIT Team
57		Case Western Reserve training	131 days	Mon 1/1/18	Sat 6/30/18	Integrated TX COD Team
58		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
59		Critical Time Intervention Train-the-Trainer	132 days	Sun 7/1/18	Mon 12/31/18	Care Transitions Team

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Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	
Split	External Tasks	Inactive Summary	Manual Summary	Progress	
Milestone	External Milestone	Manual Task	Start-only		
Summary	Inactive Task	Duration-only	Finish-only		

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
60		Critical Time Intervention Community of Practice meetings	132 days	Sun 7/1/18	Mon 12/31/18	Care Transitions Team
61		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
62		Critical Time Intervention Community of Practice meetings	130 days	Tue 1/1/19	Sun 6/30/19	Care Transitions Team
63		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
64		Reasses training needs and participation	132 days	Mon 7/1/19	Tue 12/31/19	[redacted]
65		Revise training plan based on most current assessment	132 days	Mon 7/1/19	Tue 12/31/19	[redacted]
66		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
67		Reasses training needs and participation	130 days	Wed 1/1/20	Tue 6/30/20	[redacted]
68		Revise training plan based on most current assessment	130 days	Wed 1/1/20	Tue 6/30/20	[redacted]
69		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
70		Reasses training needs and participation	132 days	Wed 7/1/20	Thu 12/31/20	[redacted]
71		Revise training plan based on most current assessment	132 days	Wed 7/1/20	Thu 12/31/20	[redacted]
72		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	
73		**Gap Analysis Assessment**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
74		Obtain accurate account of open positions for targets found in most recent Gap analysis	132 days	Sat 7/1/17	Sun 12/31/17	[redacted]
75		Align recruitment plan with targeted positions	132 days	Sat 7/1/17	Sun 12/31/17	[redacted]

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Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline
Split	External Tasks	Inactive Summary	Manual Summary	Progress
Milestone	External Milestone	Manual Task	Start-only	
Summary	Inactive Task	Duration-only	Finish-only	

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
76		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
77		Assess and revise recruitment plan based on feedback from N4H partners	131 days	Mon 1/1/18	Sat 6/30/18	[redacted]
78		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
79		Perform updated gap analysis of BH positions in region 4	132 days	Sun 7/1/18	Mon 12/31/18	[redacted]
80		Reassess targeted positions based on most current gap analysis	132 days	Sun 7/1/18	Mon 12/31/18	[redacted]
81		Revise recruitment plan for targeted positions based on most current gap analysis	132 days	Sun 7/1/18	Mon 12/31/18	[redacted]
82		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
83		Assess and revise recruitment plan based on feedback from N4H partners	130 days	Tue 1/1/19	Sun 6/30/19	[redacted]
84		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
85		Perform updated gap analysis	132 days	Mon 7/1/19	Tue 12/31/19	[redacted]
86		Reassess targeted positions based on most current gap analysis	132 days	Mon 7/1/19	Tue 12/31/19	[redacted]
87		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
88		Assess and revise recruitment plan based on feedback from N4H partners	130 days	Wed 1/1/20	Tue 6/30/20	[redacted]
89		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
90		Finalize and move to close open recruitment of positions with N4H partners	132 days	Wed 7/1/20	Thu 12/31/20	[redacted]
91		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	

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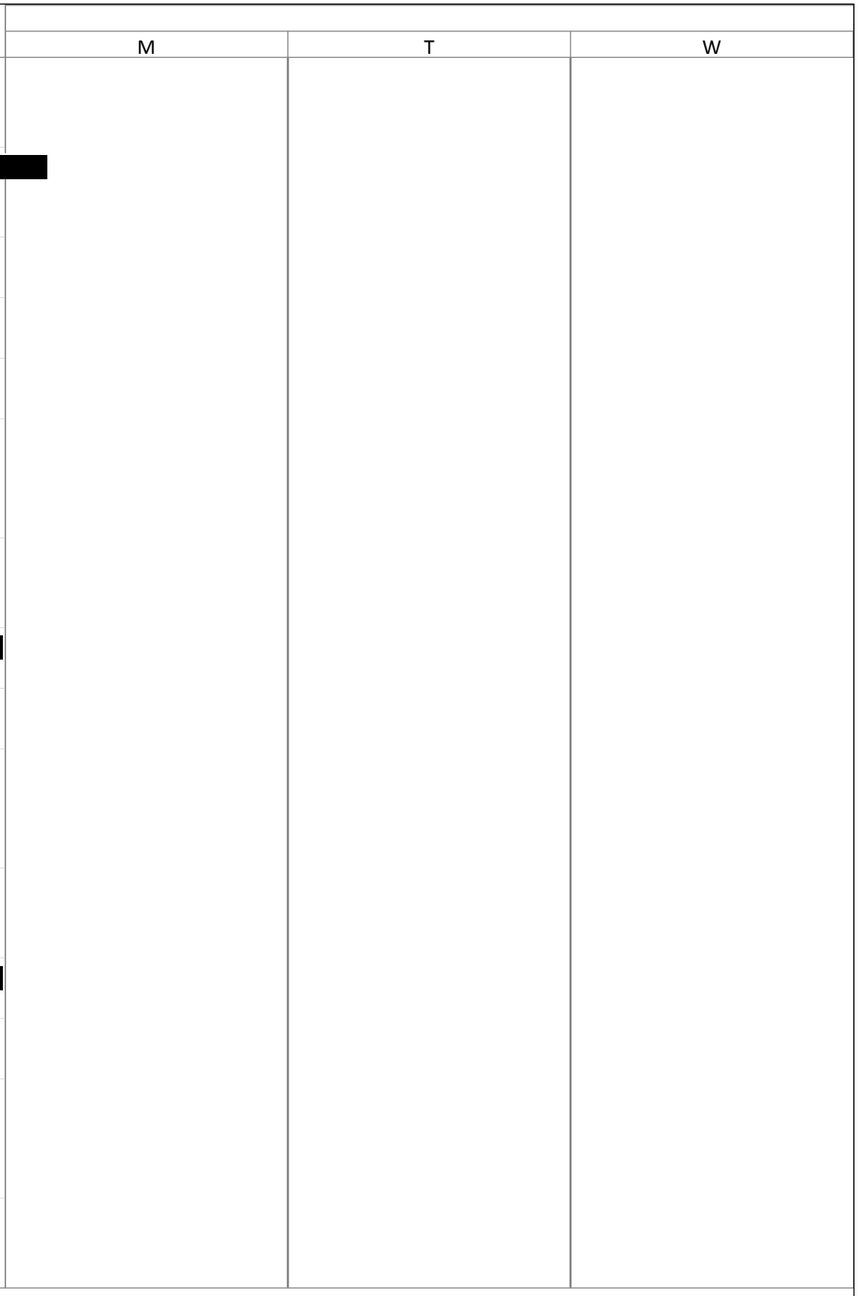
Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline			
Split	External Tasks	Inactive Summary	Manual Summary	Progress			
Milestone	External Milestone	Manual Task	Start-only				
Summary	Inactive Task	Duration-only	Finish-only				

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
92		**Statewide BH Workforce**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
93		Approve Statewide Implementation Plan	1 day	Mon 7/3/17	Mon 7/3/17	
94		Sign attestation agreeing to Statewide Implementation Plan	20 days	Tue 7/4/17	Mon 7/31/17	
95		Participate in establishing monthly work team meetings	46 days	Sat 7/1/17	Fri 9/1/17	
96		Attend monthly work team meetings as appropriate	132 days	Sat 7/1/17	Mon 1/1/18	
97		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop slate of goals, objectives, and activities for 2019 and 2020	132 days	Sat 7/1/17	Mon 1/1/18	
98		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
99		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	23 days	Mon 1/1/18	Wed 1/31/18	
100		Attend monthly work team meetings as appropriate	131 days	Mon 1/1/18	Sat 6/30/18	
101		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop slate of goals, objectives, and activities for 2019 and 2020	131 days	Mon 1/1/18	Sat 6/30/18	
102		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
103		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	22 days	Sun 7/1/18	Mon 7/30/18	
104		Attend monthly work team meetings as appropriate	132 days	Sun 7/1/18	Mon 12/31/18	
105		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop slate of goals, objectives, and activities for 2019 and 2020	132 days	Sun 7/1/18	Mon 12/31/18	
106		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	



Project: BH Workforce PP.mpp
Date: Thu 7/20/17

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline				
Split	External Tasks	Inactive Summary	Manual Summary	Progress				
Milestone	External Milestone	Manual Task	Start-only					
Summary	Inactive Task	Duration-only	Finish-only					

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
107		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	23 days	Tue 1/1/19	Thu 1/31/19	
108		Attend monthly work team meetings as appropriate	130 days	Tue 1/1/19	Sun 6/30/19	
109		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Tue 1/1/19	Sun 6/30/19	
110		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
111		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	22 days	Mon 7/1/19	Tue 7/30/19	
112		Attend monthly work team meetings as appropriate	133 days	Sun 6/30/19	Tue 12/31/19	
113		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	133 days	Sun 6/30/19	Tue 12/31/19	
114		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
115		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	23 days	Wed 1/1/20	Fri 1/31/20	
116		Attend monthly work team meetings as appropriate	130 days	Wed 1/1/20	Tue 6/30/20	
117		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Wed 1/1/20	Tue 6/30/20	
118		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
119		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	22 days	Wed 7/1/20	Thu 7/30/20	
120		Attend monthly work team meetings as appropriate	132 days	Wed 7/1/20	Thu 12/31/20	
121		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	132 days	Wed 7/1/20	Thu 12/31/20	
122		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	

M T W

Project: BH Workforce PP.mpp
Date: Thu 7/20/17

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline
Split	External Tasks	Inactive Summary	Manual Summary	Progress
Milestone	External Milestone	Manual Task	Start-only	
Summary	Inactive Task	Duration-only	Finish-only	

Integrated Delivery Network Administrative Lead Contract

Attestation Form

I, [redacted], a representative of Region # 4, attest that I have reviewed and am in acceptance on behalf of Catholic Medical Center, dba Network 4 Health 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

[redacted]

STATE OF NEW HAMPSHIRE

County of Hillsborough

The forgoing instrument was acknowledged before me this 18th day of July, 2017,

[redacted]

[redacted]

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

A2-1. IDN Participation in Statewide HIT Taskforce

Network4Health was an active member in the following Statewide HIT Taskforce activities.

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

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

Network4Health's HIT Assessment and Gap Analysis yielded similar results to those reported statewide by Myers and Stauffer in the Implementation Plan (Attachment_A2.2) (Section 2.1). Key findings from our analysis of data from our region can also be found in the Implementation Plan (Section 2.2) and are briefly summarized below including:

- Electronic Health Record (EHR) adoption, while high among hospitals and mental health facilities, remains low among community organizations and SUD agencies;
- Sharing of data remains rudimentary;
- Referrals are done manually for the most part.

Based on these findings, Network4Health aims to develop a HIT infrastructure that would support an integrated health network by implementing the following HIT solutions:

- An Event Notification System (ENS) to alert interested parties to utilization events, support integration, support implementation of alternative payment models and ultimately reduce unnecessary emergency department usage and inpatient hospital admissions and readmissions;
- Shared Care Plans to facilitate care transitions, support integration and support implementation of alternative payment models; and
- DIRECT /electronic referrals to support integration of primary care, behavioral providers and community-based organizations and support implementation of alternative payment models.

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

Network4Health has developed and submitted an HIT Implementation Plan to the state. In addition, Network4Health has developed the accompanying project plan (included as Attachment_A2.3).

The plan includes a number of components, meant to meet Network4Health partner organizations where they are. For Network4Health partners that already use an Electronic Health Record (EHR), Network4Health will work with these partners to implement DIRECT to allow for secure exchanges of client data across EHRs and to be used as a messaging protocol. In addition, Network4Health will invest in a data aggregator through which the different participating organizations within Region 4 will utilize their EHRs to provide a direct feed, allowing for data sharing across partners. Network4Health plans to either build or buy the data aggregator (to be determined) to help facilitate the management of these data across all the participating organizations.

For Network4Health partners who are not utilizing an EHR, Network4Health will implement a commercially available software solution, such as Eccovia's ClientTrack platform. These solutions connect health and human services providers collaborate across the spectrum of service delivery to address the physical, behavioral, and economic factors that impact health outcomes and quality of life. This tool will allow community organizations without an EHR to not only participate in the Comprehensive Core Standard Assessment, but to view important clinical data that they are entitled to see and which will allow them to assist their clients.

As needed, organizations that have EHRs also can interface with the platform through an application program interface (API), which allows two software programs to communicate. Any updates made to a client's Core Assessment done in the software platform will be messaged (through DIRECT or otherwise) to previous authors of the assessment. Similarly, updates to the Core Assessment done in interfaced EHRs will be updated.

Many of the commercially available solutions also offer care coordination capabilities such as referral management and care plan tracking. In addition, both the Event Notification System and the Shared Care Plan will support Care transitions.

Using the data aggregator will facilitate quality measurement for Network4Health. EHRs will have direct feeds to the data warehouse and communication to and from the EHR and the data warehouse will be secure. The data warehouse will also contain all the necessary information on utilization of health and community services by clients, which will help support movement towards alternative payment models.

The chart below shows the minimum infrastructure and how it will be implemented. Details regarding these standards can also be found in the Implementation Plan (Section 3.1-3.3).

Capability & Standard	Plan
Data Extraction / Validation	Through data aggregator
Internet Connectivity	Will assess need
Secured Data Storage	Will assess need
Electronic Data Capture	Through EHR, and commercial solution such as ClientTrack
Direct Secure Messaging (DSM)	Through EHR and commercial solution such as ClientTrack
Shared Care Plan	CMT Premanage
Event Notification Service	CMT Premanage
Transmit Event Notification Service	CMT Premanage

The chart below provides a high-level project plan with the major HIT project aims:

	6/30/17	12/31/17	6/30/18	12/31/18
Project Plan	X			
Aim 1: DIRECT set up		X		
Aim 2: sending of ADTs for ENS		X		
Aim 3: Enroll ENS subscribers, train, and transmit notifications			X	X
Aim 4: Design and Build SCP process, workflow (will build based on B1 team request)		X	X	
Aim 5: Design and Build Core Assessment and other functions (such as ClientTrack) (will build based on B1 team request)		X	X	
Aim 6: Train staff on solutions				X
Aim 7: Roll out solutions				X

A2-4. IDN HIT: Evaluation Project Targets

The implementation targets for the various solutions are noted in the Table below. We anticipate having up to 50% of our partner organizations with EHRs accessing DIRECT by the end of 2018 as well as 50% having access to and using the Event Notification System and Shared Care Plan capabilities.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partners who acquire DIRECT Secure Messaging	17 of 37 practices by 12/31/18			
The number of participating partners who acquire the Event Notification System (ENS)	17 of 37 practices by 12/31/18			
The number of participating partners who acquire the Shared Care Plan (SCP)	17 of 37 practices By 12/31/18			
The number of participating partners who implement and receive training for DIRECT Secure Messaging	17 of 37 practices by 12/31/18			
The number of participating partners who implement and receive training for the Event Notification System (ENS)	17 of 37 practices by 12/31/18			
The number of participating partners who implement and receive training for the Shared Care Plan (SCP)	17 of 37 practices By 12/31/19			
The number of participating partners who contribute to DIRECT Secure Messaging	17 of 37 practices by 12/31/18			
The number of participating partners who contribute to Event Notification System (ENS)	10 of 37 practices by 12/31/18			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 37 practices By 12/31/19			
The number of participating partners who use DIRECT Secure Messaging	10 of 37 practices by 12/31/19			
The number of participating partners who use an Event Notification System (ENS)	10 of 37 practices by 12/31/19			
The number of participating partners who use a Shared Care Plan (SCP)	5 of 37 practices By 12/31/19			

A2-5. IDN HIT: Workforce Staffing

The workforce staffing specific to this project include hiring of two application analysts. We anticipate having both positions hired by the end of 2018.

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
Application Analyst	Up to 2	0	Up to 1	Up to 1	Up to 2

A2-6. IDN HIT: Budget

Below is an estimated HIT Budget; the numbers related to the data aggregator are still being refined as we await final agreements with some of our proposed vendors.

TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
A2 HIT Revenue (New)	$ 1,693,350	$ 1,693,350.00	$ 1,073,520	$ 715,680
A2 HIT Revenue (Rollover)		$ 151,988.94	$ 927,572	$ 656,262
Total Revenue	$ 1,693,350	$ 1,845,338.94	$ 2,001,092	$ 1,371,942
Premanage ED ($0.50 per ED visit per year)	$ 78,407	$ 80,758.70	$ 83,181.46	$ 85,676.90
Premanage Community ($0.12 per Medicaid member per month)	$ 68,484	$ 70,538.03	$ 72,654.17	$ 74,833.79

Premanage PMDP ($50 / provider/yr, ~200 providers)	$ 10,000	$ 10,300.00	$ 10,609.00	$ 10,927.27
Client Track Phase 1 Implementation	$ 214,500	$ -	$ -	$
Client Track Recurring	$ 273,000	$ 256,000.00	$ 263,680	$ 271,590
Client Track Phase 2 Implementation	$ 242,500	$ -	$ -	$
Client Track Portal	$ 50,000	$ 51,500.00	$ 53,045.00	$ 54,636.35
Direct secure messaging ($750*30)	$ 22,500	$ 23,175.00	$ 23,870.25	$ 24,586.36
Data aggregator implementation	$ 57,513	$ -	$ -	$
Data aggregator Analytics	$ 74,190	$ 76,415.70	$ 78,708.17	$ 81,069.42
Data aggregator Data source Implementation	$ 208,929	$ -	$ -	$
Data aggregator DMaaS annual support	$ 31,339	$ 32,279.47	$ 33,247.85	$ 34,245.29
Query Based Exchange	$ -	$ -	$ 400,000	$ 400,000
Secure Data Storage	$ 50,000	$ 51,500.00	$ 53,045.00	$ 54,636.35
EMR Integration	$ 50,000			
Contingency Fund		$ 49,000.00	$ 50,000.00	$ 50,000.00
Internet Connectivity	$ 10,000	$ 10,300.00	$ 10,609.00	$ 10,927.27
[redacted]	$ 100,000	$ 206,000.00	$ 212,180	$ 218,545
Subtotal	$ 1,541,361	$ 917,766.89	$ 1,344,830	$ 1,371,675
Variation to Budget (Transfer Funds to Subsequent Year)	$ 151,989	$ 927,572.05	$ 656,262	$ 267

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

Below is chart with the key organizations and participants for the HIT project.

Network4Health has included New Hampshire Hospital as a key organizational partner in the below table, as we see the importance of their role and wish to collaborate with them in the future. If appropriate to the identified work plans through our B1 Integrated Healthcare project, Network4Health partners will consider whether New Hampshire Hospital should be incorporated into our first cohort of integrated healthcare efforts. Initial efforts with New Hampshire Hospital will likely be a manual effort, but Network4Health plans to reach out to them as we complete our vendor selection decisions, per our project schedule.

Name	Organization Name and Type
[redacted]	Catholic Medical Center (Hospital)
[redacted]	Catholic Medical Center (Hospital)
[redacted]	Center for Life Management (BH Provider)

Name	Organization Name and Type
[redacted]	The Mental Health Center of Greater Manchester (BH Provider)
[redacted]	Elliot Hospital (Hospital)
[redacted]	Easter Seals of NH (Community Based Organization)
[redacted]	Home Health and Hospice (Community Based Organization)
[redacted]	Home Health and Hospice (Community Based Organization)
[redacted]	Dartmouth Hitchcock Medical Center (Hospital)
New Hampshire Hospital[1]	New Hampshire Hospital

A2-8. IDN HIT. Data Agreement

Data sharing agreements are inherent in the implementation of the infrastructure products that Network4Health is deploying. There are not separate data sharing agreements yet signed, but they will be part of the implementation. For example, as part of the implementation of CMTs, participating partner organizations will sign agreements to share ADT information; this is also true for organizations that will utilize a shared care plan. Therefore, the chart below lists all Network4Health partners but indicates they have not yet signed an agreement.

Organization Name	Data Sharing Agreement Signed Y/N
American Medical Response	N
Ascentria Care Alliance	N
Bhutanese Community of NH	N
Catholic Charities of NH	N
Catholic Medical Center	N
Center for Life Management	N
Child and Family Services	N
City of Manchester Health Department	N
Community Crossroads	N
Crotched Mountain	N

[1] New Hampshire Hospital is not currently a full partner with IDN 4. IDN 4 plans to coordinate closely with New Hampshire Hospital and request project participation where appropriate.

Organization Name	Data Sharing Agreement Signed Y/N
Dartmouth-Hitchcock Clinic-Manchester	N
Derry Friendship Center	N
Easter Seals New Hampshire	N
Elliot Health System	N
Families in Transition	N
Goodwill Industries of Norther NE	N
Granite Pathways (FedCap)	N
Granite State Independent Living	N
Granite United Way	N
Greater Derry Community Health Services, Inc.	N
Hillsborough County	N
Home Health and Hospice Care	N
HOPE for New Hampshire Recovery	N
International Institute of NE	N
Life Coping Inc.	N
Makin' It Happen	N
Manchester Community Health Center	N
Manchester Housing & Redevelopment Authority	N
Manchester School District	N
National Alliance on Mental Illness (NAMI NH)	N
New Horizons for New Hampshire	N
New Hampshire Legal Assistance	N
On the Road to Wellness	N
Parkland Medical Center	N
Pastoral Counseling Services	N
Rockingham County	N

Organization Name	Data Sharing Agreement Signed Y/N
Rockingham ServiceLink Resource Center	N
St. Joseph Community Services	N
Serenity Place	N
Southern NH Services	N
The Mental Health Center of Greater Manchester	N
The Moore Center	N
The Upper Room	N

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	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	and Provider Participants					

New Hampshire
Department of Health and Human Services

Building Capacity for Transformation Waiver

Integrated Delivery Network

Health Information Technology

Implementation Plan

IDN 4

July 30, 2017

Contents

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 4 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* requires each IDN to develop HIT infrastructure required to support integrated, high-quality care throughout New Hampshire.

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

IDN Region 4 has engaged 43 partners across the continuum of care to serve 47,000 Medicaid beneficiaries. This partnership includes hospitals, physician practices, mental health and substance use providers as well as numerous community organizations. As such, there is a wide range of HIT maturity across the partners ranging from very good EHR operability to fully paper processes. We will meet these organizations where they are at regarding HIT readiness. Organizations with EHRs will become more even more sophisticated in their use of HIT for communicating with other organizations and those who have yet to adopt any IT will be provided with some of the basic IT building blocks. There is a desire and a commitment from all of the partners to deliver care in a more integrated fashion and an understanding that this will require better HIT. Our HIT leads: [redacted] will provide the vision, leadership, and support for IDN Region 4 as we move forward with implementing our projects.

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 with[3]:

- 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. IDN Region 4 participated in these sessions.

2. Gap Analysis

Myers and Stauffer were 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, desired and optional 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 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 conducted 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.

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, many community-based organizations had limited HIT infrastructure.

Key findings from the New Hampshire health IT assessment include:

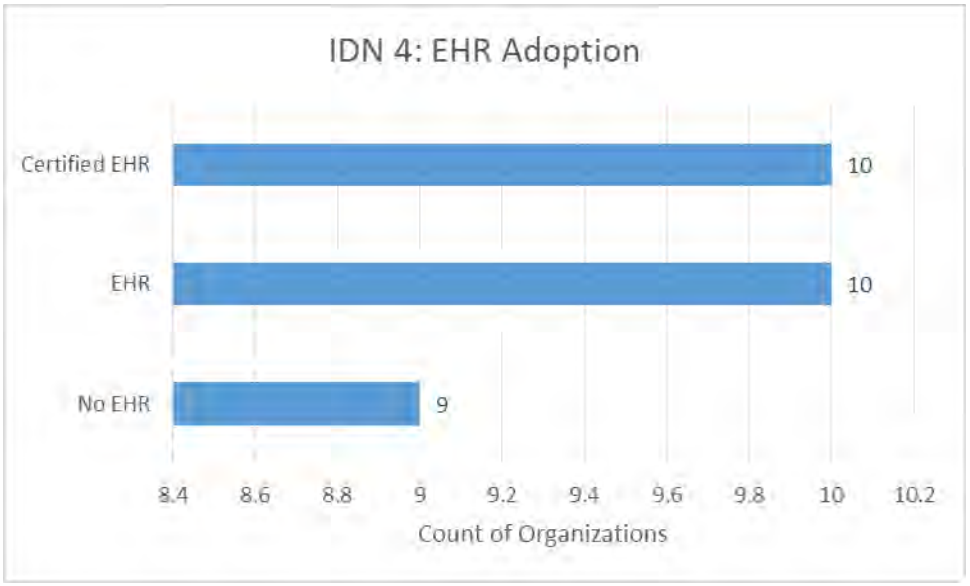
1. **Electronic health data capture capabilities are not widespread among IDN members.** While New Hampshire benefits from a high number of providers having adopted electronic health records (EHRs) at 74% of IDN members, there are a several key provider types that have less than 60% adoption rate including SUD treatment organizations at 57%, community-based organizations at 48%, and public health organizations at only 33%.
2. **Limited capabilities for electronic health data sharing throughout the state, but IDN members use available option.** Despite the limitations in electronic health data sharing among New Hampshire's providers, due in part to legislative restrictions, 48% of IDN member organizations are using or have plans to use Direct Secure Messaging (DSM) through New Hampshire Health Information Organization (NHHIO).
3. **Low rate of patient consents are captured electronically.** The ability to electronically capture patient consents still appears to be in its infancy among IDN members with only 21% of all responding organizations doing so. High adopters of health IT such as hospitals, community mental health centers, and federally qualified health centers (FQHCs) are all below 50% for collecting and storing patient consents by electronic means.
4. **Patient referrals are mostly manual processes.** Sixty-one percent of IDN members responding to the assessment stated that patient referrals are performed manually by fax, U.S. mail, or telephone. Only a small percentage of organizations, just 15%, are using DSM for referrals.
5. **Patients have limited options to access their health information electronically.** Currently, only 28% of all IDN members responding to the Assessment Tool have a patient portal.

6. **A higher than expected number of IDN members capture at least one social determinant of health data element.** While collection of social determinants of health data is fragmented and inconsistent across the health care continuum[6], 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

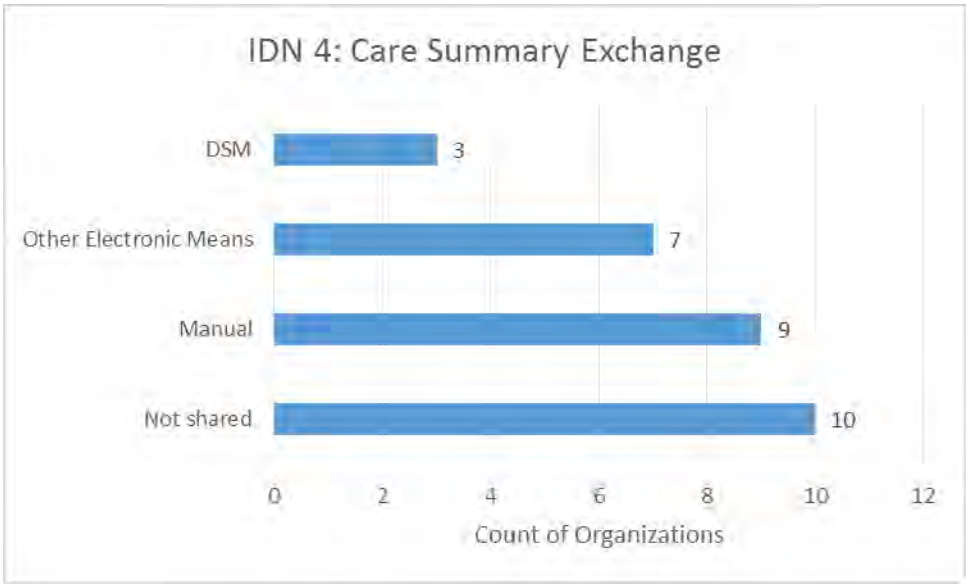
Based on the final version of the HIT Data Supplement for our region, twenty-nine organizations completed the HIT Assessment tool. Figure 1 provides the results for IDN-4 regarding EHR adoption. From the results, ten organizations attested to having a certified EHR system; ten organizations attested to having a non-certified EHR system, and nine organizations stated that they had no EHR system at all. Moreover, in the provider organizations where EHRs have been widely adopted by the key IDN partners, they are for the most part not interoperable. It is important for us to identify organizations with no EHR systems, in particular, in order to determine what further assistance they may need to meet the State's DSRIP initiative objectives and our region's goals.

Figure 1. EHR Adoption



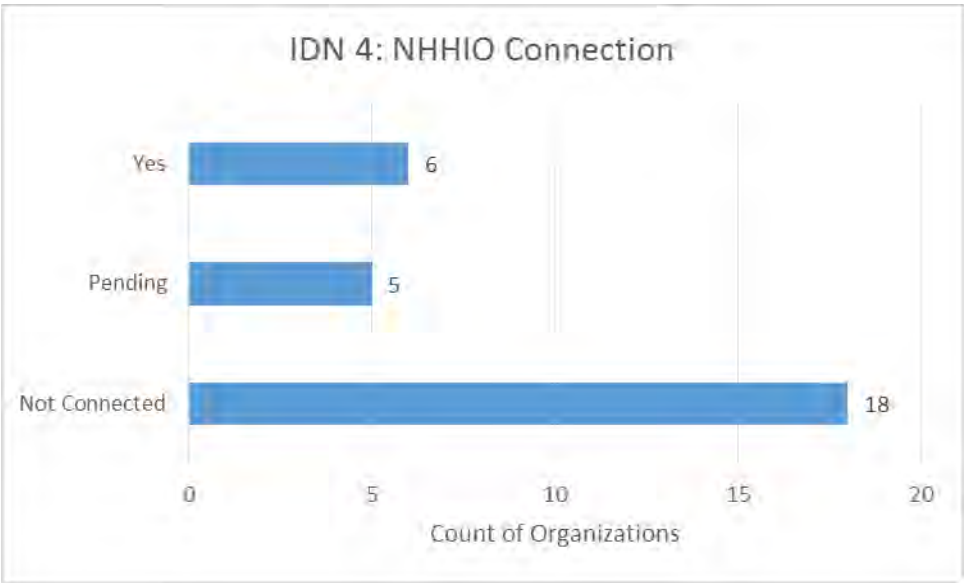
Limitations in electronic health data sharing among New Hampshire's providers exist due in part to legislative restrictions. Data sharing remains a challenge in IDN-4. Because of these limitations, Direct Secure Messaging (DSM) is used through the New Hampshire Health Information Organization (NHHIO). In the past, NHHIO served as a Health Information Service Provider (HISP) with a statewide Healthcare Provider Directory (HPD) to support Transfers of Care. NHHIO provided a secure network option for small providers with fewer resources across the care continuum, including community-based organizations. However, this organization has incurred sustainability issues recently.

Figure 2. Direct Secure Messaging



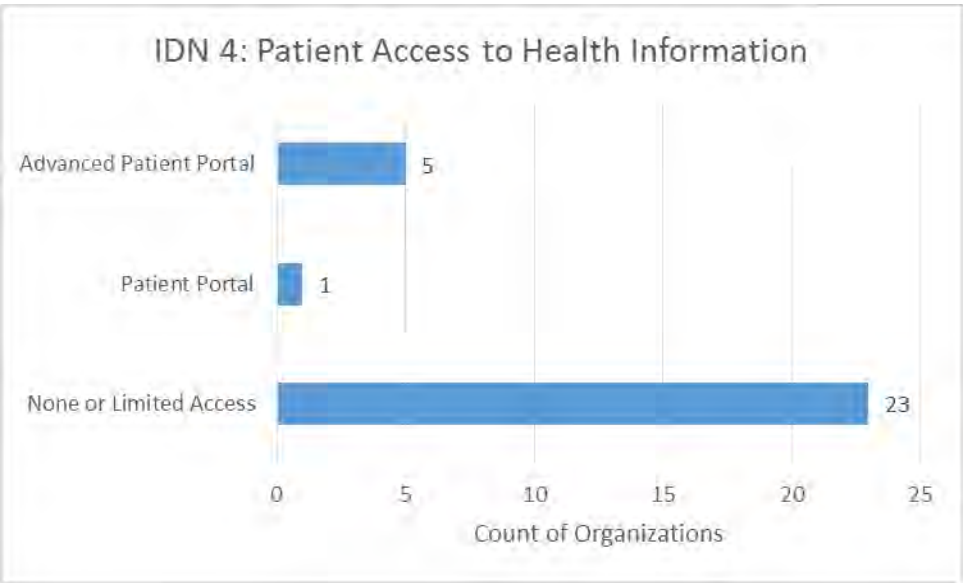
All organizations that completed the HIT Assessment tool were cross-referenced with the NHHIO's official list of organizations that are connected. In summary, for our region, six organizations are currently connected to NHHIO and an additional five organizations are in the process of connecting as shown in Figure 3 below. Eighteen organizations are not currently connected and are not planning to connect to NHHIO. While progressing through the DSRIP initiative, it will be important to ensure that organizations adopt a basic data sharing protocol including but not limited to direct secure messaging. This will ensure that all community organizations providing services to clients enrolled in the DSRIP initiatives have access to important, timely clinical and social services information on the their client.

Figure 3. NHHIO Connection



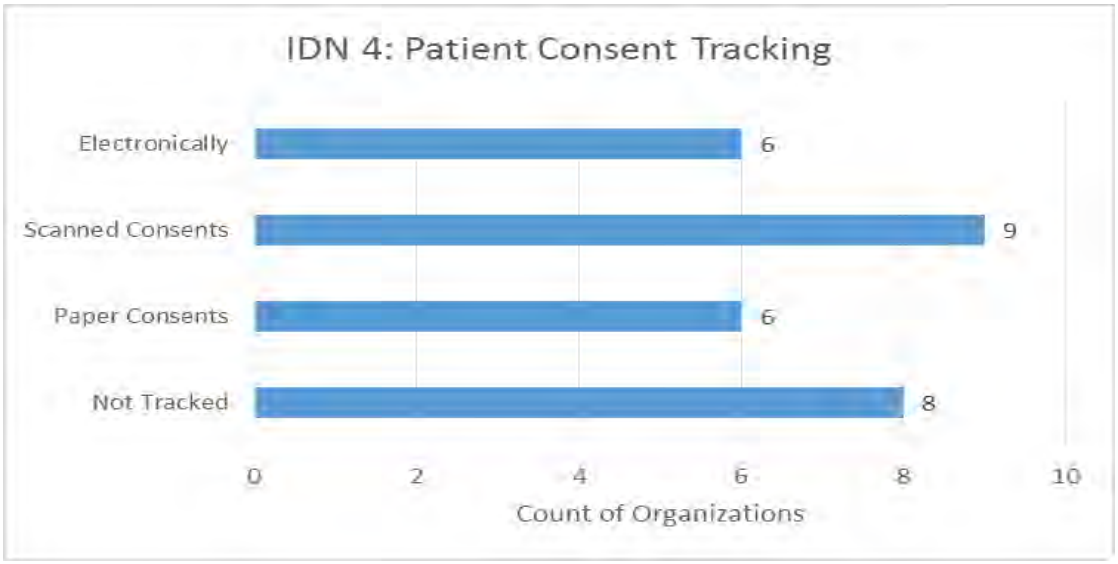
The HIT Assessment also included questions about patient access to health information. In general, most community and provider organizations do not provide their patients with easy access to their health information with the exception of larger organizations like hospitals. As shown in Figure 4 below, only five organizations in our region currently provide access to such information via an advanced patient portal that includes three or more of the following features: lab results, appointment scheduling, billing, links to health information websites, prescription refills, referrals, and secure messaging. Importantly, twenty-three organizations in the region noted that they do not currently provide a patient portal and therefore provide only limited access to patients regarding their own health care information. Although it is important to create an infrastructure that allows patients access to their health information and other features, due to limited resources, this will not be a priority for our HIT project.

Figure 4. Patient Access to Health Information



Another critical area for the waiver program is how patient consents are tracked and processed. With patients accessing services across the IDN, it is imperative to define a standardized process for patient consent. As shown in Figure 5, in our region, six organizations capture patient consent information entirely electronically in their EHR system. An additional nine organizations scan paper consents into an electronic system while another six organizations only capture consents on paper. Eight organizations do not track patient consents at all. The HIT Taskforce determined that defining a statewide consent form and process for sharing is a priority but it will require additional work outside the scope of the HIT project. If a statewide standard is defined it will be up to the HIT leads within each region to implement the infrastructure to make sharing easier.

Figure 5. Patient Consent Tracking



The responses to the HIT Assessment confirmed that across our region, many of the communication processes rely too heavily on human reconciliation from various data sources. Moreover, there is a significant technology gap related to resource disparity across members of the partnership. The resource disparity is associated with technology and material assets. Aside from the community mental health centers, most community-based behavioral health and social service providers do not utilize HIT at all and still rely primarily on paper records or non-standards based electronic data capture tools for care. In addition, providers use different care management mechanisms and tools, and to the extent that there is electronic care plans, they are not compatible with other provider systems. This leads to the potential for significant gaps in information, and importantly for this population which may have difficulty explaining conditions on an ongoing basis, requires for patients to have to repeat difficult or traumatic information as they visit each provider. These are some of the gaps we are looking to fill with our HIT initiatives.

2.3 HIT Workforce Capacity

As discussed, there is significant variation in HIT resources across the region. Although the hospitals and larger health centers have dedicated IT resources, most of the smaller community organizations do not. Moreover, even within the larger organizations, IT personnel are often internally focused and have been busy implementing new efforts including updating EHRs, launching or expanding telemedicine efforts, and working to develop population health capabilities. In addition, the federal government has implemented several new payment reform and other initiatives which require significant resources including MACRA. These efforts are added to the routine work responsibilities of IT personnel. Therefore, there has been little time to focus on IT solutions that are external to the organization that would help providers coordinate with other providers outside their four walls. Although NHHIO previously filled that role for smaller community organizations, it is unclear whether there is a path forward for them to continue to support this activity in the future. NNHIO's failure can be partially attributed to legislative limitations regarding data sharing, as well as lack of resources and competition from larger vendors offering more affordable services. It is our hope that this project will allow for additional resources to be deployed to help providers, large and small, with these efforts.

Network4Health plans to hire up to two IT application analysts to assist with implementing the HIT solutions selected for the region. In addition key IT staff from the IDN's provider members including three hospitals (Catholic Medical Center, Dartmouth Hitchcock Medical Center, and Elliot, Hospital) two behavioral health providers (Center for Life Management and Mental Health Center of Greater Manchester) and two other community providers (Easter Seals of NH, Home Health and Hospice.

3. Health Information Technology Standards

Network4Health 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 STCs[7], 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 IT standards for the statewide and regional demonstration projects, as agreed upon and adopted by the HIT Task Force. As described above in the Process for Reaching Consensus section, each table had extensive input from each IDN. Consensus was achieved on April 5, 2017 via an official, in-person vote with a response collected from each IDN.

Table 1. Minimum HIT Standards

New Hampshire Building Capacity for Transformation Waiver *Health IT Minimum Standards* **Minimum Definition**: Standards that apply to all IDN participants except where provider type is defined					
Capability & Standard	**Description**	**Provider Type**	**Role of IDN**	**DSRIP Project**	**Rationale for Standard Classification**
Data Extraction / Validation	Using a single vendor is an option for all IDNs; reporting metrics is mandatory - the distinction will be made in the implementation plans	All	Procurement and payment of a single collector for all IDNs. Assist organizations with transmitting data	All	All IDNs are required to report metrics
Internet Connectivity	Securely connected to the internet	All	Determine if they have it, do they need it	All	
Secured Data Storage	Ability and knowledge to secure PHI through technology and training	All	Educate or assist organization with standards. Determine PHI at organization level	All	HIPAA regulations
Electronic Data Capture	Ability to capture and convert documents to an electronic format as a minimum.	All	Education of electronic data captures 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.

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**
Direct Secure Messaging (DSM)	Ability to use the protocol DSM to transmit patient information between providers.	All	Education of DSM to organizations including use cases, assist in procurement	All	DSM establishes standards and documentation to support pushing data from where it is to where it's needed, supporting more robust interoperability in the future.
Shared Care Plan	Ability to access and/or contribute to an electronic shared care plan for an individual patient	Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment	Education of shared care plan to organizations including use cases, assist in procurement and payment	All	A shared care plan is a patient-centered health record designed to facilitate communication and sharing data among members of the care team, including the patient. A shared plan of care combines physical and behavioral health aspects to encourage a team approach to care.

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

Table 2. Desired HIT Standards

New Hampshire Building Capacity for Transformation Waiver *Health IT Desired Standards* **Desired Definition**: Applies to only some IDN participants			
Capability & Standard	**Description**	**Role of IDN**	**DSRIP Project**
Discrete Electronic Data Capture	Ability to capture discrete data and/or usage of a Certified Electronic Health Record Technology (CEHRT) as desired	Education of EHRs including certified EHRs, assist in procurement	All

Integrated Direct Secure Messaging	Ability to use the protocol DSM to transmit patient information between providers. Integration in EHR system as a desired	Education of DSM to organizations including use cases, assist in procurement	All
Query Based Exchange	Ability to use Inter-Vendor capabilities to share data, query, and retrieve.	Education of query-based exchange capabilities such as Care quality 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 HIT implementation Plan developed for IDN-4 includes the tasks needed to implement the region's multifaceted strategy. Region 4 intends to implement all minimum standards as defined in Table 1 above.

We are exploring the following desired standard: discrete electronic data capture for certain partners who currently do not have that capability and query-based exchange (through Commonwell / CareQuality) One other desired standard: Integrated direct secure messaging, while valuable, is not our priority at this time. In addition, we are currently evaluating the feasibility of implementing the following optional standards: closed loop e-referral and population health tools (care coordination tool and analytics tool). We are actively participating in a due diligence evaluation with multiple vendors for these two optional standards. The figure below graphically depicts the plan for IDN-4.

4.1 Future Vision

Network4Health's Health Information Technology platform will be transformed from a group of health and community providers with little access to client information across electronic and paper platforms to a more integrated system of client-information sharing. Our plan is to meet community organizations where they are at to cause as little disruption in their current protocols as possible while providing enhanced capabilities for them to better serve their clients. We will therefore be enhancing the capabilities of all organizations throughout the IDN but they will not all be required to have the exact same level of technological expertise. Through the combination of minimum, desired, and optional standards that IDN is committed to and actively exploring, we believe that we will transform how population health will be managed in our region, in caring for Medicaid patients.

There are four pillars that have been identified as critical to population health management including: connectivity, care coordination, analytics, and patient engagement. We will address all but one (patient engagement) of these areas with innovative IT solutions. Internet Connectivity is an essential element to any IT solutions. Connectivity will be greatly improved by the use of a DIRECT Secure Messaging system to allow providers to securely connect more effectively with each other when treating the same client. This solution is particularly relevant for Network4Health partners that already use an Electronic Health Record (EHR), as it allows for the secure exchange of client data across multiple EHRs and can also be used as a messaging protocol. This will enhance the capabilities of the more technologically advanced providers by allowing them to link electronic records.

For Network4Health partners who are not utilizing an EHR, Network4Health will implement a platform, such as Eccovia's ClientTrack that offers a viable solution that can connect health and

human service providers to allow case workers and care providers to collaborate across the spectrum of service delivery to address the physical, behavioral, and economic factors that impact health outcomes and quality of life for their clients. This tool will allow these providers to not only participate in the Comprehensive Core Standard Assessment that will be implemented across all projects, but to view important clinical data that they are entitled to see and which will allow them to better assist their clients. We are currently evaluating the capabilities of several vendor products.

IT solutions also are needed to help with care coordination of complex patients. We will implement a shared care plan to enable providers to access a holistic care plan at their fingertips. An event notification system will be deployed to alert interested parties to clients' utilization events, including emergency department and inpatient utilization. These systems support the integration of care and implementation of alternative payment models and ultimately lead to reduced unnecessary and costly health care utilization. It is essential for providers caring for complex clients to have access to these events when they happen so that care plans can be actionable at the point of care

We will implement population health tools including a data aggregator and data extraction and validation tools as well as the necessary population health analytics to improve care coordination and transform care plans into action at point of care and to enable deeper insights of gaps in care, wait times, and capacity management. A data aggregator will be implemented through which the different participating organizations within Region 4 will utilize their EHRs to provide a direct feed, allowing for data sharing across partners. This will allow provider organizations to collaborate across the spectrum of service delivery to address the physical, behavioral, and economic factors that impact health outcomes and quality of life for their clients. This tool will allow providers to not only participate in the Comprehensive Core Standard Assessment that will be implemented across all projects, but to view important clinical data that they are entitled to see and which will allow them to better assist their clients.

We are evaluating the feasibility of using an eReferral closed loop system to aggregate referrals so providers can more easily track patients across the continuum of care enabling deeper insights into gaps in care, wait times, and capacity management.

Finally, although we recognize the importance of patient engagement in population health management, at this point, due to the finite resources associated with this waiver program, it is lower on our priority. While we have no intention to implement any new HIT solutions that will help advance patient engagement, we will continue to re-evaluate annually.

An example of how our IT solutions will help improve care for complex patients, we have provided a case below.

Case: Mary is a 45-year old female with poorly controlled Type-2 diabetes mellitus with co-occurring depression and alcoholism. Due to financial and transportation constraints, she missed 50% of her scheduled primary care appointments. Unfortunately, this resulted in multiple complications from her diabetes, including renal failure and neuropathy. She is on disability and frequently visits 3 of the local emergency departments in our Region when her health deteriorates.

- **Current scenario**: It wasn't until Mary had presented to our emergency department (ED) 10 times (30 times across the 3 hospitals) over the past year that she was identified by physicians as a high utilizer. At her 10th visit, a case manager in the emergency department understood the socioeconomic constraints that contribute to Mary's health. The case manager manually called several transportation agencies, as well as Mary's PCP to let her know about the situation.
- **Future vision:** Through the Event Notification System, Mary will be identified much earlier and flagged as a high utilizer. A care coordinator will be assigned to help direct her care, creating a Shared Care Plan that gives all of Mary's care providers a holistic view of Mary's conditions. Her PCP and care coordinator are automatically alerted if and when Mary has another ED visit. Through the Care Coordinator tool, referrals can be sent electronically, with a 360-degree closed loop system to ensure timely follow up. Direct Secure Messaging will allow for asynchronous, but secure and fast communication across the care continuum. Through our population health analytics tools, other patients who are "at risk" of becoming a high utilizer can be identified early and intervened on sooner.

4.2 Populations and Providers in Scope

All providers working with the DSRIP projects will be required to improve their capabilities regarding ability to track data, communicate across providers, and provide improved care coordination for the clients they are serving. However, because we are meeting organizations where they are at, and because not all organizations have the same needs for sharing or using data, they will not all have the same electronic capabilities. Below we detail the types of organizations that will be excluded from the minimum standards and the rationale for exclusion.

- Data extraction / validation
  - Provider type excluded: Providers that do not collect data that is relevant to the reporting metrics for attributed members.
  - Rational for exclusion: Any measures that are outside of the 1115 reporting metrics are out of scope for this standard.
- Internet Connectivity
  - Provider type excluded: None
  - Rational for exclusion: NA
- Secure Data Storage
  - Provider type excluded: Partners that do not store PHI data.
  - Rational for exclusion: Non-PHI data are out of scope for this standard.
- Electronic Data Capture

  - Provider type excluded: Partners that do not capture PHI data.
  - Rational for exclusion: Non-PHI data are out of scope for this standard.
- Direct Secure Messaging (DSM)
  - Provider type excluded: Partners that do not send or receive PHI data.
  - Rational for exclusion: Non-PHI communication does not need DSM.
- Shared Care Plan
  - Provider type excluded: Partners that are not involved in patient care.
  - Rational for exclusion: Partners that are not involved in patient care do not need access to shared care plan.
- Event Notification Service
  - Provider type excluded: Partners that are not involved in patient care.
  - Rational for exclusion: Partners that are not involved in patient care do not need access to event notification.
- Transmit Event Notification Service
  - Provider type excluded: Only hospital facilities are included; all other partners are excluded.
  - Rational for exclusion: Only hospital facilities will be sending ADTs.

4.3 Priorities

Our top two priorities for IDN-4 are to implement Direct Secure Messaging and an Event Notification System. We believe that these two priorities will lay the foundation for improved communication and care coordination across providers. Closely following these essential features is the implementation of a Shared Care Plan and fostering the capabilities for Electronic Data Capture. These efforts would build upon existing technologies within the region and further facilitate integrated delivery. We also would like to implement discrete data capture, query-based exchange, Ereferral closed loop system, and population health tools but they are lower on our priority list.

4.4 Technology

The table below provides the planned outreach and education, process for vendor selection and procurement and onboarding and training plans for each of the IT capabilities/standards.

Capability & Standard	Planned Outreach / Education	Vendor Selection/ Procurement	Onboarding/ Training / Workflow redesign
Data Extraction / Validation	Identify all partners who house data that contribute to the reporting metrics for the demonstration projects; determine in what clinical systems the data are currently stored (both electronically and on paper).	Statewide HIT Taskforce is currently reviewing multiple vendors as the data aggregator for this standard.	Work with partners' IT departments to establish data feeds on a scheduled basis.
Direct Secure Messaging (DSM)	Identify all partners who don't currently have DIRECT capabilities; determine whether they currently send PHI data.	NHHIO-Kno2; NHHIO has been active in the state in NH in advocating / procuring / supporting DIRECT technologies.	Webmail version is lightweight for onboarding. Training and workflow redesign will need to be managed at the Partners level, as this will be a new process. Best practice workflow will be developed and communicated to partners.
Shared Care Plan	Identify all partners who need the ability to: 1) document in Shared Care Plans, and 2) view Shared Care Plans.	Statewide HIT Taskforce explored 3 vendors, and selected CMT as the preferred vendor by consensus.	Both Clinical and IT onboarding. Will need clinical consensus on content of Shared Care Plan, who can modify, etc. We will work with our B1 team leadership on the clinical onboarding. For training, we will follow a train-the-trainer model.
Event Notification Service	Identify all partners who need notification alerts.	Statewide HIT Taskforce explored 3 vendors, and selected CMT as the preferred vendor by consensus.	Both Clinical and IT onboarding. Will need clinical consensus on alert triggering criteria. IT onboarding will need to establish subscriptions.

4.5 HIT Workforce Capacity

As indicated in Section 2.3, one of the identified HIT workforce gaps is that there lacks a workforce whose work spans partners in the region, rather than within a partner. We therefore, aim to address that gap by hiring 2 clinical application analysts. These two analysts, while employed by Catholic Medical Center (our lead agency), will be shared across all partner organizations. They will support the various applications that are specific to the 1115 Waiver. They will serve as the trainers using a "train the trainer" model with the various partners. They also will serve as liaisons between the partners and the vendors. These analysts will provide the primary workforce that will focus on working across all partner organizations in our region in advancing each towards integrated health delivery; thereby filling a workforce gap that is needed.

4. Governance

The foundational principle of Network4Health's governance strategy and structure is "partnership." This highly collaborative and cooperative approach is critical to Catholic Medical Center's (CMC's) strategy to ensure continued partner engagement. However, just as collaboration and cooperation are built into the governance structure, so is performance accountability. CMC is the lead agency for Network4Health and, as such, retains final authority and responsibility for all decision making. While CMC is the lead agency, all partner organizations participate as full partners, as reflected in the IDN partnership organizational structure. The IDN has not established or pursued a separate legal entity to date.

Lead Agency

As the lead agency for Network4Health, CMC has responsibility and accountability above and beyond that of the other IDN partner organizations. [redacted]t, chairs both the IDN Partnership Team and the Steering Committee (described below), and senior CMC leaders—including CMC's Chief Medical Officer, Executive Director of Community Mission, and Director of Behavioral Health—participate on both. CMC financial staff will be responsible for managing IDN funds and will ensure that all IDN funds remain separate and segregated from CMC revenue.

Partnership Team

The IDN Partnership Team is the oversight body for the IDN. It is composed of representatives from the CMC Leadership Team, and one representative from each of the 43 partner organizations. While organizations may have only one official member of the Partnership Team, organizations may choose to bring as many additional individuals as they wish to Partnership Team meetings.

The primary role of the Partnership Team is to provide overall project guidance, approval of high-level strategic, IDN-wide, or financial issues/decisions, and resolution of issues not able to be resolved at a lower level.

Steering Committee

Network4Health's Steering Committee, composed of the CMC Leadership Team and leaders of the IDN's selected key partner organizations, is responsible for guiding the day-to-day work for the project and for the project-specific workgroups. This 12-member committee is the primary governing body for the IDN and is directly accountable to the Partnership Team. As described in the Steering Committee Charter, the Steering Committee is limited to twelve members, with no more than one voting member from each IDN partner. Any IDN partner can petition to join the Steering Committee. Membership is determined by majority vote of the Steering Committee members. Initial composition of the Steering Committee was approved by the Network4Health Partnership Team, which includes representation from each Partner organization. The committee includes at least two steering committee members that have no financial interest in the process (impartial representation).

Steering Committee membership approved by the Network4Health Partnership Team is as follows:

[redacted]

The Steering Committee is responsible for guiding the work of the individual workgroups, providing initial and ongoing guidance to the workgroups, providing feedback on workgroup recommendations, addressing mid-level issues, and escalating higher-level, strategic issues to the Partnership Team as warranted.

Executive Director: Network4Health has appointed [redacted] as its Executive Director. In his role as Executive Director, [redacted] is responsible for the overall success of Network4Health and the projects it is implementing. He is the key contact with the state and also works collaboratively with the other IDNs across the state.

[redacted]

Health Information Technology (HIT) Infrastructure to Support Integration Project Team: [redacted] serve as the co-chairs of this team. Membership is comprised of representatives from throughout the partnership. The Team Co-leads have been active participants in the statewide HIT team supported through a contract that the state of NH created with Myers & Stauffer LC for purposes of technical assistance. This consultation resulted in the creation of the state plan and served as a platform for the seven regional integrated delivery networks to work collaborative on review and selection of potential technology solutions.

5. Major Milestones

The table below identifies the major milestones with expected dates of completion for our major HIT projects.

	6/30/17	12/31/17	6/30/18	12/31/18
Project Plan	X			
Aim 1: DIRECT set up / Training		X		
Aim 2: Sending of ADTs for ENS			X	
Aim 3: Enroll ENS subscribers, train, and transmit notifications			X	X
Aim 4: Design and Build SCP process, workflow (will build based on B1 team request)			X	X
Aim 5: Data aggregator: build and feed			X	X
Aim 6: Train SCP				X
Aim 7: Roll out SCP				X

6. Top Risks

Identifying risks at the DSRIP program level occurred at the HIT Task Force meetings and the work sessions through discussion and the consensus building process.

- 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. A couple of regions did not have their hospitals directly participate in the 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.

7. Conclusion

[*Optional section*. *IDNs to provide a final statement summarizing the HIT Implementation Plan for their region. May be used by the IDN if deemed beneficial.]*

8. Appendices

9.1 Projects Selected by Each IDN

The project categories and requirements are ***excerpts*** from the New Hampshire Building Capacity for Transformation Attachment C: DSRIP Planning Protocol[8].

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	

IDN Selected Projects							
IDN	**B1**	**C1**	**C2**	**D1**	**D3**	**E4**	**E5**
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 Projects

- 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 Projects

- 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 an IDN for delivery of partial intensive outpatient, partial hospital, or residential treatment options for SUD, in conjunction with expansion of lower acuity outpatient counseling.

(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 adult and child populations with multiple physical health and behavioral health chronic conditions.

9.2 Detailed HIT Project Plan

Attachment_A2.3

A2 HIT

	Task Name	Duration	Start	Finish	Predecessors
1	HIT Implementation Plan	1065d	01/02/17	01/29/21	
2	State Level HIT Planning	390d	01/02/17	06/29/18	
3	Participate in Statewide HIT Planning	108d	01/02/17	05/31/17	
4	Receive Statewide HIT Report (informs IDN 4 Implementation Plan)	1d	06/01/17	06/01/17	
5	Create IDN 4 HIT Implementation Plan	130d	01/01/18	06/29/18	
6	Network 4 Health/IDN 4 HIT Implementation Plan	499d	09/04/17	08/01/19	
7	ED PreManage (CMT)	499d	09/04/17	08/01/19	
8	Sign Contract (Network 4 Health/CMC Admin lead)	1d	12/01/17	12/01/17	
9	Sign User Agreement	5d	12/04/17	12/08/17	
10	CMC Signed User Agreement	1w	12/04/17	12/08/17	
11	Elliot Signed User Agreement	1w	12/04/17	12/08/17	
12	Parkland Signed User Agreement	1w	12/04/17	12/08/17	
13	VPN Connectivity	20d	11/27/17	12/22/17	
14	VPN Connectivity CMC	2w	11/27/17	12/08/17	
15	VPN Connectivity Elliot	2w	12/11/17	12/22/17	
16	VPN Connectivity Parkland	2w	12/11/17	12/22/17	
17	Hospital ADT Feed / Messages	120d	09/04/17	02/16/18	
18	CMC ADT Feed / Messages	80d	09/04/17	12/22/17	
19	Test	2w	09/04/17	09/15/17	
20	Mappings	4w	09/18/17	10/13/17	
21	Prod	2w	12/11/17	12/22/17	
22	Elliot ADT Feed / Messages	40d	12/25/17	02/16/18	
23	Test	2w	12/25/17	01/05/18	
24	Mappings	4w	01/08/18	02/02/18	
25	Prod	2w	02/05/18	02/16/18	
26	Parkland ADT Feed / Messages	40d	12/25/17	02/16/18	
27	Test	2w	12/25/17	01/05/18	
28	Mappings	4w	01/08/18	02/02/18	
29	Prod	2w	02/05/18	02/16/18	
30	Process/Protocol for ENS notice receipt	35d	02/19/18	04/06/18	
31	Subscription process email/fax sign-up	3w	02/19/18	03/09/18	
32	Communication of new process to subscribers	2w	03/12/18	03/23/18	
33	Go-live	2w	03/26/18	04/06/18	
34	EMR Integration at Hospitals	224d	06/25/18	05/02/19	
35	CMC EMR Integration	45d	03/01/19	05/02/19	
36	EDIE Return Message	2w	03/01/19	03/14/19	

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	Task Name	Duration	Start	Finish	Predecessors
37	EMR Build	3w	03/15/19	04/04/19	
38	Configure Icon	2w	04/05/19	04/18/19	
39	Validation	2w	04/19/19	05/02/19	
40	Elliot EMR Integration	45d	06/25/18	08/24/18	
41	EDIE Return Message	2w	06/25/18	07/06/18	
42	EMR Build	3w	07/09/18	07/27/18	
43	Configure Icon	2w	07/30/18	08/10/18	
44	Validation	2w	08/13/18	08/24/18	
45	Parkland EMR Integration	45d	09/17/18	11/16/18	
46	EDIE Return Message	2w	09/17/18	09/28/18	
47	EMR Build	3w	10/01/18	10/19/18	
48	Configure Icon	2w	10/22/18	11/02/18	
49	Validation	2w	11/05/18	11/16/18	
50	Historical File	134d	11/19/18	05/23/19	
51	Build Historical File	3w	11/19/18	12/07/18	
52	CMT Historical File Processing	3w	05/03/19	05/23/19	
53	IT Implementation Go Live	2w	05/24/19	06/06/19	
54	Active Directory / SSO (Optional)	40d	05/03/19	06/27/19	
55	Investigate Issue	3w	05/03/19	05/23/19	
56	Identify Solution	3w	05/24/19	06/13/19	
57	Implement Solution	2w	06/14/19	06/27/19	
58	Clinical Kick Off Meeting	2w	05/03/19	05/16/19	
59	User Provisioning	20d	05/03/19	05/30/19	
60	Identify list of initial users	2w	05/03/19	05/16/19	
61	Set up initial users	2w	05/17/19	05/30/19	
62	Training	30d	05/31/19	07/11/19	
63	ED providers on EDIE Report	3w	05/31/19	06/20/19	
64	Portal Use	3w	06/21/19	07/11/19	
65	Clinical/Project Go Live	3w	07/12/19	08/01/19	
66	**Comprehensive Core Standardized Assessment**	311d	09/01/17	11/09/18	
67	Identify capable vendors	1d	09/01/17	09/01/17	
68	Select Down	4w	09/04/17	09/29/17	
69	Due diligence and scoping	5w	10/02/17	11/03/17	
70	Decide on vendor	10w	11/06/17	01/12/18	
71	Contract Negotiation	2w	01/15/18	01/26/18	
72	Sign Agreement	1w	01/29/18	02/02/18	
73	Project Initiation	2w	02/05/18	02/16/18	

Attachment_A2.3

	Task Name	Duration	Start	Finish	Predecessors
74	Analysis and Design	4w	02/19/18	03/16/18	
75	Functional Deliverables	12w	03/19/18	06/08/18	
76	Integration Deliverables	12w	06/11/18	08/31/18	
77	User Aceptance Testing	5w	09/03/18	10/05/18	
78	Training	3w	10/08/18	10/26/18	
79	Deployment Support	2w	10/29/18	11/09/18	
80	**Care Coordination Tool**	511d	09/01/17	08/16/19	
81	Identify capable vendors	1d	09/01/17	09/01/17	
82	Select Down	4w	09/04/17	09/29/17	
83	Due diligence and scopping	5w	10/02/17	11/03/17	
84	Decide on vendor	10w	11/06/17	01/12/18	
85	Contract Negotiation	2w	01/15/18	01/26/18	
86	Sign Agreement	1w	01/29/18	02/02/18	
87	Project Initiation	2w	11/12/18	11/23/18	
88	Analysis and Design	4w	11/26/18	12/21/18	
89	Functional Deliverables	12w	12/24/18	03/15/19	
90	Integration Deliverables	12w	03/18/19	06/07/19	
91	User Aceptance Testing	5w	06/10/19	07/12/19	
92	Training	3w	07/15/19	08/02/19	
93	Deployment Support	2w	08/05/19	08/16/19	
94	**Data Warehouse**	431d	09/01/17	04/26/19	
95	Identify capable vendors	1d	09/01/17	09/01/17	
96	Select Down	4w	09/04/17	09/29/17	
97	Due diligence and scoping	5w	10/02/17	11/03/17	
98	Decide on vendor	10w	11/06/17	01/12/18	
99	Contract Negotiation	2w	01/15/18	01/26/18	
100	Sign Agreement	1w	01/29/18	02/02/18	
101	Project Initiation	4w	02/05/18	03/02/18	
102	Analysis and Design	8w	03/05/18	04/27/18	
103	Functional Deliverables	18w	04/30/18	08/31/18	
104	Integration Deliverables	18w	09/03/18	01/04/19	
105	User Aceptance Testing	10w	01/07/19	03/15/19	
106	Training	4w	03/18/19	04/12/19	
107	Deployment Support	2w	04/15/19	04/26/19	
108	**Process Milestones by Reporting Period**	447d	12/01/17	08/19/19	
109	**Period ending June 30, 2017**	0	06/29/18	06/29/18	
110	IDN 4 HIT Implementation Plan Complete	0	06/29/18	06/29/18	
111	**July - December 2017**	15d	12/01/17	12/22/17	

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	Task Name	Duration	Start	Finish	Predecessors
112	ED Premanage IDN 4 Contract Signed	0	12/01/17	12/01/17	
113	ED Premanage Hospital User Agreements Signed	0	12/08/17	12/08/17	
114	CMC ADT feed in production	0	12/22/17	12/22/17	
115	**January - June 2018**	50d	01/12/18	03/23/18	
116	CMT ED PreManage: Elliot ADT feed in production	0	02/16/18	02/16/18	
117	CMT ED PreManage: Parkland ADT feed in production	0	02/16/18	02/16/18	
118	Go Live for Organizational Subscribers to ENS messages with PreManage	0	03/23/18	03/23/18	
119	Core Standardized Assessment Tool Vendor Selection Complete	0	01/12/18	01/12/18	
120	Core Standardized Assessment Tool Vendor Contract Complete	0	02/02/18	02/02/18	
121	Care Coordination Tool Vendor Selection Complete	0	01/12/18	01/12/18	
122	Care Coordination Tool Vendor Contract Complete	0	02/02/18	02/02/18	
123	Data Warehouse Vendor Selection Complete	0	01/12/18	01/12/18	
124	Data Warehouse Vendor Contract Complete	0	02/02/18	02/02/18	
125	**July - December 2018**	146d	06/08/18	12/28/18	
126	PROGRESS ASSMENT: Collect/evaluate feedback ENS message USERS	85d	09/03/18	12/28/18	
127	CMT ED PreManage: Elliot EMR Integration of ADT feeds	0	08/24/18	08/24/18	
128	CMT ED PreManage: Parkland EMR Integration of ADT feeds	0	11/16/18	11/16/18	
129	Core Standardized Assessment Configuration Complete (Functional and Integration)	0	06/08/18	06/08/18	
130	Core Standardized Assessment Training Complete	0	10/05/18	10/05/18	
131	Core Standardized Assessment Deployment Complete	0	11/09/18	11/09/18	
132	**January - December 2019**	112d	03/15/19	08/19/19	
133	PROGRESS ASSMENT: Collect/evaluate feedback CCSA USERS	60d	04/01/19	06/21/19	
134	Care Coordination Tool Complete (Functional and Integration)	1d	07/15/19	07/15/19	
135	Care Coordination Tool Configuration Complete (Functional and Integration)	1d	08/05/19	08/05/19	
136	Care Coordination Tool Assessment Deployment Complete	1d	08/19/19	08/19/19	
137	Data Warehouse User Acceptance Testing Complete	0	03/15/19	03/15/19	
138	Data Warehouse Training Complete	0	04/12/19	04/12/19	
139	Data Warehouse Deployment Support Complete	0	04/26/19	04/26/19	
140	**January - December 2020**	76d	01/15/18	04/30/18	
141	Progress Assessment: Collect/Evaluate feedback ALL TOOLS	76d	01/15/18	04/30/18	
142	**Evaluation Metrics Reporting (Data - per approved metrics)**	936d	07/01/17	01/29/21	
143	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/30/18	
144	prepare evaluation plan measures	152d	07/01/17	01/29/18	
145	submit	1d	01/30/18	01/30/18	
146	On-going data reporting for period ending 06/29/2018	152d	01/01/18	07/31/18	
147	prepare evaluation plan measures	151d	01/01/18	07/30/18	
148	submit	1d	07/31/18	07/31/18	

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	Task Name	Duration	Start	Finish	Predecessors
149	On-going data reporting for period ending 12/31/2018	155d	07/01/18	01/31/19	
150	prepare evaluation plan measures	154d	07/01/18	01/30/19	
151	submit	1d	01/31/19	01/31/19	
152	On-going data reporting for period ending 06/29/2019	152d	01/01/19	07/31/19	
153	prepare evaluation plan measures	151d	01/01/19	07/30/19	
154	submit	1d	07/31/19	07/31/19	
155	On-going data reporting for period ending 12/31/2019	155d	07/01/19	01/31/20	
156	prepare evaluation plan measures	154d	07/01/19	01/30/20	
157	submit	1d	01/31/20	01/31/20	
158	On-going data reporting for period ending 06/29/2020	153d	01/01/20	07/31/20	
159	prepare evaluation plan measures	152d	01/01/20	07/30/20	
160	submit	1d	07/31/20	07/31/20	
161	On-going data reporting for period ending 12/31/2020	153d	07/01/20	01/29/21	
162	prepare evaluation plan measures	152d	07/01/20	01/28/21	
163	submit	1d	01/29/21	01/29/21	

9.3 Member Organization List with Alignment to HIT Standards and Projects

Partner organizations that have been determined as Cohort 1 (noted in table below) will be the first cohort to implement the IT solutions in their organizations. We are currently in the planning stage for the second cohort of partner organizations and the alignment to HIT standards and projects will be determined at a later date.

Organization/ Provider	Shared Care Plan	Event Notification Service	Transmit Event Notification Service	Data Extraction / Validation	Internet Connectivity	Secured Data Storage	Electronic Data Capture	Direct Secure Messaging (DSM)
Catholic Medical Center (PCP/BH) CMC Behavioral Health Family Health and Wellness Center at Bedford Highlander Way Internal Medicine Hooksett Internal Medicine Willowbend Family Practice	x	x	x	x	x	x	x	x
Center for Life Management	x	x		x	x	x	x	x
Child and Family Services	x	x		x	x	x	x	x
Dartmouth-Hitchcock (Manchester)	x	x		x	x	x	x	x

Organization/ Provider	Shared Care Plan	Event Notification Service	Transmit Event Notification Service	Data Extraction / Validation	Internet Connectivity	Secured Data Storage	Electronic Data Capture	Direct Secure Messaging (DSM)
Easter Seals New Hampshire	x	x		x	x	x	x	x
Elliot Health System (PCP/BH) (four practice sites TBD)	x	x	x	x	x	x	x	x
Families in Transition	x	x		x	x	x	x	x
Healthcare for the Homeless	x	x		x	x	x	x	x
Manchester Community Health Center	x	x		x	x	x	x	x
Serenity Place	x	x		x	x	x	x	x
The Mental Health Center of Greater Manchester	x		x	x	x	x	x	x

[IDNs are encouraged to use the following table as a checklist of questions to answer in the following sections. IDNs do not need to include the checklist in the implementation plan. This is to be used as a reference for completeness. Please remove this checklist prior to submitting your HIT Implementation Plan.]

	HIT Implementation Plan Checklist	STC Page #
1	Addresses the following critical element of the NH vision for transformation: An HIT infrastructure that allows for the exchange of information among providers and supports a robust care management approach for beneficiaries with behavioral health conditions.	**65**
2	Identifies [HIT workforce capacity and] technology required to meet demonstration goals and with assessments of the current HIT gaps across the state and IDN regions.	**66**
3	Describes the future state vision that incorporates strategies to efficiently implement statewide or regional technology solutions.	**66**
4	If not described in the Workforce Capacity Plan, the HIT Implementation Plan addresses gaps in HIT workforce capacity.	**66**
5	Addresses how the IDN will acquire the HIT capacity needed to meet the larger demonstration objectives.	**67**
6	Assesses the current HIT infrastructure gaps across the state and IDN regions.	**67**
7	Identifies the statewide HIT implementation priorities given demonstration objectives.	**68**
8	Identifies the statewide and local IDN HIT infrastructure requirements to meet demonstration goals, including: minimum standards required of every IDN, desired standards that are strongly encouraged, and a menu of optional requirements. IDN should address how each desired and optional standard will/will not be implemented and why.	**67**
9	The HIT Implementation Plan is based on Taskforce assessments and recommendations and reflects the IDN's current HIT capacity and the IDN's specific community needs assessment.	**68**
10	The implementation plan specifically addresses gaps, could include the following: 1. Level of IDN participants utilizing ONC Certified Technologies 2. Level of IDN participants capable of conducting ePrescribing and other core functions such as registries, standardized patient assessments, collection of social determinants, treatment and care transition plans, etc. 3. Level of IDN participants utilizing Certified Electronic Health Record Technology (CEHRT). 4. Level of IDN participants capable of conducting ePrescribing and other core CEHRT functions such as registries, standardized patient assessments, collection of social data, treatment and care transition plans, etc. 5. Ability for IDN participants to exchange relevant clinical data with each other and with statewide facilities such as New Hampshire Hospital via health information exchange (HIE) standards and protocols. 6. Ability for IDN participants to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2). 7. Ability for IDN participants to use comprehensive, standardized physical and behavioral health assessments. 8. Level of IDN participants in their ability to share a community-wide care plan to support care management, care coordination, patient registries, population health management, and quality measurement. 9. Ability for IDN participants and the State's Medicaid HIT infrastructure, comprised of State and managed care organization (MCO) vendor systems, to	**68**

	HIT Implementation Plan Checklist	STC Page #
	create interoperable systems for the exchange of financial, utilization, and clinical and quality data for operational and programmatic evaluation purposes. Ability for IDN participants to directly engage with their patients for items including but not limited to bi-directional secure messaging, appointment scheduling, viewing care records, prescription management, and referral management.	
11	[If not described elsewhere in the IDN Plan,] the HIT Plan should provide a data governance plan and a plan to provide needed technology and data sharing capacity among partners (specifically, PCP and BH providers) and reporting and monitoring processes in alignment with state guidelines.	**80**
12	Identifies exact provider groups/sites/clinics that will be part of HIT integration efforts and which HIT effort/standard will be targeted for each provider (assuming it isn't the same for everyone, which it could be).	

[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.

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	Task Name	Duration	Start	Finish	Predecessors
1	**HIT Implementation Plan**	1065d	01/02/17	01/29/21	
2	**State Level HIT Planning**	390d	01/02/17	06/29/18	
3	Participate in Statewide HIT Planning	108d	01/02/17	05/31/17	
4	Receive Statewide HIT Report (informs IDN 4 Implementation Plan)	1d	06/01/17	06/01/17	
5	Create IDN 4 HIT Implementation Plan	130d	01/01/18	06/29/18	
6	**Network 4 Health/IDN 4 HIT Implementation Plan**	499d	09/04/17	08/01/19	
7	**ED PreManage (CMT)**	499d	09/04/17	08/01/19	
8	Sign Contract (Network 4 Health/CMC Admin lead)	1d	12/01/17	12/01/17	
9	Sign User Agreement	5d	12/04/17	12/08/17	
10	CMC Signed User Agreement	1w	12/04/17	12/08/17	
11	Elliot Signed User Agreement	1w	12/04/17	12/08/17	
12	Parkland Signed User Agreement	1w	12/04/17	12/08/17	
13	VPN Connectivity	20d	11/27/17	12/22/17	
14	VPN Connectivity CMC	2w	11/27/17	12/08/17	
15	VPN Connectivity Elliot	2w	12/11/17	12/22/17	
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23	Test	2w	12/25/17	01/05/18	
24	Mappings	4w	01/08/18	02/02/18	
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35	CMC EMR Integration	45d	03/01/19	05/02/19	
36	EDIE Return Message	2w	03/01/19	03/14/19	

	Task Name	Duration	Start	Finish	Predecessors
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38	Configure Icon	2w	04/05/19	04/18/19	
39	Validation	2w	04/19/19	05/02/19	
40	Elliot EMR Integration	45d	06/25/18	08/24/18	
41	EDIE Return Message	2w	06/25/18	07/06/18	
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45	Parkland EMR Integration	45d	09/17/18	11/16/18	
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48	Configure Icon	2w	10/22/18	11/02/18	
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50	Historical File	134d	11/19/18	05/23/19	
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62	Training	30d	05/31/19	07/11/19	
63	ED providers on EDIE Report	3w	05/31/19	06/20/19	
64	Portal Use	3w	06/21/19	07/11/19	
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66	**Comprehensive Core Standardized Assessment**	311d	09/01/17	11/09/18	
67	Identify capable vendors	1d	09/01/17	09/01/17	
68	Select Down	4w	09/04/17	09/29/17	
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70	Decide on vendor	10w	11/06/17	01/12/18	
71	Contract Negotiation	2w	01/15/18	01/26/18	
72	Sign Agreement	1w	01/29/18	02/02/18	
73	Project Initiation	2w	02/05/18	02/16/18	

	Task Name	Duration	Start	Finish	Predecessors
74	Analysis and Design	4w	02/19/18	03/16/18	
75	Functional Deliverables	12w	03/19/18	06/08/18	
76	Integration Deliverables	12w	06/11/18	08/31/18	
77	User Aceptance Testing	5w	09/03/18	10/05/18	
78	Training	3w	10/08/18	10/26/18	
79	Deployment Support	2w	10/29/18	11/09/18	
80	**Care Coordination Tool**	511d	09/01/17	08/16/19	
81	Identify capable vendors	1d	09/01/17	09/01/17	
82	Select Down	4w	09/04/17	09/29/17	
83	Due diligence and scopping	5w	10/02/17	11/03/17	
84	Decide on vendor	10w	11/06/17	01/12/18	
85	Contract Negotiation	2w	01/15/18	01/26/18	
86	Sign Agreement	1w	01/29/18	02/02/18	
87	Project Initiation	2w	11/12/18	11/23/18	
88	Analysis and Design	4w	11/26/18	12/21/18	
89	Functional Deliverables	12w	12/24/18	03/15/19	
90	Integration Deliverables	12w	03/18/19	06/07/19	
91	User Aceptance Testing	5w	06/10/19	07/12/19	
92	Training	3w	07/15/19	08/02/19	
93	Deployment Support	2w	08/05/19	08/16/19	
94	**Data Warehouse**	431d	09/01/17	04/26/19	
95	Identify capable vendors	1d	09/01/17	09/01/17	
96	Select Down	4w	09/04/17	09/29/17	
97	Due diligence and scoping	5w	10/02/17	11/03/17	
98	Decide on vendor	10w	11/06/17	01/12/18	
99	Contract Negotiation	2w	01/15/18	01/26/18	
100	Sign Agreement	1w	01/29/18	02/02/18	
101	Project Initiation	4w	02/05/18	03/02/18	
102	Analysis and Design	8w	03/05/18	04/27/18	
103	Functional Deliverables	18w	04/30/18	08/31/18	
104	Integration Deliverables	18w	09/03/18	01/04/19	
105	User Aceptance Testing	10w	01/07/19	03/15/19	
106	Training	4w	03/18/19	04/12/19	
107	Deployment Support	2w	04/15/19	04/26/19	
108	**Process Milestones by Reporting Period**	447d	12/01/17	08/19/19	
109	**Period ending June 30, 2017**	0	06/29/18	06/29/18	
110	IDN 4 HIT Implementation Plan Complete	0	06/29/18	06/29/18	
111	**July - December 2017**	15d	12/01/17	12/22/17	

	Task Name	Duration	Start	Finish	Predecessors
112	ED Premanage IDN 4 Contract Signed	0	12/01/17	12/01/17	
113	ED Premanage Hospital User Agreements Signed	0	12/08/17	12/08/17	
114	CMC ADT feed in production	0	12/22/17	12/22/17	
115	**January - June 2018**	50d	01/12/18	03/23/18	
116	CMT ED PreManage: Elliot ADT feed in production	0	02/16/18	02/16/18	
117	CMT ED PreManage: Parkland ADT feed in production	0	02/16/18	02/16/18	
118	Go Live for Organizational Subscribers to ENS messages with PreManage	0	03/23/18	03/23/18	
119	Core Standardized Assessment Tool Vendor Selection Complete	0	01/12/18	01/12/18	
120	Core Standardized Assessment Tool Vendor Contract Complete	0	02/02/18	02/02/18	
121	Care Coordination Tool Vendor Selection Complete	0	01/12/18	01/12/18	
122	Care Coordination Tool Vendor Contract Complete	0	02/02/18	02/02/18	
123	Data Warehouse Vendor Selection Complete	0	01/12/18	01/12/18	
124	Data Warehouse Vendor Contract Complete	0	02/02/18	02/02/18	
125	**July - December 2018**	146d	06/08/18	12/28/18	
126	PROGRESS ASSMENT: Collect/evaluate feedback ENS message USERS	85d	09/03/18	12/28/18	
127	CMT ED PreManage: Elliot EMR Integration of ADT feeds	0	08/24/18	08/24/18	
128	CMT ED PreManage: Parkland EMR Integration of ADT feeds	0	11/16/18	11/16/18	
129	Core Standardized Assessment Configuration Complete (Functional and Integration)	0	06/08/18	06/08/18	
130	Core Standardized Assessment Training Complete	0	10/05/18	10/05/18	
131	Core Standardized Assessment Deployment Complete	0	11/09/18	11/09/18	
132	**January - December 2019**	112d	03/15/19	08/19/19	
133	PROGRESS ASSMENT: Collect/evaluate feedback CCSA USERS	60d	04/01/19	06/21/19	
134	Care Coordination Tool Complete (Functional and Integration)	1d	07/15/19	07/15/19	
135	Care Coordination Tool Configuration Complete (Functional and Integration)	1d	08/05/19	08/05/19	
136	Care Coordination Tool Assessment Deployment Complete	1d	08/19/19	08/19/19	
137	Data Warehouse User Acceptance Testing Complete	0	03/15/19	03/15/19	
138	Data Warehouse Training Complete	0	04/12/19	04/12/19	
139	Data Warehouse Deployment Support Complete	0	04/26/19	04/26/19	
140	**January - December 2020**	76d	01/15/18	04/30/18	
141	Progress Assessment: Collect/Evaluate feedback ALL TOOLS	76d	01/15/18	04/30/18	
142	**Evaluation Metrics Reporting (Data - per approved metrics)**	936d	07/01/17	01/29/21	
143	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/30/18	
144	prepare evaluation plan measures	152d	07/01/17	01/29/18	
145	submit	1d	01/30/18	01/30/18	
146	On-going data reporting for period ending 06/29/2018	152d	01/01/18	07/31/18	
147	prepare evaluation plan measures	151d	01/01/18	07/30/18	
148	submit	1d	07/31/18	07/31/18	

	Task Name	Duration	Start	Finish	Predecessors
149	On-going data reporting for period ending 12/31/2018	155d	07/01/18	01/31/19	
150	prepare evaluation plan measures	154d	07/01/18	01/30/19	
151	submit	1d	01/31/19	01/31/19	
152	On-going data reporting for period ending 06/29/2019	152d	01/01/19	07/31/19	
153	prepare evaluation plan measures	151d	01/01/19	07/30/19	
154	submit	1d	07/31/19	07/31/19	
155	On-going data reporting for period ending 12/31/2019	155d	07/01/19	01/31/20	
156	prepare evaluation plan measures	154d	07/01/19	01/30/20	
157	submit	1d	01/31/20	01/31/20	
158	On-going data reporting for period ending 06/29/2020	153d	01/01/20	07/31/20	
159	prepare evaluation plan measures	152d	01/01/20	07/30/20	
160	submit	1d	07/31/20	07/31/20	
161	On-going data reporting for period ending 12/31/2020	153d	07/01/20	01/29/21	
162	prepare evaluation plan measures	152d	07/01/20	01/28/21	
163	submit	1d	01/29/21	01/29/21	

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.*

In an initial survey of our Primary Care, Mental Health Practices and Substance Use Programs, in March 2017, the Integrated Care Workgroup conducted a survey to assess for a number of perceived gaps and barriers to care, services provided and a self-rating of each practices level of integration. The survey was based on the Supplemental Excel Worksheet Template 12A: Integrated Health (Core Competency) Current-State Assessment Tool. This survey assisted us in looking at the current state of integration, but more importantly increased the level of understanding of integration within our provider community. The tool itself and the conversations that developed with our workgroup were invaluable in realizing the diversity of knowledge of integration and the need to further educate and evaluate our goals for integration. The survey proved to be of great value in obtaining a significant amount of data on our provider partners, such as the assessments/screenings being completed and tools utilized, electronic medical record (EMR) utilization, referral patterns to mental health/substance use providers and organizations, communication channels internally and externally as well as electronic or other format, care planning tools and utilization of such, the ability to collect and report out on data points, etc. Another goal of this tool was to assess the level of integration against SAMHSA's Framework for Integrated Levels of Care and the DSRIP Special Terms and Condition (STC). The results of the assessment, due to variations in how partners self-assessed their practices and an understanding of integration required a more formalized approach to accurately define the existing level of integration and a mechanism to evaluate progress along SAMSHA's Framework and STC of the DSRIP.

In order to conduct this more formal assessment, Network4Health is contracting with the University of New Hampshire (UNH) School of Law, Institute for Health Policy and Practice's Citizens Health Initiative (NH CHI) to conduct a standardized assessment of partners. NH CHI will be rolling out the assessments in two stages with up to 20 practices being assessed in each stage. The first stage will commence in the early fall and be completed with improvement plans in early 2018. The second round of assessments will start in February 2018 with improvement plans complete by July 2018. Through this standardized assessment, Network4Health will gain a better understanding of the gaps in competencies against the SAMHSA designation (and the NH DSRIP STCs), and the steps and resources needed by the selected organizations to achieve designation as either a coordinated care or integrated care entity. Under this contract, NH CHI also will re-evaluate selected partners on a six-month basis to track progress in meeting identified aspects of the SAMHSA framework where there are gaps in core competencies.

The Network4Health Integration Workgroup also utilized interns in the Masters in Social Work (MSW) program at UNH to complete an asset map of our partner organizations. The mapping process focused on the social determinants of health (SDoH). This Asset Map (referred to below and included as Attachment_B1.9d) identifies the depth of services, aligned with the SDoH that may be utilized by our partners and the multidisciplinary care team's better plan the care of our population. This document assists us in identifying the gaps in services within our region and will be used to explore avenues to increase or initiate new services with our region.

In addition, our workgroup participated in an exercise conducted to discuss existing challenges to providing care to our identified population. Four questions were proposed and discussed in small groups and then engaged the entire group in a reporting out/ discussion of these challenges.
The questions posed were as follows:

- What would you think are the top two challenges to providing patients with substance use concerns appropriate treatment and support?

- What do you think are the top two challenges to providing patients with behavioral health issues appropriate treatment and support?

- What do you think are the top two things we need to do from a systems perspective to impact ED utilization and readmission to the hospital for our target population?

- What are the top two things your organization needs to effectively provide services to our target population and to coordinate care?

The small group discussion and report out session not only informed our workgroup of barriers and concerns, but was engaging for our partners in building a common understanding of the challenges that are faced daily within our region when caring for this population.

Network4Health, in collaboration with several other regions took on the task of standardizing a tool to assess SDoH. The intent was to create a set of questions for our partners to use in assessing the SDoH. These questions needed to be evidenced based, simple to administer and actionable. A variety of evidenced based assessment tools were researched and a set of questions complied for each of the domains as outlined in the STC. The document, Summary of Recommended Components for DSRIP Comprehensive Core Standardized Assessment (CCSA), was shared with the Network4Health Integrated Care Workgroup for further discussion, evaluation and implementation. Region 4 will continue to work with this tool as a guide for all our partners to capture the SDoH information needed to better care for our patient population. The CCSA will be used to guide the development of a shared care plan for each patient.

The workgroup also focused on identifying the essential elements of a shared care plan. Through this exercise the partners were able to all agree on key components that would need to be in a shared care plan model. This has guided the development of a shared care plan model that will be suggested to organizations that are participating in Integration Enhancement Projects and require a shared care plan process. Software tools to support this initiative are being investigated by the regions HIT workgroup.

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

Each IDN is required to complete a separate implementation plan for the completion of Coordinated Care and, if indicated, Integrated Care designations. Each IDN is required to demonstrate that organizations participating in this project have achieved the following process milestones during, or in advance of, the timeframe noted. All primary care and behavioral health practices within an IDN are expected to meet Coordinated Care Practice designation. As part of its Project Plan, IDNs will identify practices within the IDN that will meet the additional requirements necessary for Integrated Care Practice designation.

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.

If a narrative is needed to complement the project plan or provide further explanation, please include it.

The Coordinated Care Practice must include:

- *Comprehensive Core Standardized Assessment with required domains (**Note:** applies only to primary care, behavioral health and substance use disorder practitioners.)*
- *Use of a multi-disciplinary Core Teams*
- *Information sharing: care plans, treatment plans, case conferences*
- *Standardized workflows and protocols*

In addition to all of the requirements for the Coordinated Care Practice designation above, the Integrated Care Practice must include:

- *Medication-assisted treatment (MAT)*
- *Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)*
- *Enhanced use of technology*

The project plan must include Milestones for the following timeframes:

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

As the first step in its project plan, Network4Health conducted self-assessments of network providers competencies related to the SAMHSA framework. Due to variations in responses, Network4Health will contract with NH CHI to provide a standardized assessment and identification of partners to meet coordinated care and integrated care requirements. Network4Health plans to work with each participating partner to develop an Integrated Enhancement Plan (IEP) to meet the specific requirements of a coordinated care or integrated care entity. The IEP will include six-month progress reports towards meeting the SAMHSA framework.

Network4Health has selected partner organizations based on population served and their readiness to adopt new processes. Network4Health will conduct assessments on up to 20 practice sites at a time, over six rounds of assessments. All primary care providers and behavioral health providers that have

not achieved coordinated care practice designation and/or integrated care practice designation (based on the NH CHI assessment) will be required to participate in an IEP to address any gaps. Participating providers will be assigned an Innovation Consultant (from NH CHI) that will work directly with the partner organization to develop a project plan that results in demonstrated progress along the SAMHSA framework within six month increments.

Network4Health has also spent significant time mapping network providers and identifying an appropriate comprehensive care standard assessment, as well as a depression screening protocol and a shared care planning protocol. Network4Health will suggest protocols for these assessments but will consider partner organization assessments that are evidence-based and for which Network4Health can collect data.

In coordination with the HIT project (A2), Network4Health will help facilitate network provider participation in the core standardized assessment through electronic solutions that are currently under consideration. In addition, partners will have the opportunity to access a shared care plan using the Collective Medical Technologies (CMT) PreManage tool. In addition to facilitating a shared care plan, this tool also provides for event notification and transmission of events to subscribed providers.

Network4Health's coordinated care project plan is included as Attachment_B1.2a and the integrated care entities project plan is included as Attachment_B1.2b.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

From the IDN HIT Infrastructure Project 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		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partners who acquire DIRECT Secure Messaging	17 of 37 practices by 12/31/18			
The number of participating partners who acquire the Event Notification System (ENS)	17 of 37 practices by 12/31/18			
The number of participating partners who acquire the Shared Care Plan (SCP)	17 of 37 practices By 12/31/18			
The number of participating partners who implement and receive training for DIRECT Secure Messaging	17 of 37 practices by 12/31/18			
The number of participating partners who implement and receive training for the Event Notification System (ENS)	17 of 37 practices by 12/31/18			
The number of participating partners who implement and receive training for the Shared Care Plan (SCP)	17 of 37 practices By 12/31/19			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partners who contribute to DIRECT Secure Messaging	17 of 37 practices by 12/31/18			
The number of participating partners who contribute to Event Notification System (ENS)	10 of 37 practices by 12/31/18			
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 37 practices By 12/31/19			
The number of participating partners who use DIRECT Secure Messaging	10 of 37 practices by 12/31/19			
The number of participating partners who use an Event Notification System (ENS)	10 of 37 practices by 12/31/19			
The number of participating partners who use a Shared Care Plan (SCP)	5 of 37 practices By 12/31/19			

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.

Depending on the outcomes of the NH CHI assessments and the IEPs, additional workforce needs may be identified other than those listed below. Project proposals may include requests to fund additional workforce resources through the B1 budget.

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 Director	Recruiting up to 1	0	Recruiting 1	Recruiting 1	Recruiting 1
Innovation Consultant	Recruiting up to 2	0	Recruiting up to 1.5	Recruiting up to 2	Recruiting up to 2
Community Health Workers	Recruiting up to 10	0	Recruiting up to 5	Recruiting up to 10	Recruiting up to 10

B1-5. IDN Integrated Healthcare: 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.

The chart below provides a high-level budget for the Integrated Healthcare project. The budget will support salaries and related costs, as well as conducting standardized assessments and the development and implementation of IEPs based on those assessments. This budget has prioritized resources at the practice level so that our network providers can meet the requirements of a coordinated care or integrated care entity. The funding will support assessments and IEPs for up to 50 practices across Network4Health partner organizations. It also provides funding to allow for continuous re-assessment to assure progress is being made. All funding to partners for implementation of IEPs will require a current Letter of Commitment, Certificate of Authorization and Certificate of Vote from participating partner organizations. Approval by the N4H Steering Committee for funding for each of the plans is also required.

TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
B1: Integrated Healthcare Revenue (New)	$ 2,032,020	$ 2,032,020	$ 3,578,400	$ 4,294,080
B1: Integrated Healthcare Revenue (Rollover)		$ 1,760,812	$ 753	$ 146
Total Revenue	$ 2,032,020	$ 3,792,832	$ 3,579,153	$ 4,294,226
Salaries (benefits & transportation included) Annual 3% increase reflected Included: [redacted]	$ 67,500	$ 137,025	$ 141,135	$ 145,369
Technology (Laptops, phones, software)	$ 3,000	$ 3,000	$ 3,000	$ 3,000
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Baseline Assessment for 40 practices. Includes six month follow up assessments.	$ 5,600	$ 5,600	$ 3,750	$ 3,750
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Integration Enhancement Project plan development for up to 40 practices.	$ 11,570	$ 34,710		
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Integration coaching for up to 40 practices	$ 15,538	$ 419,744	$ 316,402	$ 327,792
Practice level Integrated Healthcare Enhancement Project plan funding which include financial support to employ up to 10 CHW/Patient Navigators.	$ 168,000	$ 3,192,000	$ 3,114,720	$ 3,814,080
Subtotal	$ 271,208	$ 3,792,079	$ 3,579,007	$ 4,293,991
Variation to Budget (Transfer Funds to Subsequent Year)	$ 1,760,812	$ 753	$ 146	$ 235

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

The key organizations that are working towards being coordinated care entities or integrated care entities under the SAMHSA Framework and the DSRIP STCs; each of these organizations have agreed to increase integration across their practices. As a first step, up to 20 practices within these organizations will undergo an assessment by NH CHI. Based on that assessment, these organizations will then develop and implement Integration Enhancement Plans (IEPs) in order to meet the requirements of a coordinated care or an integrated care entity. In agreeing to partner with Network4Health, each organization committed to improved integration.

Organization/Provider	Agreement Executed (Y/N) Pursuant to STCs, p. xxx, section (i)(ii)
Catholic Medical Center (PCP/BH) CMC Behavioral Health Family Health and Wellness Center at Bedford Highlander Way Internal Medicine Hooksett Internal Medicine Willowbend Family Practice	Y
Center for Life Management	Y
Child and Family Services	Y
Dartmouth-Hitchcock (Manchester and Bedford)	Y
Easter Seals New Hampshire	Y
Elliot Health System (PCP/BH) Elliot Family Medicine, Hooksett Elliot Pediatrics and Primary Care at Riverside	Y
Families in Transition	Y
Healthcare for the Homeless	Y
Manchester Community Health Center	Y
Serenity Place	Y
The Mental Health Center of Greater Manchester	Y

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

Name	Title	Organization	Sign Off Received (Y/N) Pursuant to STCs, p. xxx, section (e)
[redacted]	[redacted]	Catholic Medical Center	Y

Name	Title	Organization	Sign Off Received (Y/N) Pursuant to STCs, p. xxx, section (e)
[redacted]	[redacted]	Center for Life Management	Y
[redacted]	[redacted]	Child and Family Services of NH	Y
[redacted]	[redacted]	Dartmouth Hitchcock-Manchester	Y
[redacted]	[redacted]	Easter Seals	Y
[redacted]	[redacted]	Elliot Health System	Y
[redacted]	[redacted]	Granite United Way	Y
[redacted]	[redacted]	Hillsborough County	Y
[redacted]	[redacted]	Manchester Community Health Center	Y
[redacted]	[redacted]	On the Road to Wellness	Y
[redacted]	[redacted]	Manchester Health Department	Y
[redacted]	[redacted]	Families in Transition	Y

[1] As of June 30, 2017, [redacted] served on the steering committee and represented Elliot Health System. [redacted]

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

Attached to this project plan submission are a number of additional documents requested by the state as described below.

B1-8a

Network4Health has developed a comprehensive core standardized assessment to be used by network providers that have not implemented such a protocol. The assessment includes the following domains for adult patients:

- Demographic information
- Physical health review
- Substance use review
- Housing assessment
- Family and support services
- Educational attainment
- Employment or entitlement
- Access to legal services
- Suicide risk assessment
- Functional status assessment
- Universal screening using depression screening (PHQ 2 & 9) and
- Universal screening using SBIRT

In addition, for children, the following domains are included within the assessment:

- 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 evidence-based tools such as the Denver II or SWYC recommended by a nationally recognized body such as the CDC, AAP or NECTAC. See Attachment_B1.8a1 for the Denver II developmental screening. See Attachment_B1.8a2 for the SWYC developmental screening.

Network4Health completed a survey of its organizations to determine which domains are being assessed in the practices and social service agencies. See Attachment_B1.8a3: Domain Analysis. Health Care for the Homeless is the only practice collecting all the domains listed above. However, the survey did not go into sufficient detail to evaluate the tool being used by each entity and its validity.

At this point, none of the data on SDoH is being electronically shared or available among the disciplines caring for a patient unless the providers share the same EMR. Network4Health's HIT initiative will research and potentially implement a tool that allows for electronic sharing of the SDoH based on evidence-based criteria that are parsimonious and actionable. The data being assessed needs to be collectable and reportable.

Network4Health collaborated with other regions on recommendations for screening questions and tools. While several partner organizations presently collect information recommended within the CCSA they may not be using the suggested questions or tools. While we recognize that the tool utilized is not the most important aspect - the data collected is – Network4Health still needs to assure the tools

accuracy. As noted above regarding the SDOH tool, any tool used by a partner organization to collect one of the items required under the CCSA must be evidenced-based, parsimonious and actionable, and be reportable.

Going forward, Network4Health will further assess the tools being used to collect data and evaluate them against the established criteria as needed. In addition, Network4Health will develop criteria to identify who needs a CCSA and develop a protocol /workflow to assure that a CCSA is completed on the identified population. This could be a shared responsibility of many organizations who serve individuals that need a CCSA and an annual update or done at one primary practice. Network4Health will continue to work with our HIT workgroup to identify mechanisms to share the CCSA and to be made available to support or to populate a Multidisciplinary Care Plan for the patient.

Attachment_B1.8a3

Network 4 Health Domain Analysis

Organization	Physical Health	Eating	Self Care	Mobility	Communica-tion	Meal Prep	Shopping	Transporta-tion	Fiscal Management	Medication Management	Substance Use	Housing	Employment/ Entitlements	Legal	Depression	SBIRT
Elliot Health Associates Primary Care	●	●	●	●	●	◆	◆	◆	◆	●	●	●	●	◆	●	◆
Manchester Mental Health Center	●	●	●	●	●	◆	◆	●	◆	●	●	●	●	●	●	●
Dartmouth Hitchcock Primary Care	●	●	●	●	●	◆	◆	●	◆	●	●	●	●	◆	●	●
Home Health & Hospice	●	●	●	●	●	●	●	◆	◆	●	◆	◆	◆	◆	●	◆
Healthcare for the Homeless	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CMC Primary Care	●	●	●	●	●	◆	◆	◆	◆	●	◆	◆	◆	◆	●	◆
Elliot Health System Behavioral Health Services	●	●	●	●	●	◆	◆	●	◆	●	●	●	●	◆	●	◆
Mental Health Center of Greater Manchester	●	●	●	●	●	●	●	●	●	●	●	●	●	◆	●	◆
Families In Transition	●	◆	●	◆	◆	◆	◆	●	●	◆	●	●	●	●	◆	●
St. Joseph's CHS	◆	●	●	●	●	●	●	●	◆	●	◆	◆	◆	◆	◆	◆
Child & Family Services	●	◆	◆	◆	◆	◆	◆	◆	◆	◆	●	●	●	◆	●	◆
NAMI	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Partners Utilizing Domain Count	10	9	10	9	9	4	4	7	3	9	8	8	8	3	9	4
Partners Utilizing Domain Percent	83%	75%	83%	75%	75%	33%	33%	58%	25%	75%	67%	67%	67%	25%	75%	33%

Legend	
●	Organization currently utilizes domain.
◆	Organization does NOT utilize domain.

B1-8b

Network4Health understands the importance of utilizing a multi-disciplinary team to provide integrated care to patients, and their requirement as part of coordinated care and integrated care practices. As part of the NH CHI assessment, Network4Health will review whether and how participating providers have implemented multi-disciplinary teams that include the following providers, at a minimum, as core team members -- a primary care provider, behavioral health providers (including a psychiatrist), a care manager or a community health worker (if one is assigned) as well as providers who support the individuals in areas related to the social determinants of health. These multidisciplinary teams offer an opportunity for creative planning and coordination of efforts for individuals who present with complex, multiple co-morbid medical conditions as well as significant lifestyle and social challenges that impact the ability to achieve successful health outcomes.

Multidisciplinary teams have been utilized by Network4Health partners on an ad hoc basis, informal basis at times when individual consumers have been identified. This is more the case at larger partner organizations that serve large numbers of the target population. Manchester Community Health Center and the Healthcare for the Homeless (our two FQHC's), due to their current level of integration, are most able to form these teams as needed. For example, the Manchester Community Health Center utilizes a multidisciplinary core team, including the members shown in the table below, in its Medication Assisted Treatment (MAT) program.

Name	Title	Role
[redacted]	[redacted]	Physician/Prescribing Provider
[redacted]	[redacted]	Physician/Prescribing Provider
[redacted]	[redacted]	CMO and back-up MAT prescribing provider
[redacted]	[redacted]	Screening /Assessment, crisis counseling, mental health/substance abuse counseling and case management
[redacted]	[redacted]	Screening/Assessment and Direct patient care and case management
[redacted]	[redacted]	Screening/Assessment and Direct patient care and case management
[redacted]	[redacted]	Assist providers with rooming patients, collecting specimens, printing orders, scheduling appointments and care coordination.

In addition to these team members, MCHC also has adult case managers, interpreters, nutritionists, diabetic educators, call center representatives, intake and enrollment and front desk representatives that provide support for every primary and specialty care team.

Health Care for the Homeless (HCH) also utilizes multidisciplinary teams. For example, HCH participates in CMC discharge rounds, a multidisciplinary process consisting of a CMC social worker or care manager, hospitalist, HCH RN/CM, behavioral health specialists and others sub specialty and support services involved in the care of the patient, to provide for a smooth transition of care to the HCH program. In addition, the HCH program routinely conducts care focused meetings around the care of patients seen in the primary care clinics. These teams include outreach, clinical staff, provider and representatives from our behavioral health team.

B1-8c

Network4Health will provide training to key organizations and their multi-disciplinary core team service providers on a variety of topics, as identified as needed as part of the IEP including competencies, and at a minimum:

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

Attachment_B1.8c_Training Plan provides a detailed look at training that will be required of providers for our first cohort of participating practices. Per our project schedule, the Network 4 Health Integrated Healthcare project will provide additional practice level training information in alignment with the start of the cohort 2 implementation work. Beginning in August, Network4Health will be surveying partners in August/September about capacity to offer these trainings to Network4Health partner organizations. The Workforce Director (hired under A1) will be responsible for implementing this training plan.

Training Plan														
			B1: Core Series			Behavioral Health Series						Chronic Disease Series		
	TRAININGS	Staff	Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
			Includes substance use overview		Includes data analytics & pop health & 42 CFR (Part 2)									
B1: Integration Participants														
	Catholic Medical Center													
BH	CMC Behavioral Health	Clinical Staff: 7 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Primary Care	Family Health & Wellness Center at Bedford	Clinical Staff: 14 Non-clinical staff: 4 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Highlander Way Internal Medicine	Clinical Staff: 4 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Hooksett Internal Medicine	Clinical Staff: 5 Non-clinical staff: 2 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Willowbend Family Practice	Clinical Staff: 15 Non-clinical staff: 6 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Healthcare for the Homeless	Clinical Staff: 13 Non-clinical staff: 10 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
	Dartmouth Hitchcock													
Primary Care	Dartmouth-Hitchcock Manchester	Clinical Staff: 144 Non-clinical staff: 35 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Dartmouth-Hitchcock Bedford	Clinical Staff: 31 Non-clinical staff:8 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
	Elliot Health System													
Primary Care	Elliot Family Medicine at Hooksett	Clinical Staff: 13 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Elliot Pediatrics and Primary Care at Riverside	Clinical Staff: 9 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable

Training Plan														
			B1: Core Series			Behavioral Health Series						Chronic Disease Series		
	TRAININGS	Staff	Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
			includes substance use overview		Includes data analytics & pop health & 42 CFR (Part 2)									
B1: Integration Participants														
Primary Care/BH	Manchester Community Health Center	Clinical Staff: 175 Non-clinical staff: 50 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
BH	Mental Health Center of Greater Manchester	Clinical Staff: 297 Non-clinical staff: 125 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Center for Life Management	Clinical Staff: 156 Non-clinical staff: 64 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Child & Family Services	Clinical Staff: 10 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Families in Transition	Clinical Staff: 10 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Famum Center Easterseals NH	Clinical Staff: 43 Non-clinical staff: 58 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Serenity Place	Clinical Staff: 61 Non-clinical staff: 11 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Support Services	Home Health and Hospice Care		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Crotched Mountain Community Care		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Granite State Independent Living		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Buhatenese Community of NH		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Upper Room		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	The Moore Center		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional

B1-8d

Network4Health will provide training for staff that is not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management. Attachment_B1.8c_Training Plan also includes trainings that will be provided to non-clinical staff. As noted above, where possible, we will leverage trainings from Network4Health provider organizations.

Training Plan														
			B1: Core Series			Behavioral Health Series						Chronic Disease Series		
	TRAININGS	Staff	Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
			Includes substance use overview		Includes data analytics & pop health & 42 CFR (Part 2)									
B1: Integration Participants														
	Catholic Medical Center													
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Primary Care	Family Health & Wellness Center at Bedford	Clinical Staff: 14 Non-clinical staff: 4 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Highlander Way Internal Medicine	Clinical Staff: 4 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Hooksett Internal Medicine	Clinical Staff: 5 Non-clinical staff: 2 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
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Primary Care	Healthcare for the Homeless	Clinical Staff: 13 Non-clinical staff: 10 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
	Dartmouth Hitchcock													
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Primary Care	Dartmouth-Hitchcock Bedford	Clinical Staff: 31 Non-clinical staff:8 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
	Elliot Health System													
Primary Care	Elliot Family Medicine at Hooksett	Clinical Staff: 13 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Elliot Pediatrics and Primary Care at Riverside	Clinical Staff: 9 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable

Training Plan														
			B1: Core Series			Behavioral Health Series						Chronic Disease Series		
	TRAININGS	Staff	Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
			includes substance use overview		includes data analytics & pop health & 42 CFR (Part 2)									
B1: Integration Participants														
Primary Care/BH	Manchester Community Health Center	Clinical Staff: 175 Non-clinical staff: 50 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
BH	Mental Health Center of Greater Manchester	Clinical Staff: 297 Non-clinical staff: 125 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Center for Life Management	Clinical Staff: 156 Non-clinical staff: 64 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Child & Family Services	Clinical Staff: 10 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Families in Transition	Clinical Staff: 10 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Famum Center Easterseals NH	Clinical Staff: 43 Non-clinical staff: 58 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	Serenity Place	Clinical Staff: 61 Non-clinical staff: 11 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Support Services	Home Health and Hospice Care		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Crotched Mountain Community Care		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Granite State Independent Living		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Buhatenese Community of NH		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Upper Room		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	The Moore Center		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional

B1-8e

Network4Health will hold core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions on a monthly basis, or more frequently as needed by the patient. These conferences will typically be conference calls. Core team case conferences will be used to discuss patients with co-occurring disorders and a chronic medical condition and/or substance use disorder with chronic condition and/or MH disorder with a chronic condition and have been assessed as high risk to review/discuss patient progress, and assessed challenges/ barriers. High risk designations will be determined by risk stratification system established by risk identifiers. These identifiers include but are not limited to ER utilization rate, housing instability, uncontrolled/poorly controlled diabetes, hypertension or asthma, and behavioral health diagnosis. Other factors to assess non-clinical patient risk factors include sociodemographic/socioeconomic status, money and resource issues such as detailed insecurities related to food, utilities, child care, clothing, phone and legal services.

The core team case conferences will occur monthly such as the 1st Tuesday of every month (or more frequently as indicated) with potential date change based on core team availability.

CORE TEAM CONFERENCE SCHEDULE EXAMPLE

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 Core Team Conference 7:30 to 8:30	**2**	**3**	**4**	**5**
6	**7**	**8**	**9**	**10**	**11**	**12**
13	**14**	**15**	**16**	**17**	**18**	**19**
20	**21**	**22**	**23**	**24**	**25**	**26**

B1-8f

Network4Health will work with partners that use an EMR to implement DIRECT secure messaging to allow for secure exchanges of client data across EMRs and to be used as a messaging protocol.

B1-8g

Coordinated and Integrated Care Practices will track referrals to help ensure patients are safely transitioned to and from collaborating medical, behavioral and social support service providers. Attachment_B1.8g includes a sample workflow currently used by CMC. Workflow steps include:

- A referral generated either via EMR or paper based on assessed need and assigned priority or routine status
- Provider places referral on an administrative hold that triggers notification to the referral staff's desktop
- Referral staff complete the necessary steps to communicate the referral to the designated referral agency/organization and inform the patient of the referral details. This communication process may include verbal, fax or electronic methods depending on provider practice. Once the communication occurs, the referral is placed in an "in progress" status.
- Patients are informed of the details of their appointment and any other information needed to access a referred service. Communication may happen in person, via telephone or by mail, as appropriate.
- Monthly reports are generated to monitor referrals including:
    - Tracking referrals that remain on administrative hold for specific period of time to ensure they are acted upon
    - Tracking referrals "in progress" to determine whether patient has received care, either through receipt of a consultation report or other acknowledgement that the patient has received the care, treatment or service they were referred for.
- Based on review of monthly reports, partners will query referred entities to determine appointment status and if patient has connected with referral agency.
- Referring agency will outreach to patient to encourage following up with recommended referral appointments.
- Within CMT, staff will be able to update notes to reflect whether referrals have been acted upon.

B1-8h

Network4Health has documented work flows or protocols from partner organizations for the following activities that can be leveraged across network providers, including:

- Interactions between providers and community-based organizations
    - New Hampshire Medical Legal Partnership (Attachment_B1.8h1)
    - MCHC Support for Prenatal Patients (Attachment _B1.8h2)
- Timely communication
    - CMC Critical Testing Reporting (Attachment_B1.8h3)
    - CMC Verify Process Protocol (Attachment_B1.8h4)
- Privacy, including limitations on information for communications with treating provider and community based organizations

    - Sample consent form from MCHC (Project Launch) (Attachment_B1.8h5)
    - MCHC Continuum of Care Policy (Attachment_B1.8h6)
- Coordination among case managers (internal and external to IDN)
    - CMC Care Coordinator Job Description (Attachment_B1.8h7)
    - CMC Care Coordinator Responsibilities (Attachment_B1.8h8)
- Safe transitions from institutional settings back to primary care, behavioral health and social support service providers
    - CMC Hand-Off Communication Protocol (Attachment_B1.8h9)
    - MCHC Transfer to/from Hospital or Health Care Facility (Attachment_B1.8h10)
- Intake procedures that include systematically soliciting patient consent to confidentially share information among providers
    - MCHC New Patient Registration and Patient Intake Policy (Attachment_B1.8h11)
- Adherence to NH Board of Medicine guidelines on opioid use
    - CMC opioid policy (Attachment_B1.8h12)
    - MCHC Guidelines for Prescribing Opioids Prescription Drug Monitoring Program (PDMP) (Attachment_B1.8h13)

Where we don't have protocols in writing, Network4Health and partner organizations will identify where protocols are needed through the IEPs.

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 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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
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: • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				
	For pediatric providers, the CCSA must also include:	Table listing all providers by domain				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	• 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 an evidence-based screening tool by CDC, AAP or NECTAC	indicating Y/N on progress for each process detail				
B1-8b	List of multi-disciplinary core team members that includes, at minimum: • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker	Narrative				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple)	Training schedule and Table listing all providers indicating Y/N on progress for each process detail				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in	Training schedule and table listing all staff indicating progress on				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	recognition and management	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	Documented work flows and/or protocols that include, at minimum: • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support service providers • Intake procedures that include systematically soliciting patient consent to confidentially share	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
	information among providers • Adherence to NH Board of Medicine guidelines on opioid use					

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

B1-9a: Progress towards meeting coordinated care practice requirements

As noted above, Network4Health is utilizing NH CHI to conduct an assessment of where our partner organizations are on achieving the requirements of a Coordinated Care Practice. Based on the self-assessment conducted by our partners, Network4Health believes that many organizations meet all of the requirements of a coordinated care practice. These results will be validated however as part of the NH CHI assessment. The table included below reflects the initial self-assessment progress of our practices. Future reporting will include progress of our partners based on the NH CHI assessment.

NH DSRIP Waiver IDN Application: Supplemental Excel Worksheet Template

12A: Integrated Health (Core Competency) Current-State Assessment
Preliminary Current State of Integration: Assessment Tool

Instructions on using this table: List all primary care, mental health, and substance use disorder providers in the IDN and provide an initial, high-level assessment of integration using the factors indicated.

Organization Name	EMR in Use	Capability to do e-Referrals through EMR	Patient registries in use	Core standardized assessment in use	Care plans documented electronically or paper, and shared with care team	Universal screening for depression and SUD in place	Regularly scheduled patient case conferences for high-risk patients	Formal consulting arrangements with BH (for PCP) or PCP (for BH) providers	Physically co-located MH or SUD and PC services	Formalized multi-disciplinary care teams that include care coordinator or Community Health Worker	Documented description of multi-disciplinary care team roles and responsibilities	Patient panels established/maintained for each care team	Formalized cross-training of clinical staff in chronic care, mental health, and substance use issues	Evidence-based guidelines established and shared	MOU and documented referral protocols with social service support agencies
Catholic Medical Center	X		X		X					X				X	
Dartmouth Hitchcock	X	X	X		X	X	X			X			X	X	
Elliot Health System	X	X	X		X				X						
Manchester Community Health Center	X	X	X		X	X	X		X	X			X	X	
Parkland Primary Care Services of Derry	X				X									X	
Health Care for the Homeless	X				X	X	X		X	X			X	X	
Mental Health Center of Greater Manchester	X	X					X	X				X	co-occurring	X	
Center for Life Management	X	X	X				X	X		X			co-occurring	X	
Home Health and Hospice Care	X							X				X	X		
Child & Family Services					X	X	X			X			X	X	
Crotched Mountain Community Care	X		X		X		X			X			X	X	
Serenity Place	X				X		X			X				X	
Granite State Independent Living							X			X				X	
Buhatenese Community of NH					X		X						X		
Families in Transition	X				X		X						X	X	
Upper Room					X		X							X	
The Moore Center	X				X		X								

B1-9b: Protocols for MAT and Impact

Health Care for the Homeless (HCH) and the Manchester Community Health Center (MCHC) are working towards becoming integrated practices. Both organizations are qualified Patient Centered Medical Homes; HCH is certified as Level 2 and MCHC is certified as Level 3.

Included as Attachment B1-9b Protocols for MAT are the following documents:

- The NH BDAS Guidance Document on Best Practices: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire. (Attachment_B1.9b1)
- MCHC's Patient Guide for Home Induction (Attachment_B1.9b2)
- MCHC's Progressive Response Plan for Managing Patients in Treatment for Opioid Addiction (Attachment_B1.9b3)
- ASAM's National Practice Guideline (Attachment_B1.9b4)

While neither HCH nor MCHC have implemented the IMPACT or other evidence based model to date, both do some screening for depression. For example, HCH does utilize the PHQ-2, followed up by a PHQ-9 if there is an elevated score on the PHQ-2. MCHC completes a full screening at each physical exam for patients ages 12 and up that includes a depression screen (PHQ-2), an anxiety screen (GAD-4), a suicidality screen (SAD), and substance abuse screening (SBIRT using a NIDA screening tool).

B1-9c: Use of Technology

Network4Health practices use EMR systems that have the capacity to identify at-risk patients and use a variety of methods for identifying at-risk patients based on an assessment of the presenting and identified risks as evidenced by use of validated tools and clinical findings. These are specific to each partner. Attachment_B1.9c provides an example of HCH's risk identification tool, as an example of how one Network4Health partner identifies risk. Once the statewide data aggregator comes on-line we plan to look at this at an IDN/State level to inform the shift to a value based payment model. Network4Health's data analyst will work to develop specific algorithms for risk identification and cost containment.

Network4Healthis also evaluating an HIT tool that would facilitate the identification of groups of patients and assign workflows and protocols around how they are managed. For example, the tool may identify a list of diabetic patients with behavioral health conditions and create a specific plan for managing their health based on those diagnoses. The plan could be modified based on other factors, such as housing insecurity or transportation needs, which may require a higher level of interaction to ensure that patients can make it to appointments and access all available services within the community.

Network4Health partners also utilize workflows within their EMRs to set goals and track progress towards meeting these goals. Network4Health is currently evaluating HIT products that would allow tracking and updating of a patient's progress within a system and report out. Similarly, the state HIT taskforce's selected vendor, CMT, will be providing a Shared Care Plan tool that allows for participating providers to note progress of patients.

Health Care for the Homeless and the Manchester Community Health Center have both implemented similar processes for closed loop referrals, as detailed in B1-8g above. Through workflows and protocols, Network4Health partners will generate referrals, communicate referrals to appropriate agencies and patients, and monitor whether referred appointments occur. Partners will seek to communicate about the referred appointments and to outreach to patients to encourage keeping referred appointments as needed. Communication will be completed through technology where available, but for certain partners without EMRs, some referrals may occur by paper and communication may occur via mail. When CMT is implemented, however, it will allow for providers (including community health workers, primary care providers, mental health providers and SUD treatment providers) to share information on CMT to reflect whether referrals are acted upon.

Integrated Healthcare Practices - Use of Technology				
Technology Use / Practice Name	**At Risk Patients**	**Plan Care**	**Monitor/manage patient progress toward goals**	**Closed Loop Referrals**
Manchester Community Health Center	Yes	Yes	Currently only for certain patients such as prenatal patients and those with diabetes.	Yes
Healthcare for the Homeless	Yes	Yes	Yes	No

B1-9d

Network4Health has done significant work to develop a network asset map and network map. These activities highlight the existing services and connections between partners, and provide a foundation on which Network4Health can build on the existing connections and leverage the successes to date with partners integrating with each other to manage population health.

The Network4Health Asset Map provides an outline of services provided by Network4Health partner organizations. The Asset Map highlights that there is a robust support network within Region 4 and will inform the work that the Innovation Coaches do with the practices to leverage and replicate workflows as part of their IEPs.

Attachment_B1.9d1 is a Network Map tab provides a visual of existing business agreements between Network4Health partners. The Network Asset Map tab includes a list of providers. Both serve as a reference guide for IEPs.

B1-10. 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: • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated	Protocols (Submit all in use)				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		Practice setting either through use of the IMPACT or other evidence-supported model					
B1-9c		Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	Table listing all providers indicating progress on each process detail				
B1-9d		Documented work flows with community based social support service providers including, at minimum: • Joint service protocols • Communication channels	Work flows (Submit all in use)				

B1-11. 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.

As noted above, Network4Health will be conducting an assessment of practices with NH CHI. Given that those assessments have not yet started, we have not validated the number of practices that meet the qualifications to be designated as a coordinated care practice or integrated care practice as of June 30, 2017. We have listed below the practice level information for our IDN's target practices for achieving Coordinated Care Practices and Integrated Care Practices. Provider level information will be made available after each practice completes a site assessment with NH CHI and creates an integration enhancement plan to outline their efforts to reach Coordinated or Integrated Care practice designation.

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	Up to 37	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2			
Integrated Care Practice	Up to 2	Dependent on IEPs by Q1 2018			

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
Catholic Medical Center - CMC Behavioral Health				
Catholic Medical Center - Family				

Health & Wellness Center at Bedford				
Catholic Medical Center - Highlander Way Internal Medicine				
Catholic Medical Center - Hooksett Internal Medicine				
Catholic Medical Center - Willowbend Family Practice				
Catholic Medical Center - Healthcare for the Homeless				
Catholic Medical Center - Amoskeag Family Practice				
Catholic Medical Center - Family Physicians of Manchester				
Catholic Medical Center -Goffstown Family Practice				
Catholic Medical Center - Granite State Internal Medicine				
Catholic Medical Center - Lakeview Internal Medicine				

Catholic Medical Center - Queen City Medical Associates				
Catholic Medical Center - Webster Street Internal Medicine				
Dartmouth-Hitchcock Manchester				
Dartmouth-Hitchcock Bedford				
Elliot Health System - Elliot Family Medicine at Hooksett				
Elliot Health System - Elliot Pediatrics and Primary Care at Riverside				
Elliot Health System - Elliot Family Medicine at Goffstown				
Elliot Health System - Elliot Primary Care at Bedford				
Elliot Health System - Elliott Internal Medicine at Londonderry				
Elliot Health System - Elliot Primary Care at Londonderry				

Elliot Health System - Briarwood Primary Care				
Elliot Health System - Derryfield Medical Group				
Elliot Health System - Doctors Park Pediatrics				
Elliot Health System - Dr. Kenneth D. Thomas				
Elliot Health System - Pediatric Health Associates, Manchester				
Elliot Health System - Senior Health Primary Care				
Elliot Health System - Elliot Pediatrics at Windham				
Elliot Health System - Elliot Family Medicine at Windham				
Elliot Health System - Elliot Behavioral Health Services				
Mental Health Center of Greater Manchester				
Center for Life Management				

Child & Family Services				
Serenity Place				
Families in Transition / Family Willows Treatment Center				
Easterseals NH/ Farnum Center				
Home Health & Hospice Care				

Integrated Care Practice	**List of providers identified to make progress toward Integrated Care Practice designation**	**12/31/17**	**6/30/18**	**12/31/18**
Manchester Community Health Center				
Healthcare for the Homeless				

B1 - Coordinated Care Practices

	Task Name	Duration	Start	Finish	Predecessors
1	**HIT Implementation Plan**	1065d	01/02/17	01/29/21	
2	**State Level HIT Planning**	390d	01/02/17	06/29/18	
3	Participate in Statewide HIT Planning	108d	01/02/17	05/31/17	
4	Receive Statewide HIT Report (informs IDN 4 Implementation Plan)	1d	06/01/17	06/01/17	
5	Create IDN 4 HIT Implementation Plan	130d	01/01/18	06/29/18	
6	**Network 4 Health/IDN 4 HIT Implementation Plan**	499d	09/04/17	08/01/19	
7	**ED PreManage (CMT)**	499d	09/04/17	08/01/19	
8	Sign Contract (Network 4 Health/CMC Admin lead)	1d	12/01/17	12/01/17	
9	Sign User Agreement	5d	12/04/17	12/08/17	
10	CMC Signed User Agreement	1w	12/04/17	12/08/17	
11	Elliot Signed User Agreement	1w	12/04/17	12/08/17	
12	Parkland Signed User Agreement	1w	12/04/17	12/08/17	
13	VPN Connectivity	20d	11/27/17	12/22/17	
14	VPN Connectivity CMC	2w	11/27/17	12/08/17	
15	VPN Connectivity Elliot	2w	12/11/17	12/22/17	
16	VPN Connectivity Parkland	2w	12/11/17	12/22/17	
17	Hospital ADT Feed / Messages	120d	09/04/17	02/16/18	
18	CMC ADT Feed / Messages	80d	09/04/17	12/22/17	
19	Test	2w	09/04/17	09/15/17	
20	Mappings	4w	09/18/17	10/13/17	
21	Prod	2w	12/11/17	12/22/17	
22	Elliot ADT Feed / Messages	40d	12/25/17	02/16/18	
23	Test	2w	12/25/17	01/05/18	
24	Mappings	4w	01/08/18	02/02/18	
25	Prod	2w	02/05/18	02/16/18	
26	Parkland ADT Feed / Messages	40d	12/25/17	02/16/18	
27	Test	2w	12/25/17	01/05/18	
28	Mappings	4w	01/08/18	02/02/18	
29	Prod	2w	02/05/18	02/16/18	
30	Process/Protocol for ENS notice receipt	35d	02/19/18	04/06/18	
31	Subscription process email/fax sign-up	3w	02/19/18	03/09/18	
32	Communication of new process to subscribers	2w	03/12/18	03/23/18	
33	Go-live	2w	03/26/18	04/06/18	
34	EMR Integration at Hospitals	224d	06/25/18	05/02/19	
35	CMC EMR Integration	45d	03/01/19	05/02/19	
36	EDIE Return Message	2w	03/01/19	03/14/19	
37	EMR Build	3w	03/15/19	04/04/19	
38	Configure Icon	2w	04/05/19	04/18/19	
39	Validation	2w	04/19/19	05/02/19	
40	Elliot EMR Integration	45d	06/25/18	08/24/18	

	Task Name	Duration	Start	Finish	Predecessors
41	EDIE Return Message	2w	06/25/18	07/06/18	
42	EMR Build	3w	07/09/18	07/27/18	
43	Configure Icon	2w	07/30/18	08/10/18	
44	Validation	2w	08/13/18	08/24/18	
45	Parkland EMR Integration	45d	09/17/18	11/16/18	
46	EDIE Return Message	2w	09/17/18	09/28/18	
47	EMR Build	3w	10/01/18	10/19/18	
48	Configure Icon	2w	10/22/18	11/02/18	
49	Validation	2w	11/05/18	11/16/18	
50	Historical File	134d	11/19/18	05/23/19	
51	Build Historical File	3w	11/19/18	12/07/18	
52	CMT Historical File Processing	3w	05/03/19	05/23/19	
53	IT Implementation Go Live	2w	05/24/19	06/06/19	
54	Active Directory / SSO (Optional)	40d	05/03/19	06/27/19	
55	Investigate Issue	3w	05/03/19	05/23/19	
56	Identify Solution	3w	05/24/19	06/13/19	
57	Implement Solution	2w	06/14/19	06/27/19	
58	Clinical Kick Off Meeting	2w	05/03/19	05/16/19	
59	User Provisioning	20d	05/03/19	05/30/19	
60	Identify list of initial users	2w	05/03/19	05/16/19	
61	Set up initial users	2w	05/17/19	05/30/19	
62	Training	30d	05/31/19	07/11/19	
63	ED providers on EDIE Report	3w	05/31/19	06/20/19	
64	Portal Use	3w	06/21/19	07/11/19	
65	Clinical/Project Go Live	3w	07/12/19	08/01/19	
66	**Comprehensive Core Standardized Assessment**	311d	09/01/17	11/09/18	
67	Identify capable vendors	1d	09/01/17	09/01/17	
68	Select Down	4w	09/04/17	09/29/17	
69	Due diligence and scoping	5w	10/02/17	11/03/17	
70	Decide on vendor	10w	11/06/17	01/12/18	
71	Contract Negotiation	2w	01/15/18	01/26/18	
72	Sign Agreement	1w	01/29/18	02/02/18	
73	Project Initiation	2w	02/05/18	02/16/18	
74	Analysis and Design	4w	02/19/18	03/16/18	
75	Functional Deliverables	12w	03/19/18	06/08/18	
76	Integration Deliverables	12w	06/11/18	08/31/18	
77	User Aceptance Testing	5w	09/03/18	10/05/18	
78	Training	3w	10/08/18	10/26/18	
79	Deployment Support	2w	10/29/18	11/09/18	
80	**Care Coordination Tool**	511d	09/01/17	08/16/19	
81	Identify capable vendors	1d	09/01/17	09/01/17	
82	Select Down	4w	09/04/17	09/29/17	

	Task Name	Duration	Start	Finish	Predecessors
83	Due diligence and scopping	5w	10/02/17	11/03/17	
84	Decide on vendor	10w	11/06/17	01/12/18	
85	Contract Negotiation	2w	01/15/18	01/26/18	
86	Sign Agreement	1w	01/29/18	02/02/18	
87	Project Initiation	2w	11/12/18	11/23/18	
88	Analysis and Design	4w	11/26/18	12/21/18	
89	Functional Deliverables	12w	12/24/18	03/15/19	
90	Integration Deliverables	12w	03/18/19	06/07/19	
91	User Aceptance Testing	5w	06/10/19	07/12/19	
92	Training	3w	07/15/19	08/02/19	
93	Deployment Support	2w	08/05/19	08/16/19	
94	**Data Warehouse**	431d	09/01/17	04/26/19	
95	Identify capable vendors	1d	09/01/17	09/01/17	
96	Select Down	4w	09/04/17	09/29/17	
97	Due diligence and scoping	5w	10/02/17	11/03/17	
98	Decide on vendor	10w	11/06/17	01/12/18	
99	Contract Negotiation	2w	01/15/18	01/26/18	
100	Sign Agreement	1w	01/29/18	02/02/18	
101	Project Initiation	4w	02/05/18	03/02/18	
102	Analysis and Design	8w	03/05/18	04/27/18	
103	Functional Deliverables	18w	04/30/18	08/31/18	
104	Integration Deliverables	18w	09/03/18	01/04/19	
105	User Aceptance Testing	10w	01/07/19	03/15/19	
106	Training	4w	03/18/19	04/12/19	
107	Deployment Support	2w	04/15/19	04/26/19	
108	**Process Milestones by Reporting Period**	447d	12/01/17	08/19/19	
109	**Period ending June 30, 2017**	0	06/29/18	06/29/18	
110	IDN 4 HIT Implementation Plan Complete	0	06/29/18	06/29/18	
111	**July - December 2017**	15d	12/01/17	12/22/17	
112	ED Premanage IDN 4 Contract Signed	0	12/01/17	12/01/17	
113	ED Premanage Hospital User Agreements Signed	0	12/08/17	12/08/17	
114	CMC ADT feed in production	0	12/22/17	12/22/17	
115	**January - June 2018**	50d	01/12/18	03/23/18	
116	CMT ED PreManage: Elliot ADT feed in production	0	02/16/18	02/16/18	
117	CMT ED PreManage: Parkland ADT feed in production	0	02/16/18	02/16/18	
118	Go Live for Organizational Subscribers to ENS messages with PreManage	0	03/23/18	03/23/18	
119	Core Standardized Assessment Tool Vendor Selection Complete	0	01/12/18	01/12/18	
120	Core Standardized Assessment Tool Vendor Contract Complete	0	02/02/18	02/02/18	
121	Care Coordination Tool Vendor Selection Complete	0	01/12/18	01/12/18	
122	Care Coordination Tool Vendor Contract Complete	0	02/02/18	02/02/18	
123	Data Warehouse Vendor Selection Complete	0	01/12/18	01/12/18	
124	Data Warehouse Vendor Contract Complete	0	02/02/18	02/02/18	

	Task Name	Duration	Start	Finish	Predecessors
125	**July - December 2018**	146d	06/08/18	12/28/18	
126	PROGRESS ASSMENT: Collect/evaluate feedback ENS message USERS	85d	09/03/18	12/28/18	
127	CMT ED PreManage: Elliot EMR Integration of ADT feeds	0	08/24/18	08/24/18	
128	CMT ED PreManage: Parkland EMR Integration of ADT feeds	0	11/16/18	11/16/18	
129	Core Standardized Assessment Configuration Complete (Functional and Integration)	0	06/08/18	06/08/18	
130	Core Standardized Assessment Training Complete	0	10/05/18	10/05/18	
131	Core Standardized Assessment Deployment Complete	0	11/09/18	11/09/18	
132	**January - December 2019**	112d	03/15/19	08/19/19	
133	PROGRESS ASSMENT: Collect/evaluate feedback CCSA USERS	60d	04/01/19	06/21/19	
134	Care Coordination Tool Complete (Functional and Integration)	1d	07/15/19	07/15/19	
135	Care Coordination Tool Configuration Complete (Functional and Integration)	1d	08/05/19	08/05/19	
136	Care Coordination Tool Assessment Deployment Complete	1d	08/19/19	08/19/19	
137	Data Warehouse User Acceptance Testing Complete	0	03/15/19	03/15/19	
138	Data Warehouse Training Complete	0	04/12/19	04/12/19	
139	Data Warehouse Deployment Support Complete	0	04/26/19	04/26/19	
140	**January - December 2020**	76d	01/15/18	04/30/18	
141	Progress Assessment: Collect/Evaluate feedback ALL TOOLS	76d	01/15/18	04/30/18	
142	**Evaluation Metrics Reporting (Data - per approved metrics)**	936d	07/01/17	01/29/21	
143	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/30/18	
144	prepare evaluation plan measures	152d	07/01/17	01/29/18	
145	submit	1d	01/30/18	01/30/18	
146	On-going data reporting for period ending 06/29/2018	152d	01/01/18	07/31/18	
147	prepare evaluation plan measures	151d	01/01/18	07/30/18	
148	submit	1d	07/31/18	07/31/18	
149	On-going data reporting for period ending 12/31/2018	155d	07/01/18	01/31/19	
150	prepare evaluation plan measures	154d	07/01/18	01/30/19	
151	submit	1d	01/31/19	01/31/19	
152	On-going data reporting for period ending 06/29/2019	152d	01/01/19	07/31/19	
153	prepare evaluation plan measures	151d	01/01/19	07/30/19	
154	submit	1d	07/31/19	07/31/19	
155	On-going data reporting for period ending 12/31/2019	155d	07/01/19	01/31/20	
156	prepare evaluation plan measures	154d	07/01/19	01/30/20	
157	submit	1d	01/31/20	01/31/20	
158	On-going data reporting for period ending 06/29/2020	153d	01/01/20	07/31/20	
159	prepare evaluation plan measures	152d	01/01/20	07/30/20	
160	submit	1d	07/31/20	07/31/20	
161	On-going data reporting for period ending 12/31/2020	153d	07/01/20	01/29/21	
162	prepare evaluation plan measures	152d	07/01/20	01/28/21	
163	submit	1d	01/29/21	01/29/21	

B1-Integrated Care Practices

Task Name	Duration	Start	Finish	Predecessors
B1 Integrated Healthcare - Integrated Care Practices	**143d**	**03/01/17**	**09/15/17**	
Development of Core Deliverables and Process	143d	03/01/17	09/15/17	
Comprehensive Core Standardized Assessment Tool/Process	88d	03/01/17	06/30/17	
Develop Comprehensive Core Standardized Assessment Tool	50d	03/01/17	05/09/17	
Develop Comprehensive Core Standardized Assessment Process	25d	05/10/17	06/13/17	
Refine Comprehensive Core Standardized Assessment Process	5d	06/14/17	06/20/17	
Finalize Comprehensive Core Standardized Assessment Process	8d	06/21/17	06/30/17	
Depression Treatment Protocol/Process	88d	03/01/17	06/30/17	
Develop Evidence Based Depression Treatment	50d	03/01/17	05/09/17	
Develop Evidence Based Depression Treatment Process	25d	05/10/17	06/13/17	
Develop Evidence Based Depression Treatment Process	5d	06/14/17	06/20/17	
Develop Evidence Based Depression Treatment Process	8d	06/21/17	06/30/17	
Shared Care Plan	143d	03/01/17	09/15/17	
Develop Shared Care Plan Tool	60d	03/01/17	05/23/17	
Develop Shared Care Plan Process	60d	05/24/17	08/15/17	
Refine Shared Care Plan Process	20d	08/16/17	09/12/17	
Finalize Shared Care Plan Process	3d	09/13/17	09/15/17	
MAT Treatment Program	143d	03/01/17	09/15/17	
Research MAT Model	60d	03/01/17	05/23/17	
Develop MAT Plan/Protocol	60d	05/24/17	08/15/17	
Refine MAT Plan/Protocol	20d	08/16/17	09/12/17	
Finalize MAT Plan/Protocol	3d	09/13/17	09/15/17	
Participant Selection Process	85d	03/01/17	06/27/17	
Define Selection Criteria	50d	03/01/17	05/09/17	
Develop Selection Process	30d	05/10/17	06/20/17	
Select CHI Participants	1w	06/21/17	06/27/17	
Sign CHI Agreement	22d	07/03/17	08/01/17	
Integrated Practice Cohort (up to 2 Practices)	791d	08/02/17	08/12/20	
CHI Assessment Integrated Cohort Baseline	71d	08/02/17	11/08/17	
CHI Assessment Administered	40d	08/02/17	09/26/17	
CHI Results Collected	30d	09/27/17	11/07/17	
CHI Report Delivered	1d	11/08/17	11/08/17	
Participant Implementation Process Integrated Practice Cohort Round 1	145d	11/08/17	05/29/18	
Up to 2 Participants Selected for Integrated Care Practice Round 1	1w	11/08/17	11/14/17	
CHI Assessment Results Reviewed	1w	11/15/17	11/21/17	
Integration Enhancement Project Team Created	3w	11/22/17	12/12/17	
Integration Enhancement Targets Identified based on CHI Review and SAMHSA framework	1w	12/13/17	12/19/17	
Integration Enhancement Project Implementation Plan Created	2w	12/20/17	01/02/18	
Intiate Implementation Plan	20w	01/03/18	05/22/18	
Evaluation Plan Created and Implemented	6w	04/11/18	05/22/18	
Lessons Learned	1w	05/23/18	05/29/18	

Task Name	Duration	Start	Finish	Predecessors
CHI Assessment Integrated Cohort Follow-up 1 (Progress Assessment Checkpoint)	36d	03/28/18	05/16/18	
CHI Assessment Administered	15d	03/28/18	04/17/18	
CHI Results Collected	20d	04/18/18	05/15/18	
CHI Report Delivered	1d	05/16/18	05/16/18	
Participant Implementation Process Integrated Practice Cohort Round 2	150d	05/30/18	12/25/18	
Up to 2 Participants Selected for Integrated Care Practice Round 1	1w	05/30/18	06/05/18	
CHI Assessment Results Reviewed	1w	06/06/18	06/12/18	
Integration Enhancement Project Team Created	3w	06/13/18	07/03/18	
Integration Enhancement Targets Identified based on CHI Review and SAMHSA framework	1w	07/04/18	07/10/18	
Integration Enhancement Project Implementation Plan Created	3w	07/11/18	07/31/18	
Intiate Implementation Plan	20w	08/01/18	12/18/18	
Evaluation Plan Created and Implemented	6w	11/07/18	12/18/18	
Lessons Learned	1w	12/19/18	12/25/18	
CHI Assessment Integrated Cohort Follow-up 2 (Progress Assessment Checkpoint)	36d	10/17/18	12/05/18	
CHI Assessment Administered	15d	10/17/18	11/06/18	
CHI Results Collected	20d	11/07/18	12/04/18	
CHI Report Delivered	1d	12/05/18	12/05/18	
Participant Implementation Process Integrated Practice Cohort Round 3	150d	12/26/18	07/23/19	
Up to 2 Participants Selected for Integrated Care Practice Round 1	1w	12/26/18	01/01/19	
CHI Assessment Results Reviewed	1w	01/02/19	01/08/19	
Integration Enhancement Project Team Created	3w	01/09/19	01/29/19	
Integration Enhancement Targets Identified based on CHI Review and SAMHSA framework	1w	01/30/19	02/05/19	
Integration Enhancement Project Implementation Plan Created	3w	02/06/19	02/26/19	
Intiate Implementation Plan	20w	02/27/19	07/16/19	
Evaluation Plan Created and Implemented	6w	06/05/19	07/16/19	
Lessons Learned	1w	07/17/19	07/23/19	
CHI Assessment Integrated Cohort Follow-up 3 (Progress Assessment Checkpoint)	36d	05/08/19	06/26/19	
CHI Assessment Administered	15d	05/08/19	05/28/19	
CHI Results Collected	20d	05/29/19	06/25/19	
CHI Report Delivered	1d	06/26/19	06/26/19	
Participant Implementation Process Integrated Practice Cohort Round 4	145d	07/24/19	02/11/20	
Up to 2 Participants Selected for Integrated Care Practice Round 1	1w	07/24/19	07/30/19	
CHI Assessment Results Reviewed	1w	07/31/19	08/06/19	
Integration Enhancement Project Team Created	3w	08/07/19	08/27/19	
Integration Enhancement Targets Identified based on CHI Review and SAMHSA framework	1w	08/28/19	09/03/19	
Integration Enhancement Project Implementation Plan Created	3w	09/04/19	09/24/19	
Intiate Implementation Plan	20w	09/25/19	02/11/20	
Evaluation Plan Created and Implemented	6w	08/14/19	09/24/19	
Lessons Learned	1w	09/25/19	10/01/19	
CHI Assessment Integrated Cohort Follow-up 4 (Progress Assessment Checkpoint)	36d	11/27/19	01/15/20	
CHI Assessment Administered	15d	11/27/19	12/17/19	
CHI Results Collected	20d	12/18/19	01/14/20	

Task Name	Duration	Start	Finish	Predecessors
CHI Report Delivered	1d	01/15/20	01/15/20	
Participant Implementation Process Integrated Practice Cohort Round 5	150d	01/16/20	08/12/20	
Up to 2 Participants Selected for Integrated Care Practice Round 1	1w	01/16/20	01/22/20	
CHI Assessment Results Reviewed	1w	01/23/20	01/29/20	
Integration Enhancement Project Team Created	3w	01/30/20	02/19/20	
Integration Enhancement Targets Identified based on CHI Review and SAMHSA framework	1w	02/20/20	02/26/20	
Integration Enhancement Project Implementation Plan Created	3w	02/27/20	03/18/20	
Intiate Implementation Plan	20w	03/19/20	08/05/20	
Evaluation Plan Created and Implemented	6w	06/25/20	08/05/20	
Lessons Learned	1w	08/06/20	08/12/20	
Evaluation Metrics Reporting (Data - per approved metrics)	936d	07/01/17	01/29/21	
On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/30/18	
prepare	152d	07/01/17	01/29/18	
submit	1d	01/30/18	01/30/18	
On-going data reporting for period ending 06/29/2018	152d	01/01/18	07/31/18	
prepare	151d	01/01/18	07/30/18	
submit	1d	07/31/18	07/31/18	
On-going data reporting for period ending 12/31/2018	155d	07/01/18	01/31/19	
prepare	154d	07/01/18	01/30/19	
submit	1d	01/31/19	01/31/19	
On-going data reporting for period ending 06/29/2019	152d	01/01/19	07/31/19	
prepare	151d	01/01/19	07/30/19	
submit	1d	07/31/19	07/31/19	
On-going data reporting for period ending 12/31/2019	155d	07/01/19	01/31/20	
prepare	154d	07/01/19	01/30/20	
submit	1d	01/31/20	01/31/20	
On-going data reporting for period ending 06/29/2020	153d	01/01/20	07/31/20	
prepare	152d	01/01/20	07/30/20	
submit	1d	07/31/20	07/31/20	
On-going data reporting for period ending 12/31/2020	153d	07/01/20	01/29/21	
prepare	152d	07/01/20	01/28/21	
submit	1d	01/29/21	01/29/21	
Process Milestones	1066d	01/01/17	01/29/21	
Milestones for period ending 06/31/2017	152d	01/01/17	07/31/17	
Develop Implementation Plan	152d	01/01/17	07/31/17	
Implementation timeline	152d	01/01/17	07/31/17	
Budget	152d	01/01/17	07/31/17	
Workforce Plan	152d	01/01/17	07/31/17	
Participant Selection	152d	01/01/17	07/31/17	
Organizational Leadership Sign-off	152d	01/01/17	07/31/17	
Develop Core Deliverables	152d	01/01/17	07/31/17	
Shared Care Plan	152d	01/01/17	07/31/17	

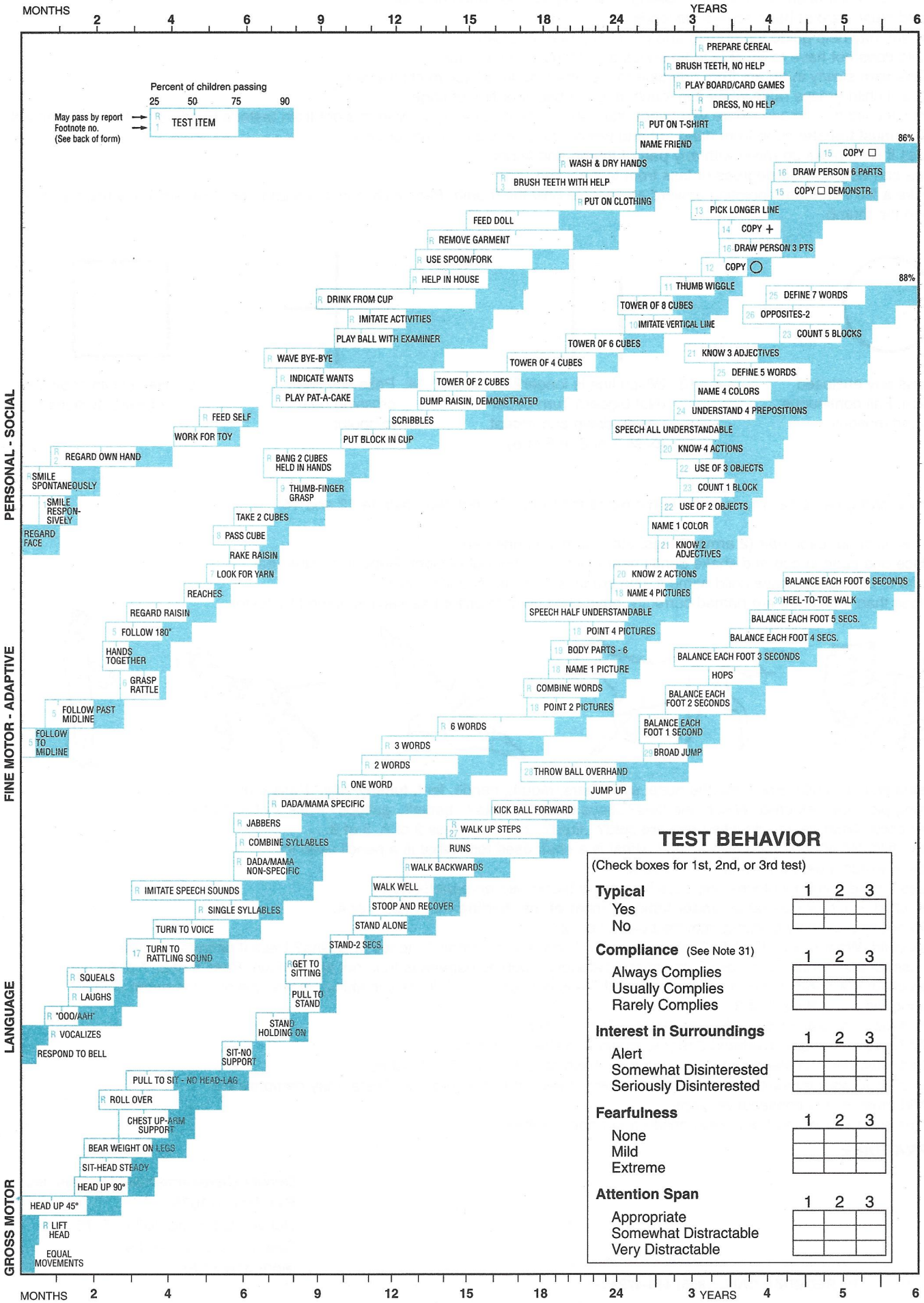
Task Name	Duration	Start	Finish	Predecessors
Comprehensive Core Standardized Assessment	152d	01/01/17	07/31/17	
Referral Protocols	152d	01/01/17	07/31/17	
Protocals for Assessment, treatment, management	152d	01/01/17	07/31/17	
Core team meetings	152d	01/01/17	07/31/17	
Writtent Roles and Responsibilities for core team	152d	01/01/17	07/31/17	
Training Plan for Core Team	152d	01/01/17	07/31/17	
Training Curricula	152d	01/01/17	07/31/17	
Agreements with Collaborating Providers	152d	01/01/17	07/31/17	
Evaluation Plan	152d	01/01/17	07/31/17	
Milestones for period ending 12/31/2017	153d	07/01/17	01/30/18	
Implementation of Workplan	153d	07/01/17	01/30/18	
Deployment of training plan	153d	07/01/17	01/30/18	
Use of CCSA	153d	07/01/17	01/30/18	
Use of Shared Care Plan	153d	07/01/17	01/30/18	
Operationalization of Core Team meeting/Communication plan	153d	07/01/17	01/30/18	
Use of shared EHR, electronic coordinated care management system, or other documented workflow that ensures timely	153d	07/01/17	01/30/18	
Initiation of Data Reporting	153d	07/01/17	01/30/18	
Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/17	01/30/18	
Up to 2 participants have demonstrated progress towards Integrated Care Practice	153d	07/01/17	01/30/18	
Milestones for period ending 06/31/2018	151d	01/01/18	07/30/18	
Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	151d	01/01/18	07/30/18	
Up to 2 participants have demonstrated progress towards Integrated Care Practice	151d	01/01/18	07/30/18	
Milestones for period ending 12/31/2018	154d	07/01/18	01/30/19	
Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2 Coordinated Care	154d	07/01/18	01/30/19	
Up to 2 participants have demonstrated progress towards Integrated Care Practice	154d	07/01/18	01/30/19	
Milestones for period ending 06/31/2019	152d	01/01/19	07/31/19	
Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2 Coordinated Care	152d	01/01/19	07/31/19	
Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	152d	01/01/19	07/31/19	
Milestones for period ending 12/31/2019	155d	07/01/19	01/31/20	
Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2 Coordinated Care	155d	07/01/19	01/31/20	
Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	155d	07/01/19	01/31/20	
Milestones for period ending 06/29/20	153d	01/01/20	07/31/20	
Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2 Coordinated Care	153d	01/01/20	07/31/20	
Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	01/01/20	07/31/20	
Milestones for period ending 12/31/2020	153d	07/01/20	01/29/21	
Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2 Coordinated Care	153d	07/01/20	01/29/21	
Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	07/01/20	01/29/21	

DENVER II

DDM, INC. 1-800-419-4729
CATALOG #2115

Examiner:
Date:

Name:
Birthdate:
ID No.:



TEST BEHAVIOR

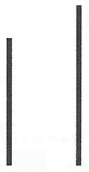
(Check boxes for 1st, 2nd, or 3rd test)

	1	2	3
Typical			
Yes			
No			
Compliance (See Note 31)	1	2	3
Always Complies			
Usually Complies			
Rarely Complies			
Interest in Surroundings	1	2	3
Alert			
Somewhat Disinterested			
Seriously Disinterested			
Fearfulness	1	2	3
None			
Mild			
Extreme			
Attention Span	1	2	3
Appropriate			
Somewhat Distractable			
Very Distractable			

DIRECTIONS FOR ADMINISTRATION

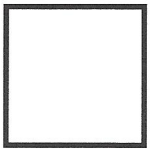
1. Try to get child to smile by smiling, talking or waving. Do not touch him/her.
2. Child must stare at hand several seconds.
3. Parent may help guide toothbrush and put toothpaste on brush.
4. Child does not have to be able to tie shoes or button/zip in the back.
5. Move yarn slowly in an arc from one side to the other, about 8" above child's face.
6. Pass if child grasps rattle when it is touched to the backs or tips of fingers.
7. Pass if child tries to see where yarn went. Yarn should be dropped quickly from sight from tester's hand without arm movement.
8. Child must transfer cube from hand to hand without help of body, mouth, or table.
9. Pass if child picks up raisin with any part of thumb and finger.
10. Line can vary only 30 degrees or less from tester's line. |/
11. Make a fist with thumb pointing upward and wiggle only the thumb. Pass if child imitates and does not move any fingers other than the thumb.

12. Pass any enclosed form. Fail continuous round motions.



13. Which line is longer? (Not bigger.) Turn paper upside down and repeat. (pass 3 of 3 or 5 of 6)

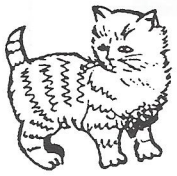
14. Pass any lines crossing near midpoint.

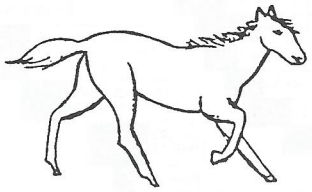


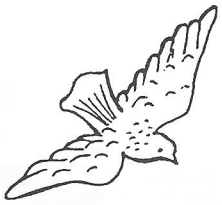
15. Have child copy first. If failed, demonstrate.

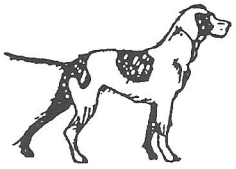
When giving items 12, 14, and 15, do not name the forms. Do not demonstrate 12 and 14.

16. When scoring, each pair (2 arms, 2 legs, etc.) counts as one part.
17. Place one cube in cup and shake gently near child's ear, but out of sight. Repeat for other ear.
18. Point to picture and have child name it. (No credit is given for sounds only.)
    If less than 4 pictures are named correctly, have child point to picture as each is named by tester.









19. Using doll, tell child: Show me the nose, eyes, ears, mouth, hands, feet, tummy, hair. Pass 6 of 8.
20. Using pictures, ask child: Which one flies?...says meow?...talks?...barks?...gallops? Pass 2 of 5, 4 of 5.
21. Ask child: What do you do when you are cold?...tired?...hungry? Pass 2 of 3, 3 of 3.
22. Ask child: What do you do with a cup? What is a chair used for? What is a pencil used for? Action words must be included in answers.
23. Pass if child correctly places and says how many blocks are on paper. (1,5).
24. Tell child: Put block **on** table; **under** table; **in front of** me, **behind** me. Pass 4 of 4. (Do not help child by pointing, moving head or eyes.)
25. Ask child: What is a ball?...lake?...desk?...house?...banana?...curtain?...fence?...ceiling? Pass if defined in terms of use, shape, what it is made of, or general category (such as banana is fruit, not just yellow). Pass 5 of 8, 7 of 8.
26. Ask child: If a horse is big, a mouse is ___? If fire is hot, ice is ___? If the sun shines during the day, the moon shines during the ___? Pass 2 of 3.
27. Child may use wall or rail only, not person. May not crawl.
28. Child must throw ball overhand 3 feet to within arm's reach of tester.
29. Child must perform standing broad jump over width of test sheet (8 1/2 inches).
30. Tell child to walk forward,  heel within 1 inch of toe. Tester may demonstrate. Child must walk 4 consecutive steps.
31. In the second year, half of normal children are non-compliant.

OBSERVATIONS:

Denver Developmental Materials, Inc.
P.O. Box 371075
Denver, Colorado 80237-5075
Tele. #: (303) 355-4729
(800) 419-4729

SWYC™: 2 months

1 months, 0 days to 3 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Makes sounds that let you know he or she is happy or upset	☐	☐	☐
Seems happy to see you	☐	☐	☐
Follows a moving toy with his or her eyes	☐	☐	☐
Turns head to find the person who is talking	☐	☐	☐
Holds head steady when being pulled up to a sitting position	☐	☐	☐
Brings hands together	☐	☐	☐
Laughs	☐	☐	☐
Keeps head steady when held in a sitting position	☐	☐	☐
Makes sounds like "ga," "ma," and "ba"	☐	☐	☐
Looks when you call his or her name	☐	☐	☐

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	☐	☐	☐
Does your child have a hard time in new places?	☐	☐	☐
Does your child have a hard time with change?	☐	☐	☐
Does your child mind being held by other people?	☐	☐	☐
Does your child cry a lot?	☐	☐	☐
Does your child have a hard time calming down?	☐	☐	☐
Is your child fussy or irritable?	☐	☐	☐
Is it hard to comfort your child?	☐	☐	☐
Is it hard to keep your child on a schedule or routine?	☐	☐	☐
Is it hard to put your child to sleep?	☐	☐	☐
Is it hard to get enough sleep because of your child?	☐	☐	☐
Does your child have trouble staying asleep?	☐	☐	☐

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

8	In general, how would you describe your relationship with your spouse/partner?	**No tension** ☐	**Some tension** ☐	**A lot of tension** ☐	**Not applicable** ☐
9	Do you and your partner work out arguments with:	**No difficulty** ☐	**Some difficulty** ☐	**Great difficulty** ☐	**Not applicable** ☐

SWYC™: 4 months

4 months, 0 days to 5 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Holds head steady when being pulled up to a sitting position	☐	☐	☐
Brings hands together	☐	☐	☐
Laughs	☐	☐	☐
Keeps head steady when held in a sitting position	☐	☐	☐
Makes sounds like "ga," "ma," or "ba"	☐	☐	☐
Looks when you call his or her name	☐	☐	☐
Rolls over	☐	☐	☐
Passes a toy from one hand to the other	☐	☐	☐
Looks for you or another caregiver when upset	☐	☐	☐
Holds two objects and bangs them together	☐	☐	☐

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	☐	☐	☐
Does your child have a hard time in new places?	☐	☐	☐
Does your child have a hard time with change?	☐	☐	☐
Does your child mind being held by other people?	☐	☐	☐
Does your child cry a lot?	☐	☐	☐
Does your child have a hard time calming down?	☐	☐	☐
Is your child fussy or irritable?	☐	☐	☐
Is it hard to comfort your child?	☐	☐	☐
Is it hard to keep your child on a schedule or routine?	☐	☐	☐
Is it hard to put your child to sleep?	☐	☐	☐
Is it hard to get enough sleep because of your child?	☐	☐	☐
Does your child have trouble staying asleep?	☐	☐	☐

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

8	In general, how would you describe your relationship with your spouse/partner?	**No tension** ☐	**Some tension** ☐	**A lot of tension** ☐	**Not applicable** ☐
9	Do you and your partner work out arguments with:	**No difficulty** ☐	**Some difficulty** ☐	**Great difficulty** ☐	**Not applicable** ☐

SWYC™: 6 months

6 months, 0 days to 8 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Makes sounds like "ga," "ma," or "ba"	☐	☐	☐
Looks when you call his or her name	☐	☐	☐
Rolls over	☐	☐	☐
Passes a toy from one hand to the other	☐	☐	☐
Looks for you or another caregiver when upset	☐	☐	☐
Holds two objects and bangs them together	☐	☐	☐
Holds up arms to be picked up	☐	☐	☐
Gets into a sitting position by him or herself	☐	☐	☐
Picks up food and eats it	☐	☐	☐
Pulls up to standing	☐	☐	☐

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	☐	☐	☐
Does your child have a hard time in new places?	☐	☐	☐
Does your child have a hard time with change?	☐	☐	☐
Does your child mind being held by other people?	☐	☐	☐
Does your child cry a lot?	☐	☐	☐
Does your child have a hard time calming down?	☐	☐	☐
Is your child fussy or irritable?	☐	☐	☐
Is it hard to comfort your child?	☐	☐	☐
Is it hard to keep your child on a schedule or routine?	☐	☐	☐
Is it hard to put your child to sleep?	☐	☐	☐
Is it hard to get enough sleep because of your child?	☐	☐	☐
Does your child have trouble staying asleep?	☐	☐	☐

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

SWYC™: 9 months

9 months, 0 days to 11 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Holds up arms to be picked up	☐	☐	☐
Gets into a sitting position by him or herself	☐	☐	☐
Picks up food and eats it	☐	☐	☐
Pulls up to standing	☐	☐	☐
Plays games like "peek-a-boo" or "pat-a-cake"	☐	☐	☐
Calls you "mama" or "dada" or similar name	☐	☐	☐
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	☐	☐	☐
Copies sounds that you make	☐	☐	☐
Walks across a room without help	☐	☐	☐
Follows directions - like "Come here" or "Give me the ball"	☐	☐	☐

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	☐	☐	☐
Does your child have a hard time in new places?	☐	☐	☐
Does your child have a hard time with change?	☐	☐	☐
Does your child mind being held by other people?	☐	☐	☐
Does your child cry a lot?	☐	☐	☐
Does your child have a hard time calming down?	☐	☐	☐
Is your child fussy or irritable?	☐	☐	☐
Is it hard to comfort your child?	☐	☐	☐
Is it hard to keep your child on a schedule or routine?	☐	☐	☐
Is it hard to put your child to sleep?	☐	☐	☐
Is it hard to get enough sleep because of your child?	☐	☐	☐
Does your child have trouble staying asleep?	☐	☐	☐

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

SWYC™: 12 months

12 months, 0 days to 14 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Picks up food and eats it	☐	☐	☐
Pulls up to standing	☐	☐	☐
Plays games like "peek-a-boo" or "pat-a-cake"	☐	☐	☐
Calls you "mama" or "dada" or similar name	☐	☐	☐
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	☐	☐	☐
Copies sounds that you make	☐	☐	☐
Walks across a room without help	☐	☐	☐
Follows directions - like "Come here" or "Give me the ball"	☐	☐	☐
Runs	☐	☐	☐
Walks up stairs with help	☐	☐	☐

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	☐	☐	☐
Does your child have a hard time in new places?	☐	☐	☐
Does your child have a hard time with change?	☐	☐	☐
Does your child mind being held by other people?	☐	☐	☐
Does your child cry a lot?	☐	☐	☐
Does your child have a hard time calming down?	☐	☐	☐
Is your child fussy or irritable?	☐	☐	☐
Is it hard to comfort your child?	☐	☐	☐
Is it hard to keep your child on a schedule or routine?	☐	☐	☐
Is it hard to put your child to sleep?	☐	☐	☐
Is it hard to get enough sleep because of your child?	☐	☐	☐
Does your child have trouble staying asleep?	☐	☐	☐

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********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

SWYC™: 15 months

15 months, 0 days to 17 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Calls you "mama" or "dada" or similar name	☐	☐	☐
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	☐	☐	☐
Copies sounds that you make	☐	☐	☐
Walks across a room without help	☐	☐	☐
Follows directions - like "Come here" or "Give me the ball"	☐	☐	☐
Runs	☐	☐	☐
Walks up stairs with help	☐	☐	☐
Kicks a ball	☐	☐	☐
Names at least 5 familiar objects - like ball or milk	☐	☐	☐
Names at least 5 body parts - like nose, hand, or tummy	☐	☐	☐

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	☐	☐	☐
Does your child have a hard time in new places?	☐	☐	☐
Does your child have a hard time with change?	☐	☐	☐
Does your child mind being held by other people?	☐	☐	☐
Does your child cry a lot?	☐	☐	☐
Does your child have a hard time calming down?	☐	☐	☐
Is your child fussy or irritable?	☐	☐	☐
Is it hard to comfort your child?	☐	☐	☐
Is it hard to keep your child on a schedule or routine?	☐	☐	☐
Is it hard to put your child to sleep?	☐	☐	☐
Is it hard to get enough sleep because of your child?	☐	☐	☐
Does your child have trouble staying asleep?	☐	☐	☐

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********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

SWYC™: 18 months

18 months, 0 days to 22 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Runs	☐	☐	☐
Walks up stairs with help	☐	☐	☐
Kicks a ball	☐	☐	☐
Names at least 5 familiar objects - like ball or milk	☐	☐	☐
Names at least 5 body parts - like nose, hand, or tummy	☐	☐	☐
Climbs up a ladder at a playground	☐	☐	☐
Uses words like "me" or "mine"	☐	☐	☐
Jumps off the ground with two feet	☐	☐	☐
Puts 2 or more words together - like "more water" or "go outside"	☐	☐	☐
Uses words to ask for help	☐	☐	☐

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	☐	☐	☐
	Seem sad or unhappy?	☐	☐	☐
	Get upset if things are not done in a certain way?	☐	☐	☐
	Have a hard time with change?	☐	☐	☐
	Have trouble playing with other children?	☐	☐	☐
	Break things on purpose?	☐	☐	☐
	Fight with other children?	☐	☐	☐
	Have trouble paying attention?	☐	☐	☐
	Have a hard time calming down?	☐	☐	☐
	Have trouble staying with one activity?	☐	☐	☐
Is your child…	Aggressive?	☐	☐	☐
	Fidgety or unable to sit still?	☐	☐	☐
	Angry?	☐	☐	☐
Is it hard to…	Take your child out in public?	☐	☐	☐
	Comfort your child?	☐	☐	☐
	Know what your child needs?	☐	☐	☐
	Keep your child on a schedule or routine?	☐	☐	☐
	Get your child to obey you?	☐	☐	☐

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PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	■	■	■	■	■

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	■	■	■	■	■
When you say a word or wave your hand, will your child try to copy you?	■	■	■	■	■
Does your child look at you when you call his or her name?	■	■	■	■	■
Does your child look if you point to something across the room?	■	■	■	■	■

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	■	■	■
Do you have any concerns about your child's behavior?	■	■	■

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone smoke tobacco at home?	■	■
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	■	■
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	■	■
4 Has a family member's drinking or drug use ever had a bad effect on your child?	■	■
5 In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	■	■

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	■	■	■	■
7 Feeling down, depressed, or hopeless?	■	■	■	■

8 In general, how would you describe your relationship with your spouse/partner?	No tension ■	Some tension ■	A lot of tension ■	Not applicable ■
9 Do you and your partner work out arguments with:	No difficulty ■	Some difficulty ■	Great difficulty ■	Not applicable ■

SWYC™: 24 months

23 months, 0 days to 28 months, 31 days

V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Names at least 5 body parts - like nose, hand, or tummy	■	■	■
Climbs up a ladder at a playground	■	■	■
Uses words like "me" or "mine"	■	■	■
Jumps off the ground with two feet	■	■	■
Puts 2 or more words together - like "more water" or "go outside"	■	■	■
Uses words to ask for help	■	■	■
Names at least one color	■	■	■
Tries to get you to watch by saying "Look at me"	■	■	■
Says his or her first name when asked	■	■	■
Draws lines	■	■	■

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	■	■	■
	Seem sad or unhappy?	■	■	■
	Get upset if things are not done in a certain way?	■	■	■
	Have a hard time with change?	■	■	■
	Have trouble playing with other children?	■	■	■
	Break things on purpose?	■	■	■
	Fight with other children?	■	■	■
	Have trouble paying attention?	■	■	■
	Have a hard time calming down?	■	■	■
	Have trouble staying with one activity?	■	■	■
Is your child…	Aggressive?	■	■	■
	Fidgety or unable to sit still?	■	■	■
	Angry?	■	■	■
Is it hard to…	Take your child out in public?	■	■	■
	Comfort your child?	■	■	■
	Know what your child needs?	■	■	■
	Keep your child on a schedule or routine?	■	■	■
	Get your child to obey you?	■	■	■

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********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	■	■	■	■	■

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	■	■	■	■	■
When you say a word or wave your hand, will your child try to copy you?	■	■	■	■	■
Does your child look at you when you call his or her name?	■	■	■	■	■
Does your child look if you point to something across the room?	■	■	■	■	■

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	■	■	■
Do you have any concerns about your child's behavior?	■	■	■

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone smoke tobacco at home?	■	■
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	■	■
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	■	■
4 Has a family member's drinking or drug use ever had a bad effect on your child?	■	■
5 In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	■	■

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	■	■	■	■
7 Feeling down, depressed, or hopeless?	■	■	■	■

8 In general, how would you describe your relationship with your spouse/partner?	No tension ■	Some tension ■	A lot of tension ■	Not applicable ■
9 Do you and your partner work out arguments with:	No difficulty ■	Some difficulty ■	Great difficulty ■	Not applicable ■

SWYC™: 30 months

29 months, 0 days to 34 months, 31 days

V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Names at least one color	☐	☐	☐
Tries to get you to watch by saying "Look at me"	☐	☐	☐
Says his or her first name when asked	☐	☐	☐
Draws lines	☐	☐	☐
Talks so other people can understand him or her most of the time	☐	☐	☐
Washes and dries hands without help (even if you turn on the water)	☐	☐	☐
Asks questions beginning with "why" or "how" - like "Why no cookie?"	☐	☐	☐
Explains the reasons for things, like needing a sweater when it's cold	☐	☐	☐
Compares things - using words like "bigger" or "shorter"	☐	☐	☐
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	☐	☐	☐

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	☐	☐	☐
	Seem sad or unhappy?	☐	☐	☐
	Get upset if things are not done in a certain way?	☐	☐	☐
	Have a hard time with change?	☐	☐	☐
	Have trouble playing with other children?	☐	☐	☐
	Break things on purpose?	☐	☐	☐
	Fight with other children?	☐	☐	☐
	Have trouble paying attention?	☐	☐	☐
	Have a hard time calming down?	☐	☐	☐
	Have trouble staying with one activity?	☐	☐	☐
Is your child…	Aggressive?	☐	☐	☐
	Fidgety or unable to sit still?	☐	☐	☐
	Angry?	☐	☐	☐
Is it hard to…	Take your child out in public?	☐	☐	☐
	Comfort your child?	☐	☐	☐
	Know what your child needs?	☐	☐	☐
	Keep your child on a schedule or routine?	☐	☐	☐
	Get your child to obey you?	☐	☐	☐

********** Please continue on the back **********

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	■	■	■	■	■

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	■	■	■	■	■
When you say a word or wave your hand, will your child try to copy you?	■	■	■	■	■
Does your child look at you when you call his or her name?	■	■	■	■	■
Does your child look if you point to something across the room?	■	■	■	■	■

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	■	■	■
Do you have any concerns about your child's behavior?	■	■	■

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone smoke tobacco at home?	■	■
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	■	■
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	■	■
4 Has a family member's drinking or drug use ever had a bad effect on your child?	■	■
5 In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	■	■

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	■	■	■	■
7 Feeling down, depressed, or hopeless?	■	■	■	■

8 In general, how would you describe your relationship with your spouse/partner?	No tension ■	Some tension ■	A lot of tension ■	Not applicable ■
9 Do you and your partner work out arguments with:	No difficulty ■	Some difficulty ■	Great difficulty ■	Not applicable ■

SWYC™: 36 months

35 months, 0 days to 46 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Talks so other people can understand him or her most of the time	☐	☐	☐
Washes and dries hands without help (even if you turn on the water)	☐	☐	☐
Asks questions beginning with "why" or "how" - like "Why no cookie?"	☐	☐	☐
Explains the reasons for things, like needing a sweater when it's cold	☐	☐	☐
Compares things - using words like "bigger" or "shorter"	☐	☐	☐
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	☐	☐	☐
Tells you a story from a book or tv	☐	☐	☐
Draws simple shapes - like a circle or a square	☐	☐	☐
Says words like "feet" for more than one foot and "men" for more than one man	☐	☐	☐
Uses words like "yesterday" and "tomorrow" correctly	☐	☐	☐

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	☐	☐	☐
	Seem sad or unhappy?	☐	☐	☐
	Get upset if things are not done in a certain way?	☐	☐	☐
	Have a hard time with change?	☐	☐	☐
	Have trouble playing with other children?	☐	☐	☐
	Break things on purpose?	☐	☐	☐
	Fight with other children?	☐	☐	☐
	Have trouble paying attention?	☐	☐	☐
	Have a hard time calming down?	☐	☐	☐
	Have trouble staying with one activity?	☐	☐	☐
Is your child…	Aggressive?	☐	☐	☐
	Fidgety or unable to sit still?	☐	☐	☐
	Angry?	☐	☐	☐
Is it hard to…	Take your child out in public?	☐	☐	☐
	Comfort your child?	☐	☐	☐
	Know what your child needs?	☐	☐	☐
	Keep your child on a schedule or routine?	☐	☐	☐
	Get your child to obey you?	☐	☐	☐

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	**Some tension**	**A lot of tension**	**Not applicable**
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

SWYC™: 48 months

47 months, 0 days to 58 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Compares things - using words like "bigger" or "shorter"	☐	☐	☐
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	☐	☐	☐
Tells you a story from a book or tv	☐	☐	☐
Draws simple shapes - like a circle or a square	☐	☐	☐
Says words like "feet" for more than one foot and "men" for more than one man	☐	☐	☐
Uses words like "yesterday" and "tomorrow" correctly	☐	☐	☐
Stays dry all night	☐	☐	☐
Follows simple rules when playing a board game or card game	☐	☐	☐
Prints his or her name	☐	☐	☐
Draws pictures you recognize	☐	☐	☐

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	☐	☐	☐
	Seem sad or unhappy?	☐	☐	☐
	Get upset if things are not done in a certain way?	☐	☐	☐
	Have a hard time with change?	☐	☐	☐
	Have trouble playing with other children?	☐	☐	☐
	Break things on purpose?	☐	☐	☐
	Fight with other children?	☐	☐	☐
	Have trouble paying attention?	☐	☐	☐
	Have a hard time calming down?	☐	☐	☐
	Have trouble staying with one activity?	☐	☐	☐
Is your child…	Aggressive?	☐	☐	☐
	Fidgety or unable to sit still?	☐	☐	☐
	Angry?	☐	☐	☐
Is it hard to…	Take your child out in public?	☐	☐	☐
	Comfort your child?	☐	☐	☐
	Know what your child needs?	☐	☐	☐
	Keep your child on a schedule or routine?	☐	☐	☐
	Get your child to obey you?	☐	☐	☐

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

SWYC™: 60 months

59 months, 0 days to 65 months, 31 days
V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Tells you a story from a book or tv	■	■	■
Draws simple shapes - like a circle or a square	■	■	■
Says words like "feet" for more than one foot and "men" for more than one man	■	■	■
Uses words like "yesterday" and "tomorrow" correctly	■	■	■
Stays dry all night	■	■	■
Follows simple rules when playing a board game or card game	■	■	■
Prints his or her name	■	■	■
Draws pictures you recognize	■	■	■
Stays in the lines when coloring	■	■	■
Names the days of the week in the correct order	■	■	■

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	■	■	■
	Seem sad or unhappy?	■	■	■
	Get upset if things are not done in a certain way?	■	■	■
	Have a hard time with change?	■	■	■
	Have trouble playing with other children?	■	■	■
	Break things on purpose?	■	■	■
	Fight with other children?	■	■	■
	Have trouble paying attention?	■	■	■
	Have a hard time calming down?	■	■	■
	Have trouble staying with one activity?	■	■	■
Is your child…	Aggressive?	■	■	■
	Fidgety or unable to sit still?	■	■	■
	Angry?	■	■	■
Is it hard to…	Take your child out in public?	■	■	■
	Comfort your child?	■	■	■
	Know what your child needs?	■	■	■
	Keep your child on a schedule or routine?	■	■	■
	Get your child to obey you?	■	■	■

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	☐	☐	☐
Do you have any concerns about your child's behavior?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	☐	☐
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
4	Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	☐	☐	☐	☐
7	Feeling down, depressed, or hopeless?	☐	☐	☐	☐

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	☐	☐	☐	☐

Network 4 Health Domain Analysis

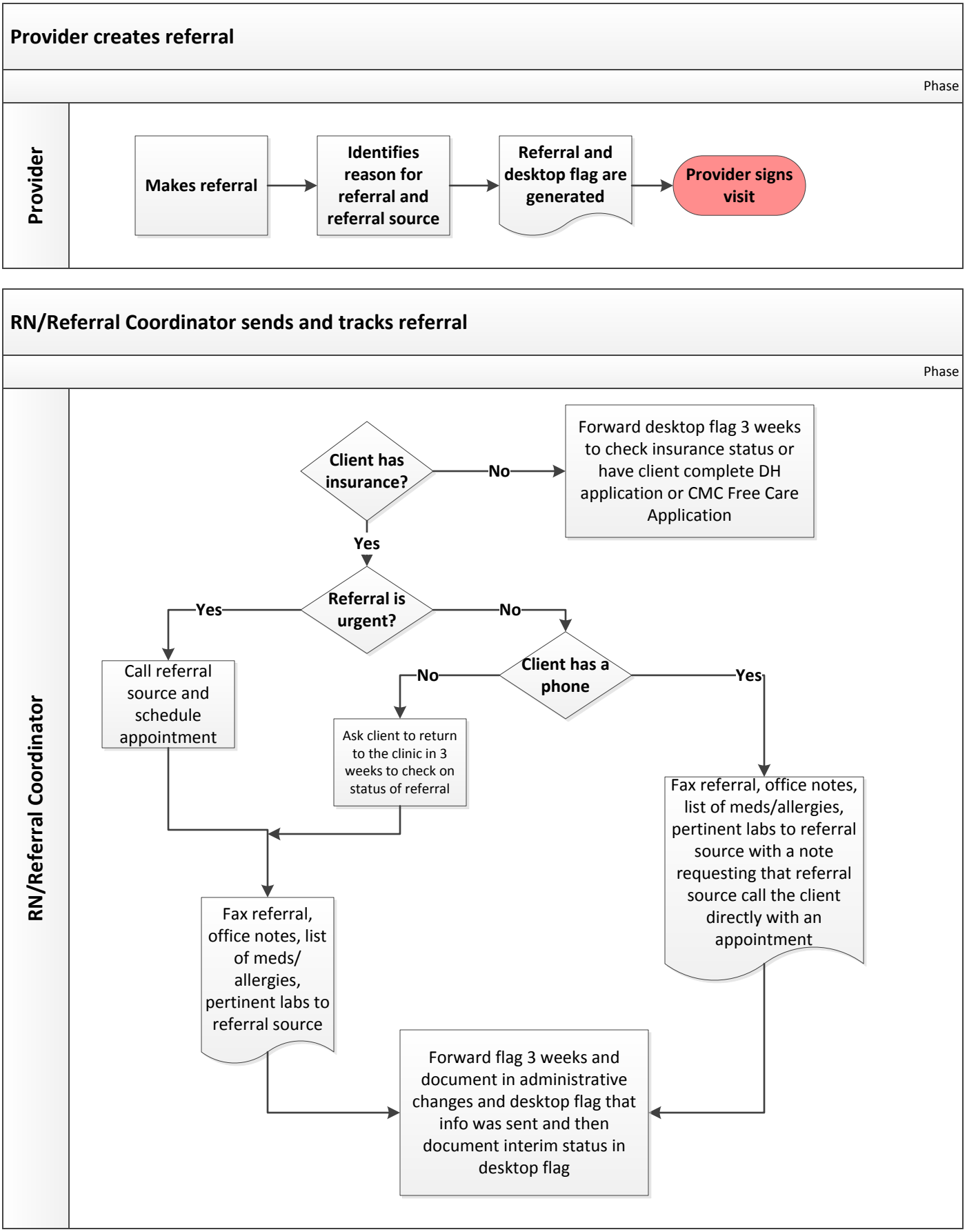
Organization	Physical Health	Eating	Self Care	Mobility	Communica-tion	Meal Prep	Shopping	Transporta-tion	Fiscal Management	Medication Management	Substance Use	Housing	Employment/ Entitlements	Legal	Depression	SBIRT
Elliot Health Associates Primary Care	●	●	●	●	●	◆	◆	◆	◆	●	●	●	●	◆	●	◆
Manchester Mental Health Center	●	●	●	●	●	◆	◆	●	◆	●	●	●	●	●	●	●
Dartmouth Hitchcock Primary Care	●	●	●	●	●	◆	◆	●	◆	●	●	●	●	◆	●	●
Home Health & Hospice	●	●	●	●	●	●	●	◆	◆	●	◆	◆	◆	◆	●	◆
Healthcare for the Homeless	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
CMC Primary Care	●	●	●	●	●	◆	◆	◆	◆	●	◆	◆	◆	◆	●	◆
Elliot Health System Behavioral Health Services	●	●	●	●	●	◆	◆	●	◆	●	●	●	●	◆	●	◆
Mental Health Center of Greater Manchester	●	●	●	●	●	●	●	●	●	●	●	●	●	◆	●	◆
Families In Transition	●	◆	●	◆	◆	◆	◆	●	●	◆	●	●	●	●	◆	●
St. Joseph's CHS	◆	●	●	●	●	●	●	●	◆	●	◆	◆	◆	◆	◆	◆
Child & Family Services	●	◆	◆	◆	◆	◆	◆	◆	◆	◆	●	●	●	◆	●	◆
NAMI	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Partners Utilizing Domain Count	10	9	10	9	9	4	4	7	3	9	8	8	8	3	9	4
Partners Utilizing Domain Percent	83%	75%	83%	75%	75%	33%	33%	58%	25%	75%	67%	67%	67%	25%	75%	33%

Legend	
●	Organization currently utilizes domain.
◆	Organization does NOT utilize domain.

Training Plan															
			B1: Core Series			Behavioral Health Series						Chronic Disease Series		
	TRAININGS	**Staff**	**Behavioral Health 101** includes substance use overview	**Core Standardized Assessment**	**Integration in Practice** includes data analytics & pop health & 42 CFR (Part 2)	**Mental Health First Aid**	**SBIRT**	**Recovery and Recovery Support**	**Prescription Drug Misuse and Abuse**	**Cultural Competence**	**Motivational Interviewing**	**Diabetes/ Hyperglycemia**	**Dyslipidemia**	**Hypertension**
B1: Integration Participants														
	Catholic Medical Center													
BH	CMC Behavioral Health	Clinical Staff: 7 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Primary Care	Family Health & Wellness Center at Bedford	Clinical Staff: 14 Non-clinical staff: 4 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Highlander Way Internal Medicine	Clinical Staff: 4 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Hooksett Internal Medicine	Clinical Staff: 5 Non-clinical staff: 2 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Willowbend Family Practice	Clinical Staff: 15 Non-clinical staff: 6 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Healthcare for the Homeless	Clinical Staff: 13 Non-clinical staff: 10 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
	Dartmouth Hitchcock													
Primary Care	Dartmouth-Hitchcock Manchester	Clinical Staff: 144 Non-clinical staff: 35 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Dartmouth-Hitchcock Bedford	Clinical Staff: 31 Non-clinical staff:8 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
	Elliot Health System													
Primary Care	Elliot Family Medicine at Hooksett	Clinical Staff: 13 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
Primary Care	Elliot Pediatrics and Primary Care at Riverside	Clinical Staff: 9 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable

Training Plan														
			B1: Core Series			Behavioral Health Series						Chronic Disease Series		
	TRAININGS	**Staff**	**Behavioral Health 101**	**Core Standardized Assessment**	**Integration in Practice**	**Mental Health First Aid**	**SBIRT**	**Recovery and Recovery Support**	**Prescription Drug Misuse and Abuse**	**Cultural Competence**	**Motivational Interviewing**	**Diabetes/ Hyperglycemia**	**Dyslipidemia**	**Hypertension**
			includes substance use overview		includes data analytics & pop health & 42 CFR (Part 2)									
B1: Integration Participants														
Primary Care/BH	**Manchester Community Health Center**	Clinical Staff: 175 Non-clinical staff: 50 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	not applicable	not applicable	not applicable
BH	**Mental Health Center of Greater Manchester**	Clinical Staff: 297 Non-clinical staff: 125 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	**Center for Life Management**	Clinical Staff: 156 Non-clinical staff: 64 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	**Child & Family Services**	Clinical Staff: 10 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	**Families in Transition**	Clinical Staff: 10 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	**Farnum Center Easterseals NH**	Clinical Staff: 43 Non-clinical staff: 58 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
BH	**Serenity Place**	Clinical Staff: 61 Non-clinical staff: 11 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Optional	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Support Services	**Home Health and Hospice Care**		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	**Crotched Mountain Community Care**		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	**Granite State Independent Living**		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	**Buhatenese Community of NH**		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	**Upper Room**		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	**The Moore Center**		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional

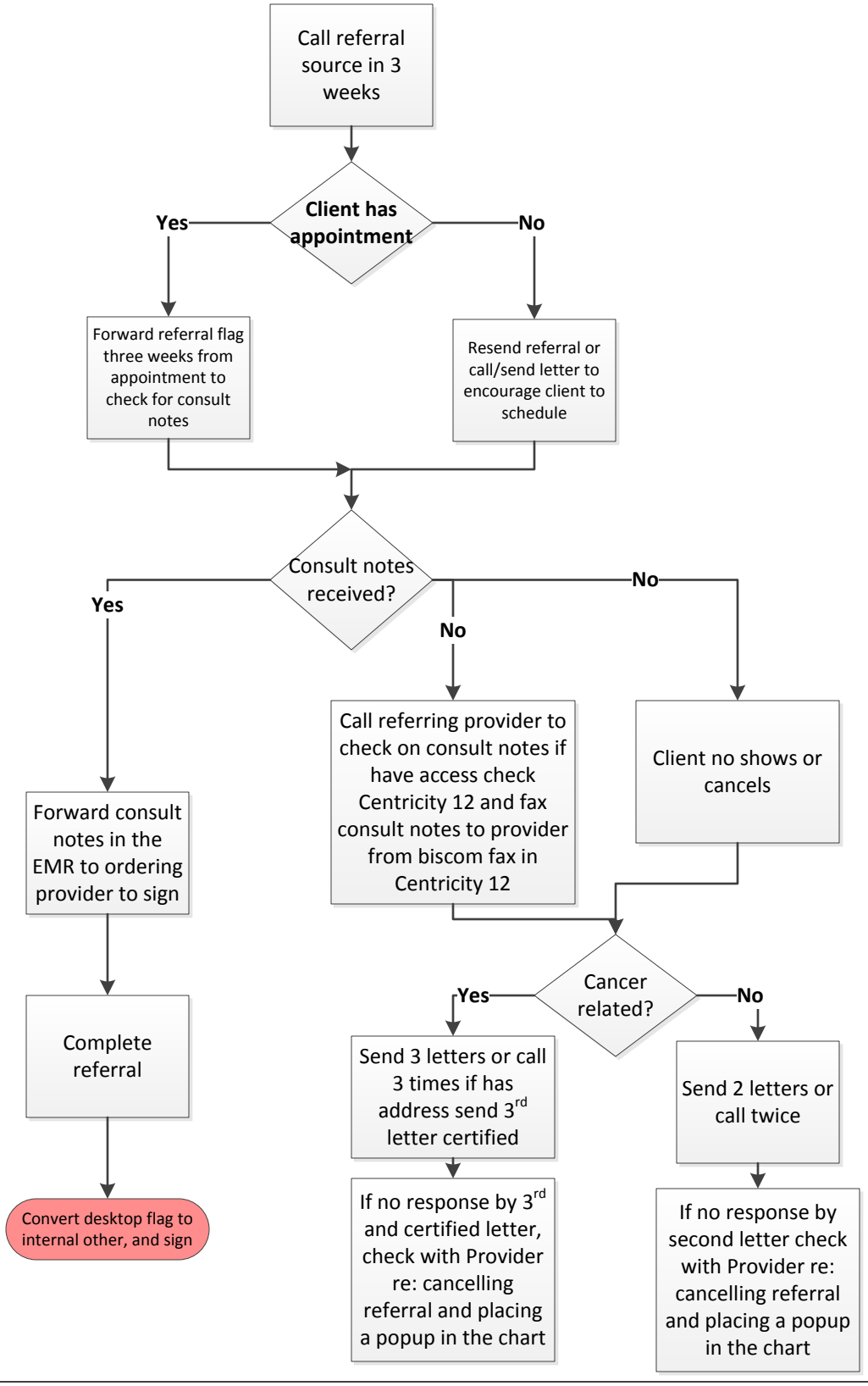
Process for Tracking Referrals



RN/Referral Coordinator tracks receipt of consult notes

Phase

RN/Referral Coordinator



**Manchester Community Health Center and New Hampshire Legal Assistance –
NH Medical Legal Partnership**

Manchester Community Health Center (MCHC), a federally qualified health center, and New Hampshire Legal Assistance (NHLA), a civil legal aid organization, partnered in 2015 to create the NH Medical Legal Partnership (NHMLP). The NHMLP serves low-income patients who often face social, economic and legal problems that have a great impact on their health. These social determinants of health - sub-standard housing, lack of health insurance, denial of basic income or nutritional benefits, domestic violence, lack of access to special education services - can negatively impact long term health and threaten family stability in profound ways.

People living in poverty often require special intervention to ensure that their health care needs are met, and this need is especially critical for the most vulnerable of populations such as children or the elderly. Sometimes that intervention can occur entirely within the health care system. However, people in poverty often face legal problems that have a great impact on their health, but fall outside the influence of even the most advocacy-minded physician.

As partners in the NHMLP, MCHC health care providers identify potential legal problems that may be impacting patient health and refer patients to NHLA. NHLA legal advocates screen patients on site and determine whether a legal intervention can improve a patient's health. Using their legal skills, NHLA advocates work together with MCHC health providers to remove economic barriers, such as lack of income, and environmental barriers, such as mold in patient homes, and other persistent social barriers that may adversely affect long term health. NHLA staff can also work closely with MCHC staff to identify potential systemic problems that impact health. Combining NHLA's capacity for statewide policy advocacy with MCHC's public health expertise, the NHMLP partners can formulate and carry out strategies seeking health care policy changes in agency and legislative arenas and through "impact" litigation when necessary.

The importance of medical legal partnerships as a vital resource for healthy communities has been recognized on a national level. With an increasing emphasis on access to preventive care, and a shift in how hospitals and health centers approach their efforts to meet the health needs of our most vulnerable residents, medical legal partnerships have emerged as a key resource. MLPs are now active in over 300 hospitals and health centers nationally.

MANCHESTER COMMUNITY HEALTH CENTER
Policy on: Prenatal Program Social Work Standards of Care

Objective: To act as a reference tool for planning in intervention with prenatal patients in need of assistance.

Policy: MCHC will adhere to the following standards in intervening with prenatal patients in need of case management, referrals and other support.

Standards/Plans:

Patient Need/ Problems	Patient Desired Outcome	Intervention/Plan
Inadequate Housing	The client will obtain adequate housing.	1. Assess other support systems that may be able to provide housing. 2. Assess cause of inadequate housing and counsel appropriately. 3. Refer and review housing referral list.
Inadequate Food	The client will obtain adequate food.	1. Assess other support systems that may be able to provide food. 2. Refer to nutritionist to enroll in WIC. 3. Refer and review Resources for Food list.
Inadequate Clothing	The client will obtain adequate clothing	1. Refer and review Resources for Clothing list.
Inadequate Fuel	The client will obtain adequate fuel	1. Refer to City Welfare for emergency fuel assistance.
Lack of Transportation	The client will have access to adequate transportation	1. Assess other support systems that may be able to provide transportation. 2. Provide client with bus tickets and bus schedule. 3. Provide client with taxi voucher following Taxi Voucher Protocol
Knowledge Deficit of Pregnancy,	The client will have adequate information	1. Refer client to Crisis Pregnancy Center, Childbirth & Parenting Classes, Our Place Parenting Classes, VNA Teen Parenting Group.

Labor, Delivery, Growth & Development	Regarding pregnancy, L&D, and growth development	
Teratogenic Risk	The client will abstain from substance use during pregnancy.	**Assess comprehensive substance use and present.** A. Educate/counsel all clients regarding effects of substance use during pregnancy. B. History of substance abuse within 12 months prior to pregnancy but denies current use. -Meet with client monthly, assess substance use, and report findings at Case Conference monthly. Notify provider of assessment. -Educate/Counsel regarding effects of substance use during pregnancy. C. History of substance abuse during pregnancy, but denies current use. -Meet with client at least every two weeks, assess substance use, and report findings at Case Conference bi-weekly. Notify provider of assessment. -Educate/counsel regarding effects of substance use during pregnancy. -Refer to appropriate support groups (i.e., AA, NA). -Suggest treatment options for maintaining abstinence of substance abuse. D. History and/or current substance use during pregnancy. -Educate/counsel regarding effects of substance use during pregnancy. -Notify provider of assessment including type and frequency of use. -Meet with client every one to two weeks, assess substance use, and report findings at Case Conference bi-weekly. Notify provider of assessment. -Assess what is her current motivation to seek treatment. Also what factors are likely to impact on success of treatment now.

		-Explore feasible treatment options with client. -Refer to drug treatment/support program, AA, NA, or other support groups. -Assess childcare needs in order to receive treatment (if appropriate). E. Post Substance Use Treatment -Suggest treatment options for maintaining abstinence.
Tobacco Use	The client will not smoke during pregnancy.	1. Assess frequency and amount of smoking during pregnancy.
Battered or Abused	The client will be safe.	1. Educate and counsel about cycle of violence and effects of battering over time. 2. Assess other support systems that may be able to provide safety. 3. Meet with client weekly to assess client's safety. 4. Refer to YWCA, Crises Center and Support. Provide client with community resources for battering (shelter and emergency numbers). Provide appropriate counseling. 5. Observe for patterns of injury in clients. Consider if the explanation for the injury is logical. 6. Observe for patterns of verbal abuse and put-downs by male to his female partner. 7. Observe/monitor no-show appointment status.
Inadequate support System	The client will have support system	1. Assess other support systems that may be able to provide support during pregnancy and after. 2. Schedule prenatal S.W. visits more frequently (at 2-4 week intervals). Follow-up on all no-shows to demonstrate internal and concern. Provide appropriate counseling.
Inadequate Finances	The client will have adequate finances	1. Refer and explain appropriate programs.

Illiterate	The client understands forms and info given.	1. Clarify with clients, if they can read. 2. Explain all written materials (verbally).
LEP (Limited English Proficiency)	The client understands information given.	1. Assess support system for person able to interpret for client. Access interpreter. 2. Provide information in client's language (translated).
History of Mental Illness	The client will have support system	1. Provide appropriate counseling. 2. Assess support system. 3. Assess and refer to past or current counselors, therapists, or case workers and encourage client's involvement. 4. Refer to counseling such as Manchester Mental Health.

CATHOLIC MEDICAL CENTER
Manchester, NH

PHYSICIAN PRACTICE ASSOCIATES

TITLE: CRITICAL TEST RESULT REPORTING

POLICY

To establish procedures for the communication of critical test results to the licensed independent practitioner and/or clinician who is licensed by the State of New Hampshire and approved by the Physician Practice Associates to take clinical action pursuant to the critical test result.

Critical results are critical findings that will require rapid communication of results.

PROCEDURE

1. A list of prioritized test results (critical values) specific to the practices will be kept in the practices. See Appendix "A". Lists of critical test results will be developed by the PPA Medical Director. New tests may be added as needed. Lists will include the name of the test, the critical value, and the value range when applicable. Critical test results are to be reported from the department performing the test and determining the result within one (1) hour of obtaining critical result.

2. Critical test results include Stat, Emergent and/or Urgent requests.
   a) Results from tests that reach the pre-established critical or "panic" level as determined by the PPA Medical Director.
   b) Results where it is clinically evident that delays in reporting have the potential for causing adverse outcomes.

3. Laboratory staff will notify clinical staff or provider of the critical test result for appropriate Clinical action.

4. **The result will be verified verbally via the read back process and clinical staff will document the critical test result, the date and the time result was received in the electronic medical record.**

5. Clinical staff will notify the provider of the critical test result and document the time of notification. The Provider will document any necessary intervention in the patient record.
   a) In the event the ordering provider responsible for the patient is not available and an alternate provider cannot be reached or is unavailable, the on call provider will be notified of the critical test result.

APPROVED BY: [redacted]

EFFECTIVE DATE: **REVIEWED: February 14, 2012**

REVISED: May 1, 2014

Appendix A

Critical Tests/Results

Below are the current critical tests/results. This list is subject to revision as deemed necessary by the Medical Director.

Lab and all critical results as defined by lab staff performing the test. Examples may include the following:

- critical potassium
- INRs

Radiology and all critical results as defined by radiology staff performing the test. Examples may include the following:

- fractures
- pneumothorax

Respiratory and all critical results as defined by respiratory staff performing the test. Examples may include the following:

- Code panel

Non-Invasive and all critical results as defined by non-invasive staff performing the test. Examples may include the following:

- Stat EKGs - interpreted by the ordering physician

APPROVED BY: [redacted]

EFFECTIVE DATE: **REVIEWED: May 1, 2014**

SUPERSEDES: **January 13, 2012**

PREPARED BY: Group Practice Administrator
Medical Director, PPA

CATHOLIC MEDICAL CENTER
PHYSICIAN PRACTICE ASSOCIATES

POLICY AND PROCEDURE MANUAL

TITLE: VERIFY PROCESS FOR CMC PPA PRIMARY CARE

POLICY:

It is the policy of Catholic Medical Center to communicate critical results of tests and diagnostic procedures in a timely manner. The objective is to provide the responsible licensed independent practitioner (LIP) and/or agent of the LIP these results within an established time frame so that the patient can be promptly treated. This communication will occur within 60 minutes and include two patient identifiers; one being patient name and a second identifier which is known to both parties. As part of CMC's ongoing efforts to improve service to our clinicians and demonstrate compliance with The Joint commission, the CMC's Diagnostic Imaging Department has entered into a partnership with Veriphy, a proven patient safety communication system to ensure that critical radiology results reach the ordering or on call provider. Veriphy creates a direct messaging channel between the CMC Diagnostic Imaging departments and the ordering or on call provider.

DEFINITIONS:

Critical Results: Those findings that warrant rapid communication of the results even if from routine tests. The list of results are approved and reviewed annually by the medical staff. The key measurement would be the time from identification of the critical results to the report of that result to the LIP or covering LIP.

DIAGNOSTIC IMAGING

The Departments of Diagnostic Imaging Critical Result Notification Policy is based on the Massachusetts Coalition for the Prevention of Medical Errors defined guidelines for critical value reporting.

The **ROY** standard is industry specific nomenclature referring to critical test values as defined by the Massachusetts Coalition according to the Joint Commission Journal on Quality and Patient Safety. They are as follows:

- Red Results/Interpretations: Those results/interpretations that indicate the patient is in imminent danger of death, significant morbidity, or serious adverse consequences unless treatment is initiated immediately. These values/interpretations require immediate (within 1 hour) interruptive alert of the responsible (ordering or covering) physician who can initiate the appropriate clinical action for the patient. A notification will be sent in 15 minute intervals until the process is completed.

- Orange Results/Interpretations: Those results/interpretations that indicate significant abnormalities that warrant rapid, but not immediate, attention by the responsible clinician. These values do not represent a clinical emergency and do not warrant a stat page to the physician. These values, however, require prompt clinical attention for the patient or for the patient's contacts to avoid serious adverse outcomes. Physicians should be notified of these values/interpretations within 9 hours and acknowledgement is required. Notification can be embargoed based on published Notification and Escalation Times. A notification will be sent in 1 hour intervals until the process is completed.

- Yellow Results/Interpretations: Those results/interpretations that indicate a significant abnormality that may threaten life, or cause significant morbidity, complications or serious adverse consequences unless diagnosis and treatment is initiated in a timely and reliable manner. There is no immediate threat to life. These test values/interpretations are targeted at diseases that merit timely detection and evaluation and for which the corrective action can be taken. Physician alert and acknowledgement should occur within three or four business days. Notification can be embargoed based on published Notification and Escalation Times.

Departments of Diagnostic Imaging Critical Test Results include but not limited to the following. Critical (Red Level) results will be communicated via Veriphy within 60 minutes. A complete listing of the ROY criteria is included in an attachment entitled *Critical Value Alignments*.

PROCEDURE

If critical values are identified by the Radiologist during his interpretation of the images the following will occur:

- The Radiologist will invoke the Veriphy communication tool upon identifying a critical value by creating a Veriphy message. The Veriphy message is in addition to any written report provided, and message retrieval by a licensed care provider is required.

- Once the Veriphy message has been created, the Veriphy system will automatically send notifications and re-notifications to the licensed care provider, or his designee. Critical result information will be auto faxed to the CMC Operator and the ordering Primary Care Practice 24 hours a day. No phone call will be made from the switchboard Monday – Friday, 8:00 AM to 5:00 PM. It is the practice responsibility to retrieve the faxed message and respond appropriately during this timeframe. After 5pm the CMC operator will notify the on call provider of the critical result via text message. NOTE: If the Practice fax machine goes down, the staff should make the switchboard aware to call the practice during that timeframe until the fax is back up and running.

- The licensed care provider, or his designee, is required to call into the Veriphy system to retrieve the critical value and close out the message.

The message retrieval steps are as follows:

1) Call (866) 753-3941
2) Enter the provider PIN followed by the pound (#) key or Press the star (*) key and enter the 6 digit message ID. The message header information is then played. Press or say 1 to accept the message, 2 to decline or 3 to repeat the message information

NOTE: It is recommended that the star (*) key and message ID be used during normal business hours so that only one patient's critical results is retrieved at a time. It is recommended that the on call provider retrieving the message after hours use their individual PIN followed by the pound (#) key so that all pending messages may be retrieved.

3) Message is played. NOTE: The entire message must be played and "1" pressed to successfully close the message.

Message Options include: 1-Close the message, 2-Repeat message information and recording, 3-Listen to the message details, 4-Additional options, 5-Reply to message, Contact the sender or (*) to return to the previous menu.

Contact Verify Support at 866-256-3178 for technical assistance or questions.

An attachment entitled *Notification and Escalation Times* describes the notification and response values for the ROY criteria.

- A periodic, unannounced internal audit to measure compliance with the Critical Test Result Communication Policy will be performed bi-annually. The audit will include one week, covering both weekdays and weekends. A sound sampling of reports generated will be reviewed to determine if Veriphy *should* have been invoked but was not. The audit process will also compare the critical values identified against the volume of messages created.

Catholic Medical Center
Departments of Diagnostic Imaging **Critical Value Alignments**

RED RESULTS (Critical)	ORANGE RESULTS (Priority)	YELLOW RESULTS (Priority)
Compliance Goal = 60 Minutes	*Compliance Goal = 12 Hours*	*Compliance Goal = Over 4 Days*
Chest:	**Chest:**	**Chest/Abdomen:**
New pneumothorax	Opportunistic infection	Suspected new or recurrent malignancy
Significant line/tube misplacement	Impending ARDS	Incidental AAA
Acute Pulmonary Embolism	Massive pleural effusion	Pulmonary nodule
Acute TB	Pulmonary embolus	**MSK/ED**
Abdomen:	Pericardial effusion	New fracture
Unexpected intra-abdominal abscess	**Abdomen:**	**Nuclear Cardiology:**
Unexpected pneumoperitoneum	Unexpected pancreatitits	Chemotherapy toxicity
New florid pneumatosis (peds)	Unexpected diverticulitis	
Small bowel volvulus (peds)	Unexpected bowel obstruction	
Intussuception (peds)	Unexpected biliary obstruction	
Acute cholecystitis	**Ultrasound:**	
Appendicitis	Pseudoaneurysm	
Ultrasound:	Molar pregnancy	
Ectopic pregnancy	**Neuro:**	
Occluded arterial bypass graft	Acute Stroke	
AAA with free fluid	**Nuclear Medicine**	
Stent leaks	Meckel's diverticulum	
Acute aortic dissection		
Ovarian or testicular torsion		
New deep vein thrombosis		
MSK:		
Epidural abcess		
New bone infection		
Osteomyleitis		
Neuro:		
New intracranial hemorrhage		
New cord compression		
New subdural empyema		
Nuclear Cardiology:		
Acute Myocardial infarction		
Life threatening arrythmias		
Hypertensive crisis		
Acute bronchospasm requiring advanced med management		
Nuclear Medicine:		
Active GI bleed		
Peds:		
Non-accidental injury		
Other:		
Intraoperative foreign body		

Catholic Medical Center
Veriphy Critical Results
Notification and Escalation Times

Finding Classification	Red	Orange	Yellow
First Alert	0 minute	0 minute	0 minute
Re-Notify	15 mins	3 hours	9 hours (1 day)
Start Backup At	15 min 1 Escalation	6 hours 2 Escalations	18 hours (2 days)
Fail Safe	30 mins	9 hours	27 hours (3 days)
Compliance Goal	60 mins	1 day @ 12 hours/day 12 hours	4 days@ 9 hours/day 36 hours
Embargo?	No	Yes	Yes
Embargo Start Time (PM)	N/A	7:00 PM	5:00 PM
Embargo End Time (AM)	N/A	7:00 AM	8:00 AM
Embargo Weekends?	FALSE	FALSE	TRUE

Finding Classification – Facilities typically have two or three findings. Naming will follow the Massachusetts Coalition recommendations (Red, Orange, Yellow)/

First Alert –the notification that is sent at the time of message creation if not during embargo.

Re-Notify –the time that will pass before an additional alert will be sent. Each additional alert is considered an Escalation.

Start Backup At – the Escalation event that will trigger alerts to Backup devices per the Ordering Clinician's Profile, the Clinical Team profile, or group alerts. In addition, Veriphy Support will be notified and will begin making live outbound calls to the Ordering Clinician based on the profile.

Fail-Safe – the final alert to the Ordering Clinician or the Clinical Team. Fail-Safe is also referred to as End Escalation which triggers Coordinator action.

Compliance Goal – the facility-wide time value that represents the outside goal for completing the entire automated notification loop. The actual goal will be to deliver the message much sooner; this also provides a benchmark for reporting.

- NOTE: The timeframe established for Compliance does NOT include the hours during a day that are Embargoed. A 'day' of compliance only includes the number of hours alerts can be sent to a physician.
    - Example: Yellows Embargoed between 5 p.m. and 8 a.m. Monday – Friday and also on Weekends. The system would calculate 9 hours of compliance each of the weekdays, therefore, a 4 day Compliance Goal would equal 27 hours (4 days x 9 hours a day= 36 hours for compliance)

Embargo – the system provides the opportunity to Embargo alerts. During embargoed hours, alerts are not sent. For less time sensitive messages, this can be used to avoid notifying

clinicians during ‘off-hours’. While this is the setting for daily Embargos, there is also a setting for weekends.

Embargo Start (PM) – the time of day the Embargo will begin in the evening.

Embargo End (AM) – the time of day the Embargo will end in the morning.

Embargo Weekend –the Embargo setting for Saturday and Sunday.

APPROVED BY: _____

[redacted]

_____

[redacted]

EFFECTIVE DATE: December 10, 2012 **REVIEWED: June 9, 2014**

SUPERSEDES:

PREPARED BY: [redacted]

PROJECT LAUNCH

Project LAUNCH

Universal Consent for Exchange of Information Form

Parent/Legal Guardian Name: _____

Child Name:_____ **D.O.B.:** ____/____/____

My family is voluntarily participating in Project LAUNCH. I understand that Project LAUNCH is a collaborative program among Child and Family Services, Child Health Services, the City of Manchester Department of Health, Easter Seals Child Development Programs, Manchester Community Health Center, NH Department of Health and Human Services Maternal Child Health Section, Southern New Hampshire Services Head Start/Early Head Start Programs, and Spark NH. I, _____, authorize the Project LAUNCH partners named above to disclose and re-disclose information as necessary to evaluate my family's need for services and to coordinate those services being provided to my family in order for our experience in Project LAUNCH to be more successful. Copies of medical records will not be made available without a separate consent form signed by me. Only information pertaining to the coordination of my family's care will be shared. These may include:

- Overall health information
- Oral Health information
- Education/developmental information
- Behavioral/mental health services
- Screening/assessment results
- Family history
- Data reporting for the purposing of grant reporting (de-identified)
- Other: _____

This permission is in effect while I am actively participating in a Project LAUNCH agency's program/services through 90 days after completion of Project LAUNCH involvement. I also understand that I may withdraw this consent in writing at any at any time.

Parent/Guardian Signature: _____ **Date**_____

Project LAUNCH Representative: _____ **Date**_____

Project LAUNCH Agency Initiating Release:

☐ Child & Family Services ☐ Child Health Services ☐ Easter Seals ☐ Manchester Community Health Center

☐ Manchester Health Department ☐ SNHS Early/Head Start

A copy of this consent form shall have the same force as the original.

Title:	**Continuum of Care**
Original Date of Implementation:	03/01/97
Written By:	[redacted]
Approved By:	[redacted]
Reviewed By Group/Committee:	
Review Date(s):	03/07/09; 04/08/10, 03/15/13, 08/08/16
Revision Date(s):	02/01/99, 06/27/05
File in the Following Manual:	Patient Care

Objective: The Manchester Community Health Center (MCHC) seeks to provide all of our patients with a strong continuum of care. This continuum is designed to address all bio/psycho/social needs of patients as they are identified through patient education, special service interventions, case conferences, specialty referrals outside MCHC, and collaborative arrangements with area community services.

Procedure:

Continuum of Care

Before Entry:

Business Office staff will screen each new patient to assess:

1. Is this an emergency situation? If so, a nurse will be consulted to assure the patient is referred to the Emergency Room if urgent care is required. If not, the normal intake and registration process will begin.
2. Does the patient have insurance or need to apply for a discount? If the patient needs a discount, the Intake Coordinator will explain the process to the patient so he/she can bring the appropriate application materials with them to their visit with a member of the Intake staff. If not, the patient will be informed to bring their insurance card to that visit.

During Entry:

The patient will first receive a New Intake Packet. They will be asked to fill in necessary forms including:

- New Patient Intake Form
- Release of information for their previous medical records
- A New Patient Authorization for Disclosure of Health Information
- A general informed consent about MCHC's requirement to report any self-reported suicidal/homicidal ideation
- A New Patient Health Screen that asks the patient to notify us of areas of concern/problems/symptoms.
- A Referral Payment Agreement
- A Patient Information Handout on MCHC Services

The patient will then meet with our Patient Accounts Representative who will assist the patient in applying for our sliding scale discount (when appropriate), applying for Medicaid benefits (prenatal patients/as needed) or collecting necessary insurance information. The Patient Accounts Representative will also explain our transportation services, review with the patient their "patient rights", Advance Directives brochure, Policy on Denial of Care, and MCHC Mission/Vision Statement. They will then have the patient fill out the Advance Directives form, and New Patient Contract for Care. (*The items with a star * are given to the patient to bring home, in the patient's target language whenever available as needed.)

NOTE: If the patient is pregnant, a Registered Nurse will complete the Prenatal Inquiry Form during the first phone contact. This patient will go to the lab, have blood work drawn (and receive a pregnancy test if there is no documentation per Prenatal Intake Protocol/Procedures) before seeing the Patient Account Representative. Prenatal patients will continue on a separate track (please see Prenatal Procedures).

In the Organization:

The patient will then meet with a provider (MD, PA or NP), who will begin compiling a database of information including past history, and a problem list, as well as formulating an assessment and a plan based on medical priorities. When appropriate, the patient will be referred to an ancillary staff person for services such as:

- Short-term mental health assessment

- Crisis Intervention
- Case Management
- Outreach
- Nutrition guidance
- Patient education
- Family therapy
- Parenting classes and parent aides

The patient's primary care provider will coordinate care as well as develop a comprehensive plan of the patient's physical, psychological/social, education and continuing care needs (including referral to outside specialty providers). All of the above will be supported on an ongoing basis by all MCHC staff, particularly with Medical Assistant and Registered Nurse interventions to support primary care provider.

Continuity of Care:
In addition to direct services provided to the patient, integration and coordination of care through a team approach is achieved when appropriate through both a general case conference, and a prenatal case conference. As the need arises, patients will be provided referrals to specialty providers both at MCHC and outside. Through a network of collaborations, affiliations, and contractual agreements, the patient will find the physical/psychological/social needs they posses supported and integrated into their optimal well-being plan.

Transfer/Denial of Care:
If a patient chooses to transfer their care to another health care provider, MCHC will follow our Medical Records Policy in releasing medical records as they are requested. Patients will only be denied care after a series of interventions have been attempted (including a psychological/social assessment and medical chart review by the Medical Director) to stabilize the patient's cooperation with MCHC Policies and Guidelines. In the case it is determined that the patient must be denied care, the patient will be offered assistance with referrals to another provider, is so desired.

CATHOLIC MEDICAL CENTER HEALTH CARE SYSTEM MISSION STATEMENT:
The heart of Catholic Medical Center is to provide health, healing, and hope in a manner that offers innovative high quality services, compassion, and respect for the human dignity of every individual who seeks or needs our care as part of Christ's healing ministry through the Catholic Church.

EFFECTIVE DATE: **January 1, 2015**

EXEMPTION STATUS: Non-Exempt

POSITION TITLE: Registered Nurse, Care Coordinator

DEPARTMENT/SERVICE: Catholic Medical Center - Physician Practice Associates

REPORTS TO: **Practice Manager**

Primary Purpose:

To promote patient, family, staff and physician satisfaction through coordination and continuity of care. To provide a systematic approach to the evaluation of patient care. To coordinate patient care through the continuum thereby facilitating the achievement of optimal quality outcomes in relation to clinical care and cost effectiveness.

Duties and Responsibilities:

Under the direct supervision of the Practice Manager and the general direction of the care coordinator management team performs the following functions:

Essential Functions:

1. Reviews and coordinates all aspects of care for patients in the practice who are identified as high risk or in need of care coordination to promote efficient coordination of care through the health care system.

2. Develops and implements a comprehensive and collaborative care plan based on the treatment needs of the patient, using evidenced based chronic care guidelines.

    a. Care plans are an individualized approach to a patients care to help all involved better manage the overall patient care needs. Care plans consist of , but are not limited to:

        i. Goals for a patient's health status
        ii. Resources necessary to benefit the patient's care
        iii. Timelines and re-evaluation schedules
        iv. Collaborative approaches to improved health

3. Monitors patient's health status and ability to manage both acute health conditions and chronic illnesses. By working with the patient to provide an understanding of treatment and treatment recommendations. Nursing care via face to face nurse visits, electronically and telephonically to best meet the needs of the patient and family.

4. Facilitates communication between patient, family, providers, team members within the practice and external to the practice, social work, therapists and community resources. Coordinator to work with the medical team to identify needs of the patient and family and refer to appropriate community resources.

5. Identifies patient's needs in regards to transitions of care from site to site and provider to provider.

6. Provide individual patient/family education and self management support based on language, cognitive ability, literacy, learning style, cultural norms, patient preference, readiness for change and resources available.

7. Coordinate and conducts patient education sessions (one on one and group formats). Assists in coordination of medical appointments/group visits.

8. Tracks referrals and test results, shares information and educates the patient about the results. Assures the patients receive appropriate follow-up amongst specialists and other disciplines based upon test results. Coordinator to arranges for special accommodations and works with the patient to decrease barriers to accessing care that is needed.

9. Coordinates the patients care amongst specialists and other disciplines, arranges for special accommodations, and works with the patient to decrease barriers to accessing care.

10. Maintains environment characterized by trust, acceptance, recognition and respect.

11. Complies with safety and emergency procedures consistent with policies and procedures.

12. Reports possible problematic situations to the practice manager. Reports problems of a clinical nature to the physician(s).

13. Assists with monitoring, assessing and implementing quality assurance measures.

14. Participates in quality assurance activities and all training seminars, OSHA and others.

15. Demonstrates courtesy, respect and caring to patients, families, physicians and staff, and maintains professional rapport with all external parties and organizations.

16. Ensures confidentiality of employee, legal, client/patient, budget and all company matters.

17. Performs similar or related duties as assigned or requested.

KNOWLEDGE, SKILLS AND ABILITIES

Individuals must possess the following knowledge, skills and abilities or be able to explain and demonstrate that the individual can perform the essential functions of the job, with or without reasonable accommodation, using some other combination of skills and abilities and to possess the necessary physical requirements, with or without the aid of mechanical devices to safely perform the essential functions of the job:

1. Ability to deliver patient care in a manner that is appropriate to the demographics and/ or specific needs of the patient population served by the hospital.

2. Demonstrates proficiency in assessing, responding and adapting treatment of care to meet the needs of the patient population served by the hospital.

3. Ability to wear safety glasses, gloves, gowns, masks and other safety equipment as necessary.

4. Ability to endure periods of heavy workload and stress.

5. Ability to work with frequent interruptions and respond appropriately to unexpected situations.

6. Ability to communicate effectively and establish a cooperative, collaborative working environment.

7. Ability to accept constructive feedback and initiate appropriate actions to correct situations.

8. Ability to maintain good communications; ability to establish and maintain positive working relationships with employees, physicians, patients, families and the public.

9. Ability to exert up to 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects.

10. Ability to transport self to and from off-site locations.

11. Requires the ability to utilize and navigate electronic clinical documentation system in order to enter patient data.
12. Basic computer keyboarding and data entry skills required.

OSHA RATING: Category I (Exposure to blood borne pathogens)

PHI ACCESS: Complete

WORK SCHEDULE:

- Generally Monday through Friday, days. May be required to work evenings or weekends depending on the schedule of the practice to which the employee is assigned.

QUALIFICATIONS:

Education:

- Graduate from an approved school of nursing.

Experience:

- A minimum of two or more years of professional nursing experience
- Medical office experience preferred.
- Case management experience preferred.

Licensure/Certification:

- Current registration in the State of NH as a Registered Nurse.
- RN BSN preferred
- BLS certified. If not BLS, certified must have the ability to obtain BLS certification during orientation period and maintain during employment.

CMC
CATHOLIC MEDICAL CENTER

Guidelines for Care Coordination

Care Coordinator role/responsibilities:

1. ID high risk patients
2. Regular contact with high risk patients
3. Triage incoming acute calls
4. Contact and schedule f/u
5. Develop care plans/goals
6. ID patients overdue for testing/appts
7. Resource for patients
8. Provide education
9. Track and report progress
10. Attend weekly/monthly scheduled meetings

Identifying High Risk Patients for Care Coordination:

1. CHF- unstable(not being followed by a provider, no consult notes in the chart, provider documents a decline in stability, medications are not being refilled appropriately) , recent admissions with 6 months
2. COPD- unstable, recent admissions with 6 months
3. DM- noncompliant, uncontrolled (a1C >9)
4. Co morbidities
5. Hospital admissions within 6 months (depending on diagnosis)
6. Readmissions within 6 months
7. Hot Spotter reports
8. Patients recommended by the PCP

9. Patients with more than 2 ED admissions within 6 months (depending on diagnosis

November 11, 2015

Evidence Based Guidelines adopted from CMS, American Diabetic Association and American Lung Association

Current Status: *Active* **PolicyStat ID:** *828246*

CMC
CATHOLIC MEDICAL CENTER

Effective: *08/2012*
Approved: *10/2013*
Last Revised: *10/2013*
Expiration: *10/2016*
Owner: [redacted]
Policy Area: *Administration*
References:

Hand Off Communication

POLICY:

To improve communication among caregivers by utilizing ISBAR communication method when patient care responsibilities are handed off from one healthcare provider to another, with the ultimate goal of improving patient safety and outcomes.

STEPS	KEY POINTS
1. "Hand off" communications will take place whenever patient care responsibilities are handed over to another caregiver. (This may include temporary or time limited situations.	• Caregivers are defined as all healthcare professionals.
2. "Hand off" communication shall include elements of the ISBAR communication method: **I** = Introductions **S** = situation-what is going on with the patient **B** = background-what is the clinical background, history, or context **A** = assessment-what is the clinical issue or problem **R** = what is the request or what do you want the caregiver to know or do prior to taking over the care of the patient.	• Accurate patient/client information regarding care, treatment, and services. • Current patient's/client's condition. • Recent or anticipated changes in the patient's/ client's condition. • Review of medications and plan of care. • After "Hand off" independent review of orders.
3. The ISBAR method will be used with each exchange of information such as, but not limited to: • Shift to shift report between nurses • ED to admission • Critical care to general care and vice versa • Transfer to/from facility • Physician practice communications • Communication between nurses and student nurses • Recovery room (PACU) to unit/floor • Critical situations; code blue, cardiac arrest, rapid response team and condition H. • RN to physician reporting change in patient condition • General and Critical care unit to radiology and diagnostic areas. • When a nurse leaves the unit for a period of time, such as lunch or to accompany a patient to another unit or diagnostic department.	• It is important to use the ISBAR handoff communication method to provide a consistent process of handoff communication. • See ISBAR example (Attachment A) for guidance • Ticket to Ride will be used for patient transfers from department to department for testing and/or treatment.
4. Healthcare professionals shall be allotted the time to "hand off" patient communication and to ask and answer	• Tape recorded report does not allow for questions, therefore, it is not acceptable for the handing off of

questions with minimal interruption.	patient information.

PROCEDURE:

STEPS	KEY POINTS
Inpatient Unit Shift-to-Shift and Unit-to-Unit Report Process	
a. Shift report should utilize the Hand Off Clinical Summary and incorporate the following components: • Review of patient orders • Review of EMR • Patient's Plan of Care • The updating of the patient's Communication Board	• White boards facilitate communication by serving as a place for the health care team to list the scheduled plan of care for the day to include but not limited to any diagnostics scheduled. The updating of the patient's communication board will help ensure that the patient is involved and aware of the daily plan and goals as well as estimated discharge date.
b. Healthcare professionals will give each other the opportunity to ask questions, answer questions, and read-back or repeat-back information as needed.	• The opportunity to ask questions of each other will ensure open lines of communication are present amongst the healthcare team and that all providers are aware of the patient's plan of care.
c. Rounds will be conducted as per unit specific protocol and will allow for confirmation of IV drips, tubing connections, and other relevant clinical assessment, including new orders.	
Emergency Department to Unit/ OR	
a. There should be two components to handoff: a. Complete Handoff with ISBAR components as defined in Step 2 above. b. Face-to-face RN update on patient at time of transfer as clinically indicated.	• The face-to-face update is to allow for confirmation of IVs, tubing connections, anesthesia used and other relevant clinical assessment, including new orders. • Face-to-face updates are a mandatory component of the transfer from ED-to-ICU and ED-to-OR.
b. Report should also incorporate the following components: • Review of patient orders • Review of EMR (PACU and units) • Patient's Plan of Care • The updating of the patient's Communication Board (to be done by unit RNs)	• White boards facilitate communication by serving as a place for the health care team to list the scheduled plan of care for the day to include but not limited to any diagnostics scheduled. The updating of the patient's communication board will help ensure that the patient is involved and aware of the daily plan and goals as well as estimated discharge date.
c.Healthcare professionals will give each other the opportunity to ask questions, answer questions, and read-back or repeat-back information as needed.	• The opportunity to ask questions of each other will ensure open lines of communication are present amongst the healthcare team and that all providers are aware of the patient's plan of care.
OR/ Endo/ PACU to Unit (and vice versa) and OR/ PACU	
a. There should be two components to handoff: a. Complete Handoff with ISBAR components as defined in Step 2 above. b. Face-to-face RN update on patient at time of transfer (for OR/PACU to unit and vice versa)	• The face-to-face update is to allow for confirmation of IVs, tubing connections, anesthesia used and other relevant clinical assessment, including new orders.
b. Report should also incorporate the following components:	• White boards facilitate communication by serving as a

• Patient Procedure • Review of patient orders • Review of EMR (PACU and units) • Patient's Plan of Care • The updating of the patient's Communication Board (to be done by unit RNs)	place for the health care team to list he scheduled plan of care for the day to include by not limited to any diagnostics scheduled. The updating of the patient's communication board will help ensure that the patient is involved and aware of the daily plan and goals as well as estimated discharge date.
c. Healthcare professionals will give each other the opportunity to ask questions, answer questions, and read-back or repeat-back information as needed.	• The opportunity to ask questions of each other will ensure open lines of communication are present amongst the healthcare team and that all providers are aware of the patient's plan of care.

Attachments:

Attachment A: SBAR

Title:	**Transfer to and From the Hospital or Other Healthcare Facility**
Original Date of Implementation:	12/01/99
Reviewed By Group/Committee:	
Review Date(s):	1/20/10, 02/26/11, 03/15/13, 2/5/15
Revision Date(s):	12/01/99, 12/01/00, 12/01/02, 06/28/05, 12/21/08, 1/20/10, 05/14/14, 09/12/16
File in the Following Manual:	Patient Care

Objective: To outline the process for transferring MCHC patients with urgent, emergent care needs or routine transport via ambulance to the Hospital and other health care facilities, and to track their discharge plan and coordinate appropriate follow up.

KEY TERMS

1. Urgent – Care needs are immediate, patient is hemodynamically stable, life support is not required.
2. Emergent – Care needs are immediate, patient is unstable; life-support may be required.
3. Routine Transport – Care needs are not immediate, patient is stable, most appropriate mode of transport for this patient is via ambulance.

Procedure:

STEPS URGENT/EMERGENT TRANSFERS OUT

1. Patient status is evaluated.
2. Need for immediate transfer to hospital is determined.
3. Patient status is determined as urgent or emergent. Attempts are made to stabilize patient prior to transfer. If patient is in cardiac/respiratory arrest, initiate CPR as per Policy for Cardiac/Respiratory Arrest
4. EMS is activated by dialing 8-911. Staff will stay on the line until the dispatcher directs them to terminate the call. The following information is given to the dispatcher: What the emergency is, location (MCHC 145 Hollis Street 2nd floor), and intervention/treatment given.
5. Provider, Team Nurse and Triage Nurse are notified STAT and will determine if additional staff is needed.
6. Front Desk Manager or designee is informed of pending EMS arrival.
7. Team Nurse will print a chart summary which includes demographics, patient problem list, and current medication list along with any necessary paperwork needed for transport, ie. EKG or NST strip.
8. At Hollis, Front Desk Manager or his/her designee will direct a member of staff to bring the elevator to the 1st floor and lock it into place until EMS crew arrives at the building for patient. (The elevator may not be utilized by others during an urgent or emergent transport) and accompany to the second floor, lock and remain with the elevator, and unlock for EMS crew is ready for departure with patient.
9. One staff person will wait at the Exit door to direct the EMS crew to the patient location.
10. MCHC staff may be utilized within the scope of their abilities, including assisting the EMS crew as needed.
10 Provider or nurse will contact the ER or Labor & Delivery as applicable with patient status.
11 The event will be documented in the patient's electronic medical record.

STEPS ROUTINE TRANSFERS OUT

1. Need for routine transport to hospital is determined by provider for a Direct Hospital Admission.
2. Provider admitting patient will obtain a bed for patient prior to nurse contacting American Medical Response Ambulance.
3. American Medical Response Ambulance dispatch number (603-882-5330) is called; necessary information is given to dispatcher. Staff person will request an ETA from dispatch and inform them to report to the Business Office.
4. Nurse/Medical Assistant will inform Business Office and other support staff of routine ambulance transfer.
5. Necessary paperwork is printed from the patient's electronic chart for transport and orders will be written by admitting provider and faxed to applicable hospital or admitting medical facility by team nurse.
6. Once ambulance arrives, Business Office staff will page support staff to direct ambulance crew to appropriate location.
7. MCHC staff may be utilized within the scope of their abilities, including assisting the EMS crew as needed.

8. The event will be documented in the patient's electronic medical record.

STEPS TO FOLLOW UP ON DISCHARGE AND PLANNING FROM OTHER HEALTHCARE FACILITIES

1. MCHC has an electronic medical record with connectivity via interface to the two local hospitals and to a local specialty care provider that does also perform procedures (Elliot Hospital, Catholic Medical Center and Dartmouth Hitchcock- Manchester).
2. MCHC receives daily electronic notices of discharge plans from the three local facilities via the electronic interface, and also receives regular faxes from other facilities that are not linked to our EMR.
3. When the document is received with the discharge information and follow up plan recommendations, the document is routed initially to the Triage Nurse or Team Nurse (for urgent and non-urgent issues respectively).
4. The Nurse is responsible for completing a Transition of Care review with the discharging facility or provider. This may be done through review of the documents we have received if they are comprehensive, or may require a follow-up call to a provider, nurse or case manager at the discharging facility or provider's office to complete a review of key items. The key items must include: any medication changes, follow-up plan, any new or modified diagnosis.
5. The Nurse will then follow up with the provider (if required) or will book any necessary follow up appointments, and will update the problem and medication list with any new information.
6. All of the plans and follow up will be documented in the patient's electronic medical record.

Title:	New Patient Registration & Patient Intake
Original Date of Implementation:	03/01/03
Written By:	[redacted]
Approved By:	[redacted]
Reviewed By Group/Committee:	[redacted]
Review Date(s):	04/20/10
Revision Date(s):	02/21/05, 03/01/03, 07/01/05, 03/24/09, 11/20/12, 10/11/13, 7/7/14, 5/11/15
File in the Following Manual:	Patient Care

Objective: It is the mission of Manchester Community Health Center to provide high-quality comprehensive primary healthcare services to all people seeking to establish care. While every effort is to be made to provide access to appropriate care, Manchester Community Health Center is not a walk-in clinic or an urgent care center. Accordingly, from time to time it may be necessary to refer non-established patients with urgent needs to other facilities until such time as appropriate appointment slots for new patients are available. This will combine and/or revise the following policies: Acceptance of Patients Referred from the Emergency Room (12/99), Admission to MCHC (12/99), Billing, Credit and Collection Intake (1/00) and New Patient Access (1/02).

Policy: Manchester Community Health Center shall afford equal and appropriate access to appointments for all new patients seeking to establish primary health care, regardless of their insurance status or ability to pay, age, or any other identifier, including individuals referred by Elliot Emergency Department (E/D) when our physicians are on duty for E/D Backup. Once established, non-urgent access will be provided on a next-available-appointment basis. It is the policy of Manchester Community Health Center to obtain appropriate billing, demographic, referral or any other such relevant information. This is necessary to ensure appropriate assignment of insurance benefits, billing of deductibles and co-payments, and determination of eligibility for discounted services in accordance with Manchester Community Health Center sliding fee discount policies.

Overview: Manchester Community Health Center typically receives requests for new patient appointments by direct patient contact, external agency referral or through the emergency department at the hospital and pre-screen individual needs to offer financial assistance, interpretation, and other services available.

An Intake appointment will be scheduled for all new patients including under-insured or non-insured individuals to determine eligibility for financial assistance in the sliding fee scale program. Next available appointments for new, non-pregnant adults will be provided on a first come, first served basis. Next available appointment for new children will be provided on a first come, first served basis. Please see the policy for Prenatal Intake for the pregnant patient workflow.

Procedure: Individuals contacting the Health Center wishing to become a patient will be processed in the following manner:

Newborn/Pediatric/Adult callers and walk-in who are not pregnant and are seeking access to healthcare at MCHC will:

1) Have a dedicated New Patient phone number: 603-935-5336. This number will be in a queue system answered by one of five individuals.

2) During the phone or walk-in registration, the staff member will ask the following question in order to schedule an appointment to meet with PCP:

   a) Have you or your child been seen at CHS/Manchester Community Health Center before? If yes, locate the chart in CPS and EMR by date of birth and name to avoid duplicate charts. If patient is allowed to re-access care, update the chart with new information. If patient has been “denied services”, “fallen out of care”, “sent to collections” follow protocol. If no, proceed to create a mini registration.
   b) If patient is a female, please ask if there is a possibility that she might be pregnant to refer client to the Perinatal Case Manager.

Mini Chart creation of New Patient

Check in Collections List in Z: Drive to verify patient hasn’t been sent to collections. If not, a new chart will be created in CPS with correct spelling of the patient’s name. If the patient is a child, the second line in the address field will be established as CO mother/father/guardian with the first line indicating the address. If patient was sent to collections, a phone note will be sent to Billing Department with patient’s current phone number so they can contact patient and make arrangements before patient can re-access care.

New Patient personnel will input the following information:

- Name
- Date of Birth
- Address
- Telephone Numbers
- Gender
- Health Insurance Information
- Primary Care Physician assigned to
- Location of care
- Guarantor/Guardian information
- Update blue banner with language needed

3) New Patient personnel will use the New Patient quick text notes to schedule any appointments.

4) New Patient personnel may schedule newborn appointments within 7 days from date of birth. Unless discharge notes require a sooner appointment. Must obtain medical records for the first appointment. Pediatric Coordinator would contact parent via phone call for delivery and feeding method assessment. All newborns will be schedule with Medicaid staff member.
   - Newborns of Mother's that had Medicaid themselves or that Medicaid application process has been started at the hospital will meet with Medicaid staff member for a shorter period of time to review status of Medicaid application, and help parent complete the new patient registration form.
   - Newborns that Medicaid application has not been started yet will meet with Medicaid staff member for a longer period of time to process Medicaid enrollment, and to help parent complete the new patient registration form.

5) New Patient personnel may schedule ED back up patients within 2 to 7 days based on discharge notes and must have medical records for first appointment.

6) New Patient Coordinator will schedule positive TB patient and must obtain medical records for first appointment.

7) New Patient personnel may schedule the next available appointment for patients under the age of 14 years old that are seeking primary care services. No medical records are needed for first appointment.
   Parents are encouraged to bring immunization record report *prior* to the first office visit, and or at first office visit including any current prescription bottles.

   All children insured and uninsured will have an intake/Medicaid appointment respectively, to receive assistance completing new patient registration form and offered services provided at MCHC/CHS. Uninsured children that are Medicaid eligible will be scheduled for a Medicaid enrollment appointment. Only CHS patients will be scheduled a Social Assessment appointment with a Case Manager for all children under 14 years old before the PCP appointment.

8) New Patient personnel may schedule, *non-seeking family planning program teenager* over 14 years old. No medical records are needed for first appointment.
   Parents are encouraged to bring immunization record report *prior* to the first office visit, and or at first office visit including any current prescription bottles.

   All teenager patients insured and uninsured will have an intake/Medicaid appointment respectively, to receive assistance completing new patient registration forms and offered services provided at MCHC/CHS.

   Uninsured teenagers that are Medicaid eligible will be scheduled for a Medicaid enrollment appointment.
   Only CHS patients will be scheduled a Social Assessment appointment with a Teen Health Clinic Coordinator for all teenagers over 14 years old before the PCP appointment.

9) Teenager seeking family planning program will be directed to Teen Health Clinic Coordinator to access care.

10) New Patient personnel will schedule the next available new patient appointment for non-acute adult patients. No medical records are needed for first appointment. For uninsured adults, Medicaid enrollment appointment for eligible patients or intake appointment for non-Medicaid eligible patients will be scheduled to process financial assistance and to complete the new registration form.

11) New Patient personnel will assign a PCP according to New Patient Access protocol. Inquire as to the patient's preference for a female, male provider and location of care. Inform individual they will not be considered a patient of MCHC until they have met with PCP. Review no show policy with patient.

12) New Patient personnel will screen for insurance, if patient is uninsured or under-insured. A Medicaid/NHHPP will be scheduled for eligible patients. An intake appointment will be schedule for non-Medicaid eligible patients. Briefly describe the discount program (financial assistance) and explain that discount will be determined during Intake appointment and inform individual of necessary documents to verify financial information.

13) New Patient personnel will schedule transportation services and an interpreter, if need be.

14) Patients will be asked to bring with them to the visit any current medications bottles, immunization records if they have them, and any discharge summaries.

NOTE: All patients/parents that indicate a need for care, treatment or services prior to the date of their pending New Patient Visit appointment scheduled will be referred to their current/most recent primary care provider and/or seek evaluation at a facility that provides Urgent/Walk-In and/or Emergency evaluation. See New Patient On-Boarding Guidance policy for more info.

The new patient is expected to check in 30 minutes prior to the new patient evaluation appointment time to fill out the New Patient Registration form until they meet with the Intake/Medicaid staff member to complete, and review all forms as well as to receive information regarding the programs and services provided at our locations. The New Patient Registration includes patient demographic, insurance, financial assistance, Community Improvement Program, Dartmouth PAIS, immunization consent, Electronic Transaction of Health Care Business and Affiliate Access Agreement, Notice of Privacy Practices, Patient Bill of Rights, Patient Contract for Care, Referral Payment Acknowledgement, Authorized Representative, Prescription Pick Up Authorization, Medical Records Pick Up Authorization, Parental Consent to Provide Care to a Minor, Language Access form consents and Patient Consent for Evaluation and Treatment. Patient will receive a Patient Handbook containing detailed information to Make Appointments, Cancel or Reschedule the Appointments, Reaching MCHC through Call Center, Patient Portal, Hours of Operation, Reaching us after Business Hours, Inclement Weather, Insurance Plans Accepted, Financial Assistance, Payment for Services, When you are Carrying a Balance, Insurance Billing, Programs and Services Available, Transfer of Medical Records, Hospital Affiliation, Referrals for Specialty Care, Documents explaining in detail about Notice of Privacy Practices, documents above mentioned and Providers full name, degree, education, and residency.

When Medicaid personnel meets with patient will also provide overview of services; review all forms for completion and education.

When Intake personnel meets with patient to determine discount eligibility, they will be issued a Medical Assistance Card prior to their provider appointment (where appropriate). Intake personnel will review and discuss with the patient how, when and where to use the Medical Assistance Card as well as expectation of payment.

Patients with an active insurance that provided us with an ID# will meet with Intake personnel prior to provider's appointment to review registration forms and go over programs and services available at the health center.

The Patient Intake personnel should add Federal demographic fields:

- Income level in terms of gross weekly and annual income
- Discount eligibility
- Sliding fee status
- Status, effective and expiration date of discount
- Children Uncompensated Care Fund, if eligible
- Citizenship status
- Living Arrangements
- Release Patient Info
- Privacy Policy
- Benefit Assignment

The Check-In/Receptionist personnel is responsible for reviewing patient's name spelling and date of birth and print labels for all registration forms requiring name and date of birth. Scan all insurance cards; enter pertinent information into the enrollment field of the insurance area in the Medical Information System, particularly the claims submission address. Updating of CHC Registration and Authorization consents.

NOTE:

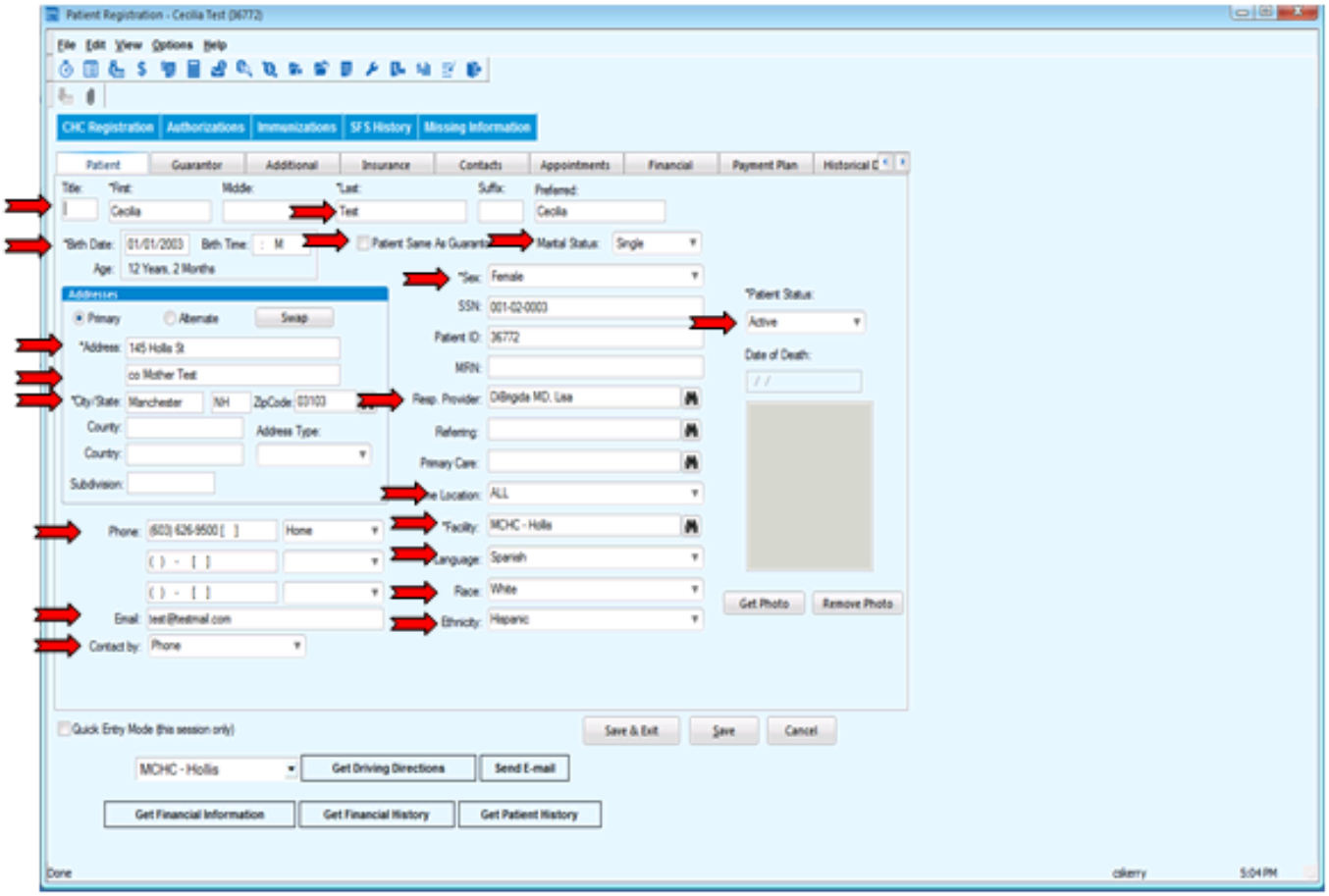
- **All patients seen at MCHC/CHS shall have a completed New Patient Registration form on file containing medical consents and financial information utilized to process their insurance enrollment or discount assistance. See New Patient Registration Form and Intake Appointment Workflow policy for more info.**
- **Pregnant women will be forwarded to the Perinatal Case Manager for processing.**
- **Teenager seeking to access Family Planning services will be forwarded to Teen Health Care Coordinator for processing.**
- **MCHC places no restrictions on access or admission due to an applicant's insurance status or ability to pay.**

Guide to Complete CPS and EMR Data Entry

The following screen prints show you step by step what fields need to be completed in both the CPS program and the EMR program.

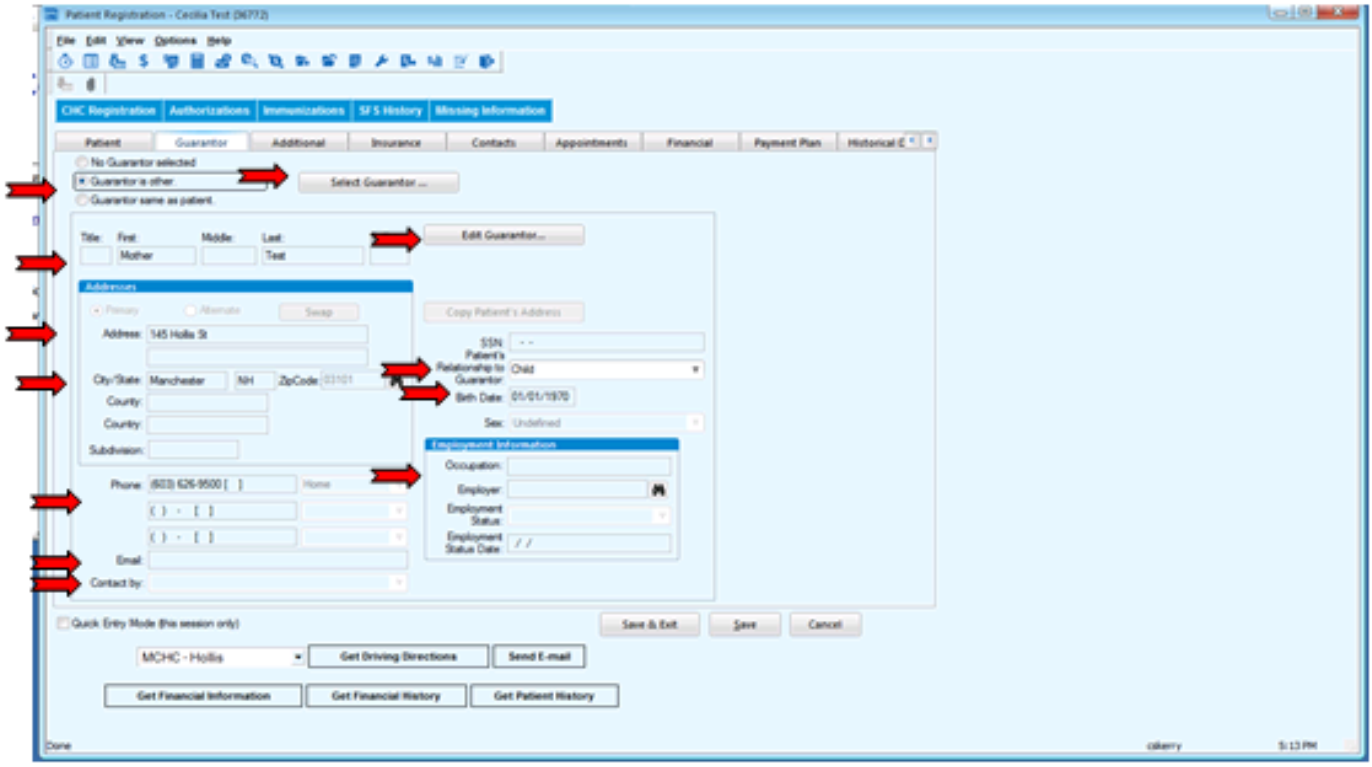
LEGEND: Anything with a " ➡ " next to it must be filled out if it is applicable

CPS Patient Information Tab



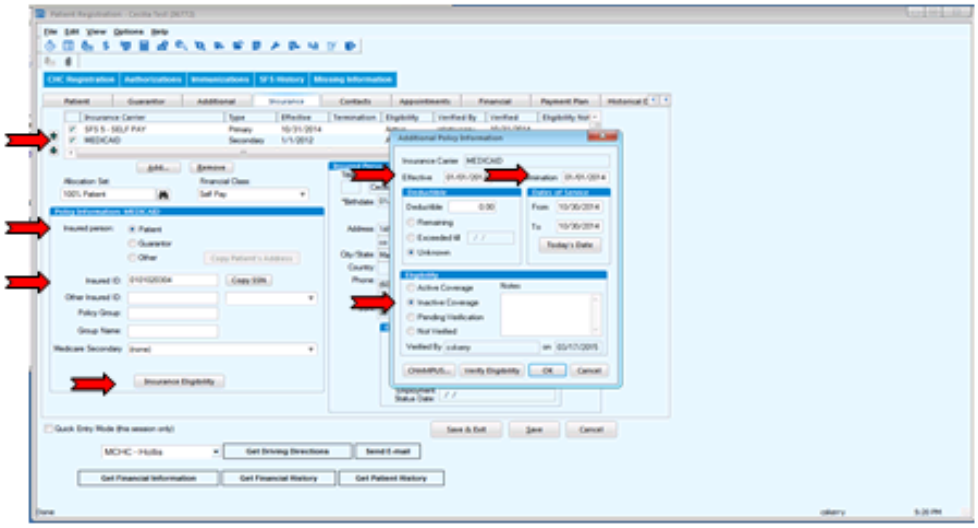
NOTE: The only time that "Primary Care Physician" needs to be filled out is if the patient has private insurance HMO (like Matthew Thornton) and their card says "Dr[redacted]" or another physician but yet they see one of the mid-levels or another provider.

Guarantor Information Tab

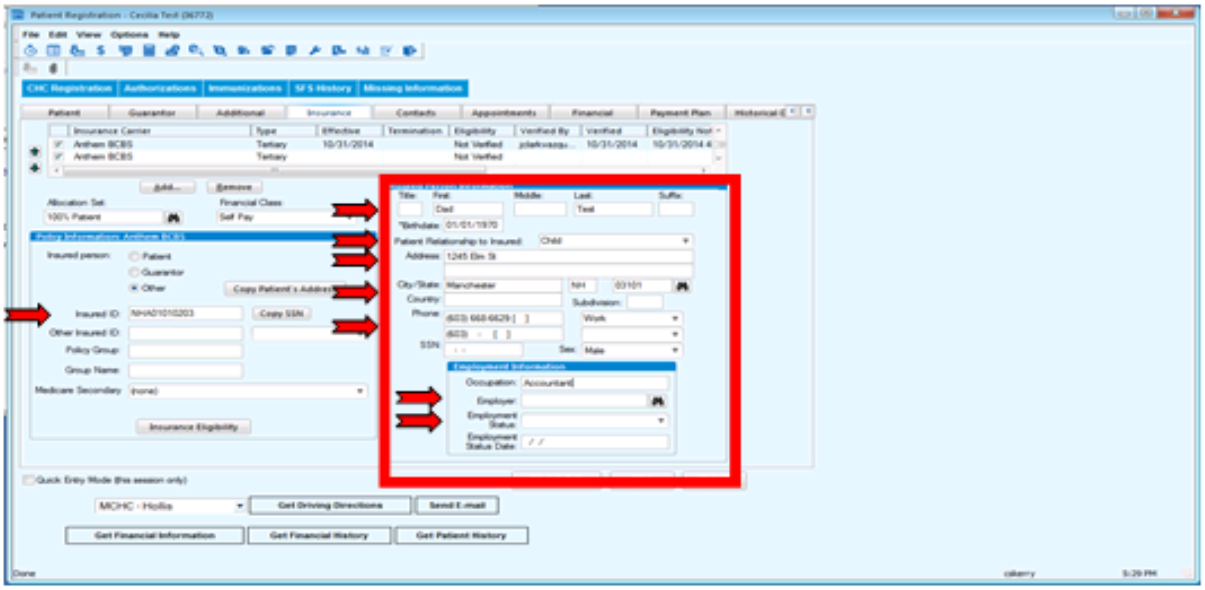


NOTE: It is very important to click "Select Guarantor" to search from MCHC's existing list of Guarantor's to link them together.

Insurance Information



NOTE: It is very important, even for discount patients, to enter in the dates of effective and termination. This will help the billing office determine which is the most recent. Even if you do not know the exact dates, but at least put when that insurance generally started up through today's date, it will help them sort it out.



NOTE: If you click the "other button" under the insured person you will see a box open on the right (see the highlighted area). Please note that in CPS the following definitions apply:

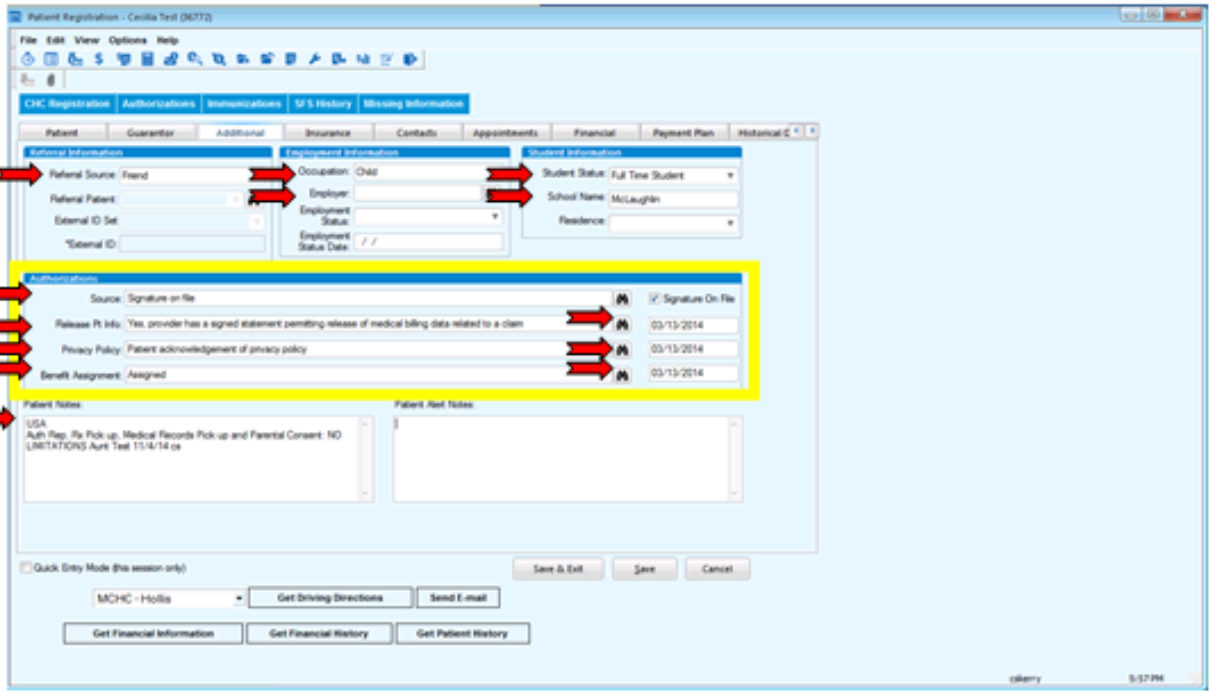
PATIENT: The person being seen by the provider
GUARANTOR: The primary contact (usually parent or guardian)
INSURED PARTY: The person who has the insurance which will pay for the patient's care.

Therefore, it is theoretically possible to have this scenario:

PATIENT: Cecilia Test
GUARANTOR: Mother Test (let's assume they are divorced and dad carries the insurance)
INSURED PARTY: Dad Test

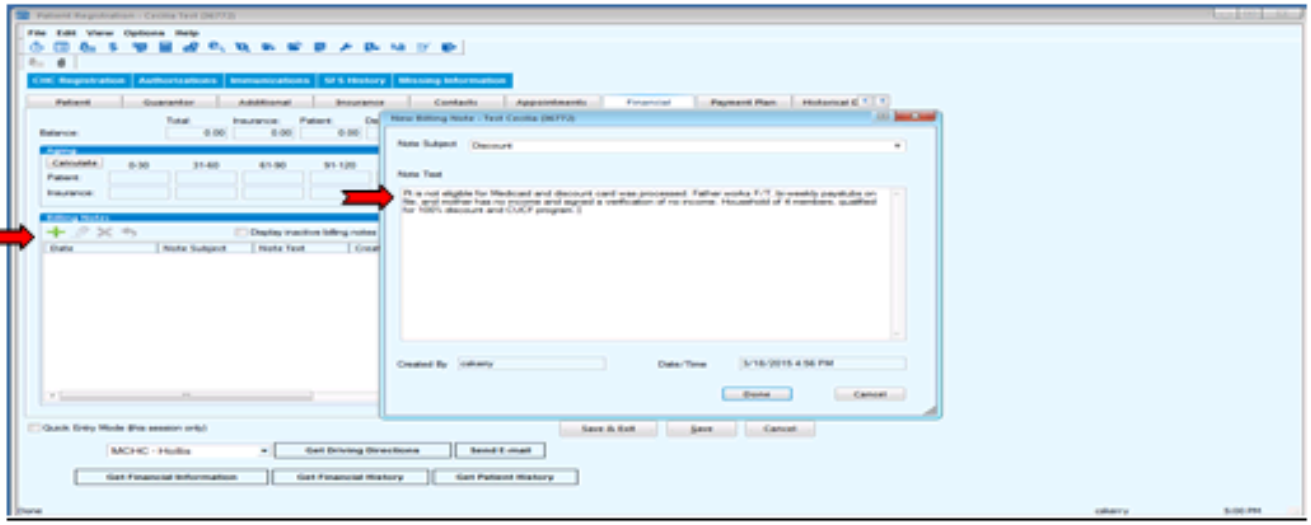
Here we see three different sets of data, with mom and dad's info not matching. This is usually only critical with PRIVATE INSURANCE. Also note that these data points are very important-
NAME, ADDRESS, GENDER, DOB, Patient's Relation to Insured Party.

Additional Information Tab



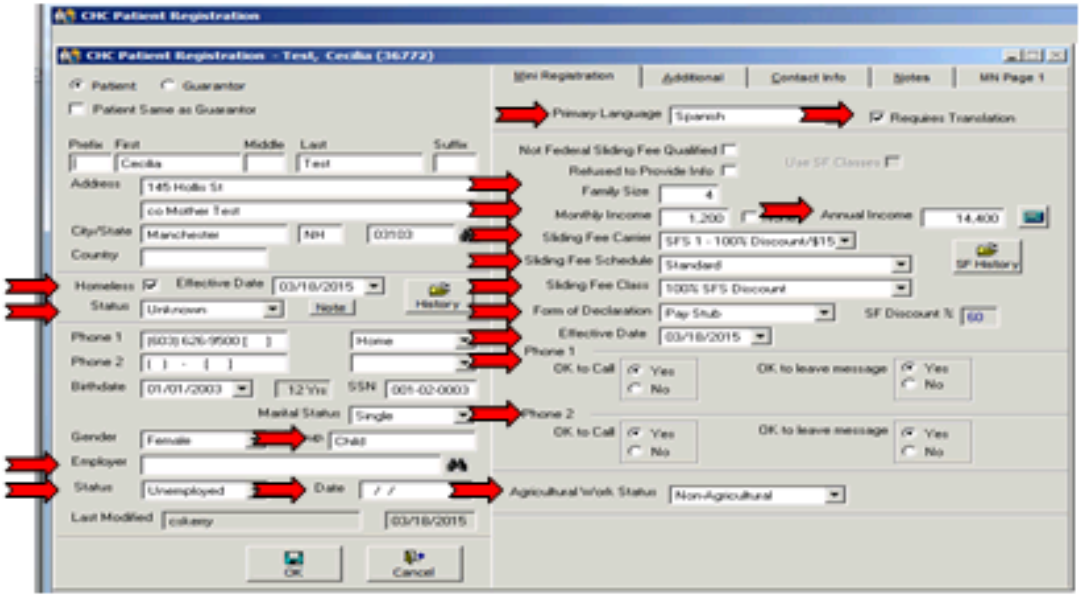
NOTE: It is critical with ALL PATIENTS that you thoroughly complete this highlighted area in the yellow box above. If you do not, the electronic claim will AUTOMATICALLY bounce back and we will not be able to send through the bill to the insurance. This causes a lot of difficulties for billing. It is also Federal Law that we show when we got HIPAA signed off by the patient.
It is very important to add to "Patient Notes", country name, next to it residency status for example "Permanent resident since 03/10" and your initials this will help the Intake team to determine when this patient may be eligible to apply for Medicaid services. Add full name and relationship of authorized person from the consent forms.

Financial Tab



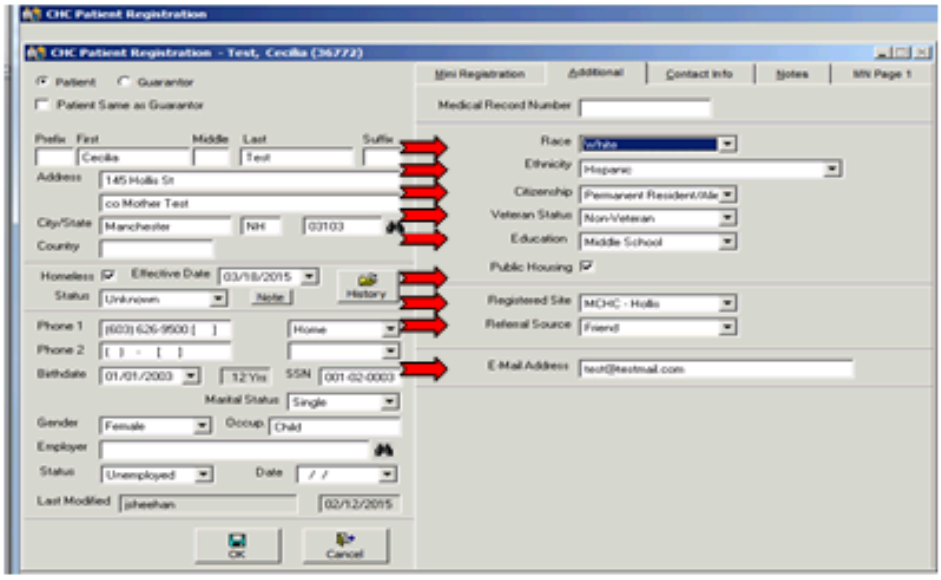
Note: Add Medicaid, NHHPP, Marketplace and or Discount comments.
Click the + sign on Billing Notes, when the window opens up add a Subject title and Financial notes.
Click Done button to save and close the note.

CHC Mini Registration



NOTE: Update all fields with red arrow. Patients MUST update once a year the Homeless status and income status for the UDS report submitted every year to the government, and change the date to the date reported via intake form.

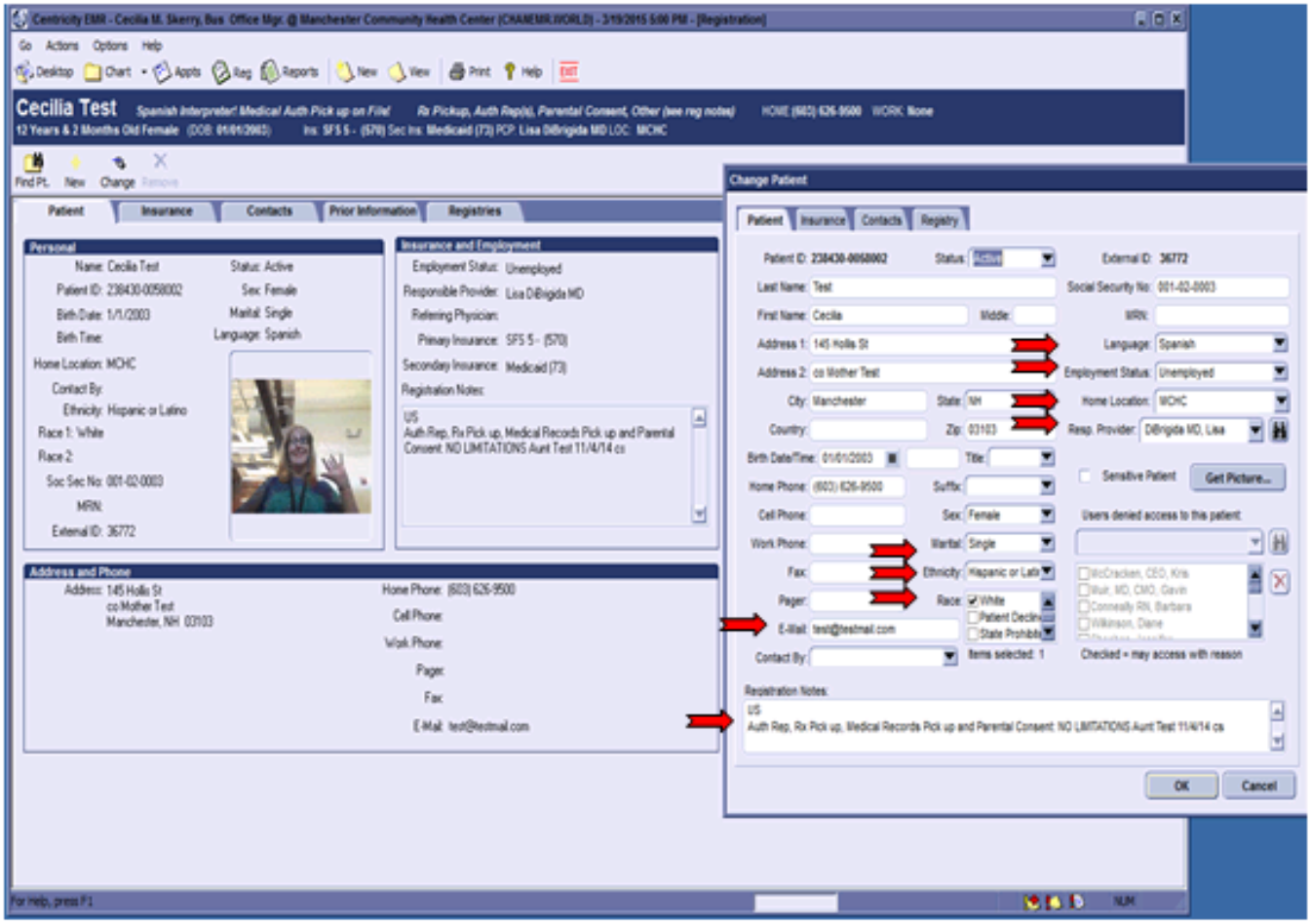
CHC Additional Tab



NOTE: Update Race, Ethnicity, Citizenship, Veteran Status, Education, Public Housing, Registered Site, Referral Source, and E-mail address.

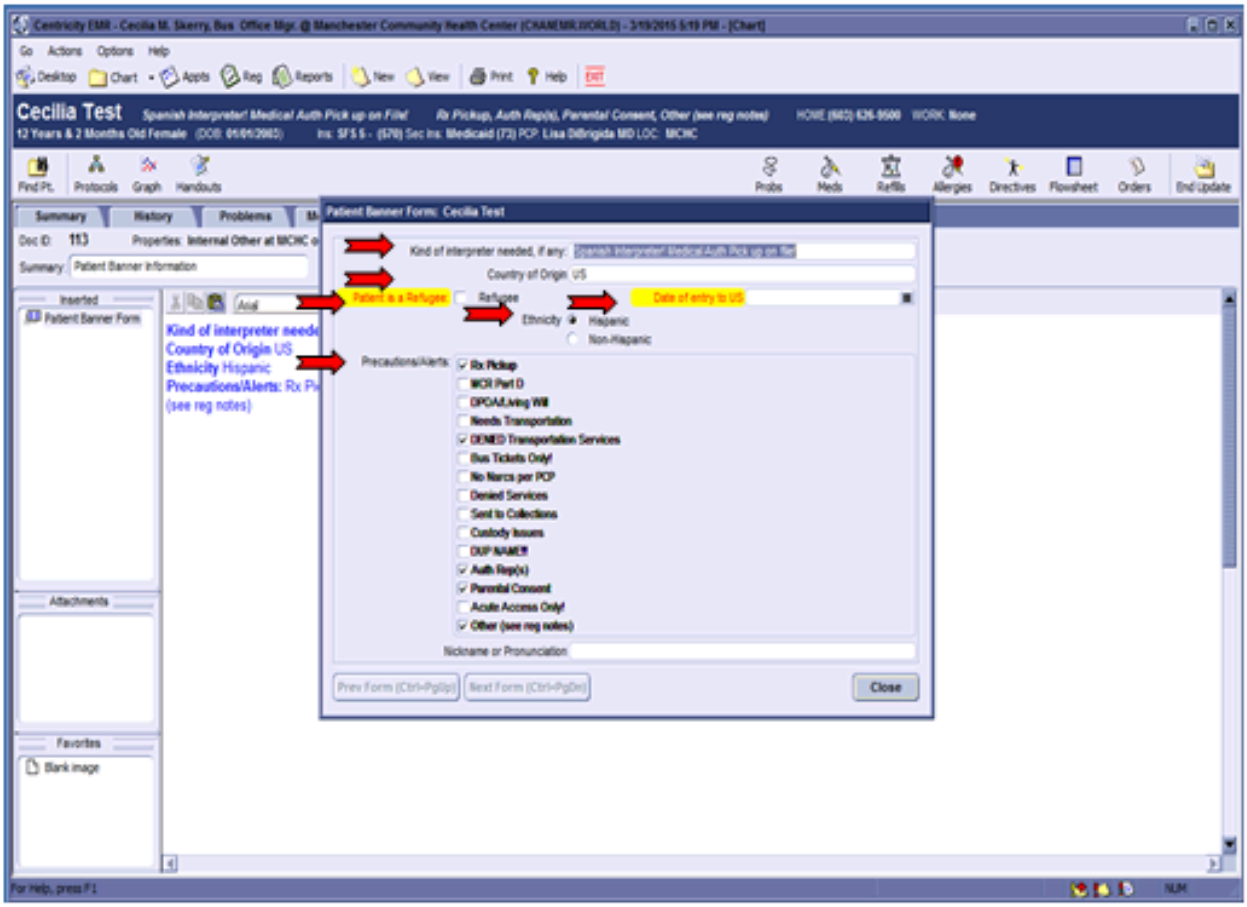
EMR

Registration Page



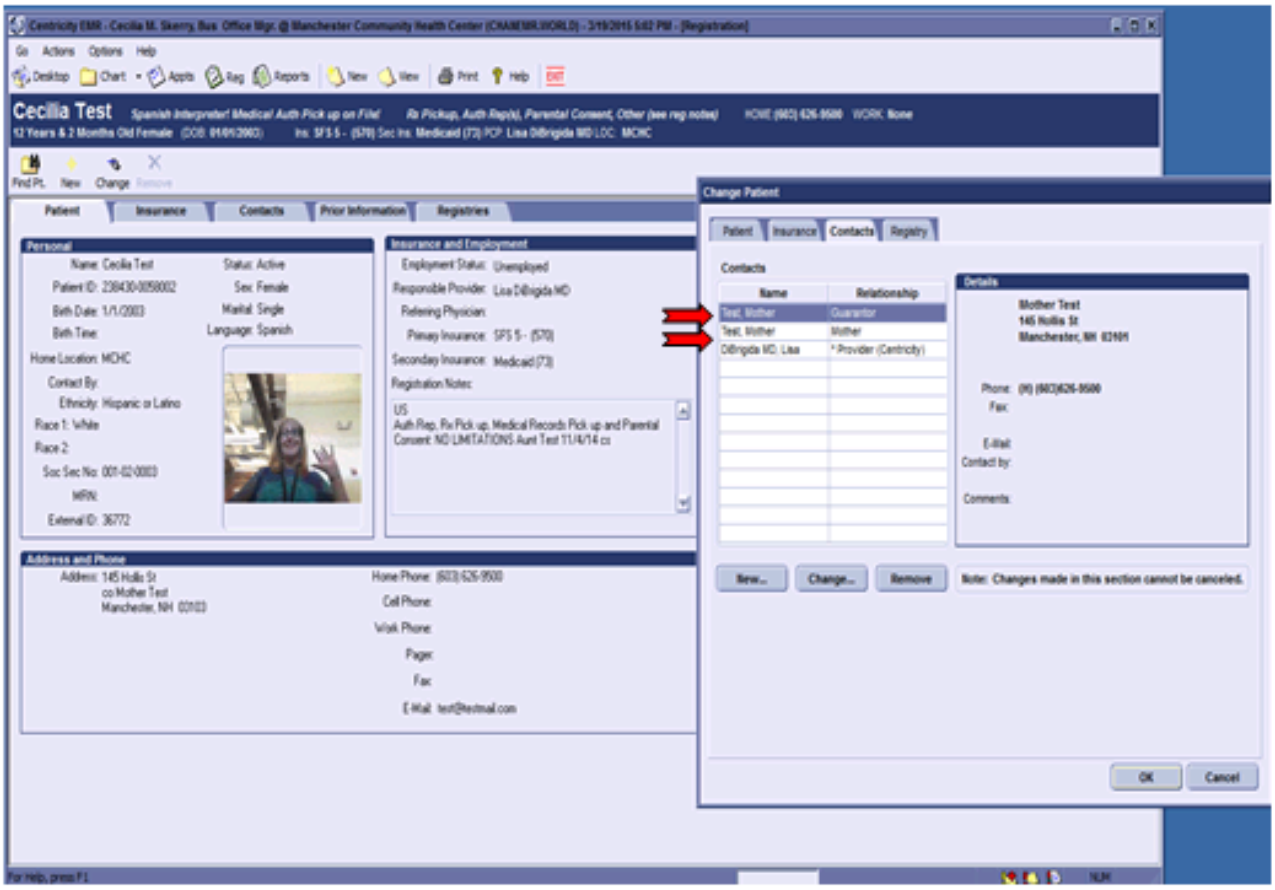
NOTES: Update the following info: Marital status, Ethnicity, Race, E-mail, Language, Employment Status, Home Location and Responsible Provider.
Add to Registration Notes: Country, Authorizations from consent forms, discount information, and any special notes.

Blue Banner Page



NOTES: Use the blue banner for critical info that must be viewed (like patient alerts) by anyone opening chart. Examples are "NIH" (no info home for confidential calling), "Parental Consent", "Rx Pickup by, "Authorized Representative", "TWINS!!!, " _____ Interpreter", "Duplicate Name", "Behavior Contract", "DCYF CUSTODY. Foster Parent: _____".
You can also use "Other (see reg notes)" if the detail is too exhaustive to fit in Interpreter line and add the comment to Registration Notes under Patient tab.

Contacts Page



NOTE: Add for a minor patient the Guarantor's name with the relationship for example Mother, Father, etc. Please remove any OLD information in ANY of these screens that is no longer accurate or applicable. For example- old providers, old insurance, old pharmacy, etc…

CATHOLIC MEDICAL CENTER

Opioid Use/Misuse Resources

Developed by [redacted]

CMC
CATHOLIC MEDICAL CENTER

1. Acute overdose bundle

Nursing Considerations

- Assess patient using Clinical Opiate Withdrawal Scale (COWS) tool
- Contact security with concerns regarding patient or personal safety. Refer to Security section for additional information.
- Contact Security to search belongings in the ED and remove ALL paraphernalia, lighters & cigarettes included.
- Follow the Search Policy and the Visitation Policy when in question
- Educate patient at the point of entry about visitation and behaviors that will NOT be tolerated during their stay at CMC, and or behavior contract.
- Designate which provider will be managing pain medication if pain management is involved. Clear guidelines so multiple MD's are not being called to change the narcotic orders.
- Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.
- Contact Nutrition services – only plastic ware on meal trays instead of metal silverware (spoons)
- Provide consistency with managing the patient starting at the point of entry throughout their stay.
- Consider need for 1:1 ratio
- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion
- Consider room assignment near Nurses Station

Provider considerations

- Utilize ICU or telemetry admission order set; add opioid withdrawal bundle
- Supplemental oxygen as needed to maintain oxygen saturation greater than 92-94%
- Consider intubation
- Utilize ICU or telemetry admission order set then add acute overdose bundle
- In patients exhibiting respiratory compromise without a clear etiology, examine the patient's body (and body cavities) for presence of transdermal patches. Remove patch(es) from the patient's body.
- Activated charcoal and gastric emptying are almost never indicated in opioid poisoning.
- The large volume of distribution of the opioids precludes removal of a significant quantity of drug by hemodialysis
- For suspicion of body packing and body stuffing (completed in the ED?)
    - Consider procedures for a GI body packer and/or body stuffer
    - *Avoid the use of oil-based laxatives. Cathartics and ipecac have not been shown to be beneficial.*
    - *Surgical intervention may be required if conservative management fails.*
- Determine the stage or severity of opiate withdrawal using COWS score
- Consider clonidine for acute withdrawal for Clinical Opiate Withdrawal Scale (COWS) score greater than 12 indicating moderate withdrawal
- For patients who continue to score greater than 36 the COWS indicating severe withdrawal, after 24 hours on clonidine, consider use of methadone for patients on long acting opioids or buprenorphine for patients on short-acting opioids
- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion

Monitoring plan

Monitor for signs/symptoms of overdose, refer to Signs and symptoms of overdose
Monitor for signs/symptoms of withdrawal, refer to Signs and symptoms of withdrawal
Telemetry (add bundle)
Vital signs
Pulse oximetry/Oxygen saturation
Monitor for suicide risk
Neuro exam
Clonidine for acute withdrawal monitoring: Hold for SBP less than 90 mmHg or DBP less than 60 mmHg; monitor

for orthostatic hypotension, sedation, dry mouth and constipation

Lab orders

ABG
Acetaminophen level
BMP or CMET
CBC
CBG
Urine tox screen (if not completed in ED), obtain sample prior to medication administration
EKG 12-lead, if not performed in the ED
Ethyl alcohol
Qualitative serum pregnancy *(~hCG) if indicated. If age greater than 55, less than 11 , or history of hysterectomy, then abstain from ordering ~hCG*
Radiology – foreign body suspected?
Salicylate level

Medications

Decontamination for body packer/stuffer (if not completed in the ED):

- Activated charcoal in water 25 grams PO/Per Tube one-time. May repeat every 4-6 hours for retained packages. *Use is contraindicated in a patient who has a diminished level of consciousness unless the airway is protected.*
- Polyethylene glycol-electrolyte solution 1500 mL PO/per tube every hour until the rectal effluent is clear. *Please note: the presence of clear effluent is not sufficient evidence to assume that all of the illicit drug packages have been eliminated. Treatment should be extended if there is corroborative evidence of the continued presence of illicit drug packages in the GI tract as determined by radiographic means.*

☐ Clonidine for symptoms of acute withdrawal

- Clonidine is 0.1 mg one-time as a test dose (consider 0.2 mg for patients weighing over 90 kg)
  - Check blood pressure 1 hour after initial dose. If SBP less than 90 mmHg or DBP less than 60 mmHg, HR less than 60 or marked postural hypotension occurs, do not continue clonidine therapy
- If patient tolerates the clonidine test dose,
  - Clonidine 0.1 mg 4-day Taper for patients weighing 90 kg and less
    - Clonidine 0.1 mg orally every 6 hours x 7 doses
    - Clonidine 0.05 mg orally every 6 hours x 4 doses
    - Clonidine 0.025 mg orally every 6 hours x 4 doses
    - Check COWS score and BP before dose, hold for SBP <90 mmHg, DBP < 60 mmHg or HR < 60 bpm
  - Clonidine 0.2 mg 4-day Taper for patients weighing over 90 kg
    - Clonidine 0.2 mg orally every 6 hours x 3 doses
    - Clonidine 0.1 mg orally every 6 hours x 4 doses
    - Clonidine 0.05 mg orally every 6 hours x 4 doses
    - Clonidine 0.025 mg orally every 6 hours x 4 doses
    - Check COWS score BP before dose, hold for SBP <90 mmHg, DBP < 60 mmHg or HR < 60 bpm

☒ Naloxone 2 mg IV every 2 minutes PRN for cardiac arrest. After reversal, may need to readminister after 20-60 minutes depending on type/duration of opioid. If no response is observed after 10 mg total, consider other causes of respiratory depression.

Naloxone 0.04 mg if spontaneous ventilations are present
Naloxone 0.2 mg for apneic patients

Supportive Medications[6]

Treatment of hypotension: IV fluids; vasopressors if unresponsive to fluids
Treatment of seizure:

- First-line therapy with benzodiazepines (eg, lorazepam), consider diazepam for seizure refractory to lorazepam
- No IV access? treatment with IM midazolam is recommended
- *Phenytoin/fosphenytoin is not generally useful in the management of poison-induced seizures; routine use is not recommended (Bey 2001)*

Ondansetron is not generally recommended due to prevalence of QT prolongation

☒ Acetaminophen 650 mg orally every 6 hours PRN myalgia, pain score 1-3. Use first.
☒ Lorazepam 4 mg IV push every 10 minutes x 4 doses PRN seizure. Use first.
☒ Dicyclomine 20 mg orally every 6 hours PRN abdominal cramping. Use first.
☒ Hydroxyzine 25 mg orally TID PRN anxiety, dysphoria, lacrimation, rhinorrhea. Use first.
☒ Ibuprofen 600 mg orally every 6 hours PRN pain score 4-10. Use first.
☒ Loperamide 4 mg orally one-time then 2 mg orally PRN each loose stool (Max 16 mg in 24 hours) . Use first.
☒ Methocarbamol (Robaxin) 1000 mg orally every 6 hours PRN muscle spasms or twitching. Use first.
☒ Milk of magnesia 30 mL orally daily PRN constipation. Use first.
☒ Nicotine patch 21 mg/day transdermal daily Conditional order: for active smokers more than 10 cigarettes/day)
☒ Nicotine patch 14 mg/day transdermal daily Conditional order: for active smokers 10 or less cigarettes/day
☒ Promethazine 12.5 mg IV every 6 hours PRN Nausea/Vomiting. Use first if unable to take PO promethazine.
☒ Promethazine 25 mg orally every 6 hours PRN Nausea/Vomiting. Use first.
☒ Trazodone 50 mg orally daily at bedtime

Consults

☐ Case management referral
☐ Social work referral
☐ Consult pain management
☐ Consult infectious disease
☐ Consult psychiatry
☐ Pastoral care referral
☐ Consult cardiology NEHI

Security

- The safety of our staff, patients and visitors is of the utmost importance. CMC Security should be contacted at extension 2029. Dial x2111 for an Emergency.
- **Search**
  In order to provide a safe environment for patients, visitors and staff, Catholic Medical Center may conduct a search of a room or area, individual and/or personal belongings when there is a reasonable suspicion for a search in accordance with CMC's Search & Seizure of Patient Care Areas, Individuals, and/or Belongings policy. The policy may be found in Policy Stat. Contact Security to search patient belongings and remove ALL paraphernalia (lighters & cigarettes included).
- **Visitor restriction**
  Catholic Medical Center permits patient visitation 24 hours a day but reserves the right to restrict visitation for certain Justified Clinical Restrictions. Refer to CMC's policy, "Visitation Policy to Support a Healing Environment" in Policy Stat.
- **Patient Behavior Agreement**
  Educate patient at the point of entry about visitation and behaviors that will NOT be tolerated during their stay at CMC, and or behavior contract.
- **Behavior Care Plan**

- **RN Safety**
  - Contact security with concerns regarding patient or personal safety.
  - CMC's Patient Code of Conduct Policy is in development
- **Patient Safety**
  Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.

Resources (educational and community)

For information refer to the following sections in CMC's Treatment of Opioid Addicted Patients plan.
Education & Information
Resources for Families

2. Addicted patient (not in a treatment program)

Nursing Considerations

- Assess patient using Clinical Opiate Withdrawal Scale (COWS) tool
- Contact security with concerns regarding patient or personal safety. Refer to Security section for additional information.
- Designate which provider will be managing pain medication if pain management is involved. Clear guidelines so multiple MD's are not being called to change the narcotic orders.
- Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.
- Contact Nutrition services – only plastic ware on meal trays instead of metal silverware (spoons)
- Follow the Search Policy and the Visitation Policy when in question
- Provide consistency with managing the patient starting at the point of entry throughout their stay.
- Educate patient at the point of entry about visitation and behaviors that will NOT be tolerated during their stay at CMC, and or behavior contract.
- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion
- Consider room assignment near Nurses Station

Provider considerations

- Utilize an admission order set; add opioid withdrawal bundle
- Patients initiated on methadone or buprenorphine must be enrolled in an addiction recovery program at discharge or the medication must be tapered off before discharge
- Determine the stage or severity of opiate withdrawal using COWS score
- Consider clonidine for acute withdrawal for Clinical Opiate Withdrawal Scale (COWS) score greater than 12 indicating moderate withdrawal
- Patients who continue to score greater than 36 the COWS indicating severe withdrawal, after 24 hours on clonidine, consider use of methadone for patients on long acting opioids and those that require analgesia or buprenorphine for patients on short-acting opioids who do not require analgesia
- Ondansetron is not generally recommended for treatment of nausea due to prevalence of QT prolongation
- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion

Monitoring plan

- Monitor for signs/symptoms of withdrawal, refer to Signs and symptoms of withdrawal. Assess patient using Clinical Opiate Withdrawal Scale (COWS) tool
- Clonidine for acute withdrawal monitoring: Hold treatment for hypotension (SBP less than 90 mmHg or DBP less than 60 mmHg), Monitor for orthostatic hypotension sedation, dry mouth, and constipation

Lab orders

Urine tox screen (if not completed in ED), obtain sample prior to medication administration

Medications

☐ Clonidine for symptoms of acute withdrawal

- Clonidine is 0.1 mg one-time as a test dose (consider 0.2 mg for patients weighing over 90 kg)
  - Check blood pressure 1 hour after initial dose. If SBP less than 90 mmHg or DBP less than 60 mmHg, HR less than 60 or marked postural hypotension occurs, do not continue clonidine therapy
- If patient tolerates the clonidine test dose,
  - Clonidine 0.1 mg 4-day Taper for patients weighing 90 kg and less
    - Clonidine 0.1 mg orally every 6 hours x 7 doses
    - Clonidine 0.05 mg orally every 6 hours x 4 doses
    - Clonidine 0.025 mg orally every 6 hours x 4 doses
    - Check COWS score and BP before dose, hold for SBP <90 mmHg, DBP < 60 mmHg or HR

< 60 bpm

- Clonidine 0.2 mg 4-day Taper for patients weighing over 90 kg
  - Clonidine 0.2 mg orally every 6 hours x 3 doses
  - Clonidine 0.1 mg orally every 6 hours x 4 doses
  - Clonidine 0.05 mg orally every 6 hours x 4 doses
  - Clonidine 0.025 mg orally every 6 hours x 4 doses
  - Check COWS score BP before dose, hold for SBP <90 mmHg, DBP < 60 mmHg or HR < 60 bpm

☒ Naloxone 2 mg IV every 2 minutes PRN for cardiac arrest. After reversal, may need to readminister after 20-60 minutes depending on type/duration of opioid. If no response is observed after 10 mg total, consider other causes of respiratory depression.

Supportive Medications

☒ Acetaminophen 650 mg orally every 6 hours PRN myalgia, pain score 1-3. Use first.
☒ Lorazepam 4 mg IV push every 10 minutes x 4 doses PRN seizure. Use first.
☒ Dicyclomine 20 mg orally every 6 hours PRN abdominal cramping. Use first.
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☒ Loperamide 4 mg orally one-time then 2 mg orally PRN each loose stool (Max 16 mg in 24 hours) . Use first.
☒ Methocarbamol (Robaxin) 1000 mg orally every 6 hours PRN muscle spasms or twitching. Use first.
☒ Milk of magnesia 30 mL orally daily PRN constipation. Use first.
☒ Nicotine patch 21 mg/day transdermal daily Conditional order: for active smokers more than 10 cigarettes/day)
☒ Nicotine patch 14 mg/day transdermal daily Conditional order: for active smokers 10 or less cigarettes/day
☒ Promethazine 12.5 mg IV every 6 hours PRN Nausea/Vomiting. Use first if unable to take PO promethazine.
☒ Promethazine 25 mg orally every 6 hours PRN Nausea/Vomiting. Use first.
☒ Trazodone 50 mg orally daily at bedtime

Consults

☐ Case management referral
☐ Social work referral
☐ Consult pain management
☐ Consult infectious disease
☐ Consult psychiatry
☐ Pastoral care referral
☐ Consult cardiology NEHI

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- **Behavior Care Plan**
- **RN Safety**

- Contact security with concerns regarding patient or personal safety.
- CMC's Patient Code of Conduct Policy is in development

- **Patient Safety**
  Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.

Resources (educational and community)

For information refer to the following sections in CMC's Treatment of Opioid Addicted Patients plan.
Education & Information
Resources for Families

3. Addicted patient (in an Addiction Recovery Program)

Nursing Considerations

- Contact security with concerns regarding patient or personal safety. Refer to Security section for additional information.
- Contact Security to search belongings in the ED and remove ALL paraphernalia, lighters & cigarettes included.
- Designate which provider will be managing pain medication if pain management is involved. Clear guidelines so multiple MD's are not being called to change the narcotic orders.
- Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.
- Contact Nutrition services – only plastic ware on meal trays instead of metal silverware (spoons)
- Follow the Search Policy and the Visitation Policy when in question
- Provide consistency with managing the patient starting at the point of entry throughout their stay.
- Educate patient at the point of entry about visitation and behaviors that will NOT be tolerated during their stay at CMC, and or behavior contract.
- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion
- Consider room assignment near Nurses Station

Provider considerations

- Utilize an admission order set; add substance use recovery bundle
- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion

Monitoring plan

If necessary, monitor for signs/symptoms of withdrawal, refer to Signs and symptoms of withdrawal. Assess patient using Clinical Opiate Withdrawal Scale (COWS) tool

Lab orders

Urine tox screen (on admission), obtain sample prior to medication administration

Medications

Maintenance medication at home dose/frequency (to be verified with ARP)
Refer to Treating Patients in Recovery information below for options for non-opiate analgesics

Supportive Medications

☒ Acetaminophen 650 mg orally every 6 hours PRN myalgia, pain score 1-3. Use first.
☒ Ibuprofen 600 mg orally every 6 hours PRN pain score 4-10. Use first.
☒ Milk of magnesia 30 mL orally daily PRN constipation. Use first
☒ Nicotine patch 21 mg/day transdermal daily Conditional order: for active smokers more than 10 cigarettes/day)
☒ Nicotine patch 14 mg/day transdermal daily Conditional order: for active smokers 10 or less cigarettes/day
☒ Promethazine 25 mg orally every 6 hours PRN Nausea/Vomiting. Use first.
☒ Trazodone 50 mg orally daily at bedtime

Consults

☐ Case management referral
☐ Social work referral
☐ Consult pain management for increased analgesic requirement beyond treatment program
☐ Consult infectious disease
☐ Consult psychiatry
☐ Pastoral care referral
☐ Consult cardiology NEHI

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- **Behavior Care Plan**
- **RN Safety**
  - Contact security with concerns regarding patient or personal safety.
  - CMC's Patient Code of Conduct Policy is in development
- **Patient Safety**
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Resources (educational and community)

For information refer to the following sections in CMC's Treatment of Opioid Addicted Patients plan.
Education & Information
Resources for Families

4. Chronic Pain Patient on Opioids

Nursing Considerations

- Assess patient using Clinical Opiate Withdrawal Scale (COWS) tool every shift
- Consider using COMM (Curran Opioid Misuse Measure) for addiction risk
- Contact security with concerns regarding patient or personal safety. Refer to Security section for additional information.
- Designate which provider will be managing pain medication if pain management is involved. Clear guidelines so multiple MD's are not being called to change the narcotic orders.
- Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.
- Follow the Search Policy and the Visitation Policy when in question
- Provide consistency with managing the patient starting at the point of entry throughout their stay.

Provider considerations

Verify with home pharmacy last medication fill date and amount of narcotic dispensed.
Check PDMP database for history of medication
Ensure that the Primary Pain provider is added to Sunrise
Consider pain consult
Consider opioid hyperalgesia

Monitoring plan

Vital signs every 4 hours with medication dose x 24 hours
If necessary, monitor for signs/symptoms of withdrawal, refer to Signs and symptoms of withdrawal. Assess patient using Clinical Opiate Withdrawal Scale (COWS) tool

Lab orders

Urine toxicology using Pain panel #1 with reflex (on admission), obtain sample prior to medication administration

Medications

Continue home analgesic regimen
Provider to contact Primary Pain provider to jointly discuss Pain management plan inpatient

Supportive Medications

☒ Acetaminophen 650 mg orally every 6 hours PRN myalgia, pain score 1-3. Use first.
☒ Ibuprofen 600 mg orally every 6 hours PRN pain score 4-10.Use first.
☒ Milk of magnesia 30 mL orally daily PRN constipation. Use first.
☒ Nicotine patch 21 mg/day transdermal daily Conditional order: for active smokers more than 10 cigarettes/day)
☒ Nicotine patch 14 mg/day transdermal daily Conditional order: for active smokers 10 or less cigarettes/day
☒ Promethazine 25 mg orally every 6 hours PRN Nausea/Vomiting. Use first.
☒ Trazodone 50 mg orally daily at bedtime

Consults

☐ Case management referral
☐ Social work referral
☐ Consult pain management for increased analgesic requirement beyond current regimen program
☐ Consult infectious disease
☐ Consult psychiatry
☐ Pastoral care referral
☐ Consult cardiology NEHI

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- **Behavior Care Plan**
- **RN Safety**
  - Contact security with concerns regarding patient or personal safety.
  - CMC's Patient Code of Conduct Policy is in development
- **Patient Safety**
  Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.

Resources (educational and community)

For information refer to the following sections in CMC's Treatment of Opioid Addicted Patients plan.
Education & Information
Resources for Families

5. Education & Information

a. Signs and symptoms of withdrawal[7, 23]

Onset of withdrawal signs and symptoms:

- 4 to 12 hours after the last dose of a short-acting opioid
- 24 to 48 hours after cessation of methadone
- Symptoms persist for several days with short-acting agents and for up to several weeks with methadone

Withdrawal onset	Clinical findings
Early 4 to 12 hours after last use	Craving, anxiety, agitation, diaphoresis
Mid-Late 8 to 24 hours after last use	Insomnia, restlessness, lacrimation, rhinorrhea, diaphoresis, mydriasis, yawning,
Late Up to 3 days after last use	Vomiting, diarrhea, chills, muscle spasms, tremor, tachycardia, piloerection
Protracted Up to 6 months after last use	Sleep disturbance, drug craving anhedonia, emotional lability, altered sexual function

Opioid withdrawal signs and symptoms:

- **Vital Signs**
  - Blood pressure increased or unchanged
  - Hypotension (if due to volume depletion from vomiting and diarrhea)
  - Heart rate increased or unchanged
  - Respiratory rate increased or unchanged
  - Temperature unchanged
- **Gastrointestinal**
  - Nausea, vomiting
  - Diarrhea, increased bowel sounds
- **Neurological**
  - Mental status usually normal, irritable
  - Restlessness
  - Seizures (neonates primarily)
  - Tremor
  - Yawning
- **Ophthalmologic**
  - Lacrimation
  - Mydriasis
- **Skin**
  - Piloerection

Patients experiencing opioid withdrawal may complain of the following:

- Dysphoria and restlessness
- Rhinorrhea and lacrimation
- Myalgias and arthralgias
- Nausea, vomiting, abdominal cramping, and diarrhea

Assessment of Withdrawal Severity based on Signs and Symptoms:
The Clinical Opiate Withdrawal Scale (COWS)[15] is an 11-item scale designed to be administered by a clinician. This tool may be utilized to rate and monitor signs and symptoms of opiate withdrawal over time. Clinicians may use the COWS score to determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids

CMC Clinical Opiate Withdrawal Scale

Opioid Pharmacodynamics/Pharmacokinetics:[6]
Data based on therapeutic doses (except where noted). Parameters may change in overdose

Medication	Protein binding	Metabolism	Half-life	Excretion
Buprenorphine	High	Primarily hepatic; extensive first-pass effect	2.2-3 hours	Feces (70%); urine (20% as unchanged drug)
Butorphanol	80%	Hepatic	2.5-4 hours	Primarily urine
Codeine	7%	Prodrug; undergoes hepatic biotransformation to morphine (active) and norcodeine (inactive)	2.5-3.5 hours	Urine (3-16% unchanged drug, norcodeine, and free and conjugated morphine)
Fentanyl	79-87%	Hepatic, primarily via CYP3A4	**IV:** 2-4 hours **Patch:** 20-27 hours **Transmucosal:** 3-14 hours	Urine 75% (primarily as metabolites, <7% to 10% as unchanged drug); feces ~9%
Heroin	40%	Rapidly metabolized by pseudocholinesterase and hepatic carboxylesterase to 6-monoacetylmorphine (more potent than morphine) and morphine (active). Morphine is further metabolized.	3-20 minutes	Urine (as morphine glucuronides)
Hydrocodone	36%	Hepatic	**Immediate release:** 3.3-4.4 hours **Extended release:** 7-9 hours	Urine (~12% unchanged, 5% as norhydrocodone, 4% as conjugated hydrocodone)
Hydromorphone	~8% to 19%	Hepatic via glucuronidation to inactive metabolites	**Immediate release:** 2-3 hours **Extended release:** ~11 hours	
Methadone	85-90%	Hepatic; N-demethylation primarily via CYP3A4, CYP2B6, and CYP2C19 to inactive metabolites	8-59 hours	Urine (<10% as unchanged drug)
Morphine	20-35%	Hepatic via conjugation with glucuronic acid to morphine-3-glucuronide (inactive), morphine-6-glucuronide (active) and other active and inactive metabolites	**Immediate release:** 2-4 hours **Extended release (Kadian):** 11 to 13 hours **Extended release (Avinza):** 24 hours	Urine (primarily as morphine-3-glucuronide, ~2-12% unchanged); feces (~7-10%)

b. Signs and symptoms of overdose[5, 6, 45]

Mechanism of Toxicity

- Opioids bind to opioid receptors in the CNS and produce generalized CNS depression and excitation of the parasympathetic nervous system resulting in bradycardia, hypotension, and pupil constriction.
- Opioid-induced respiratory depression occurs primarily by inhibiting mu receptors in the medulla. Hypotension may be mediated by histamine release.
- Methadone may prolong QTc by interfering with potassium channels.
- Opioids with significant serotonergic activity (meperidine, tramadol) have been associated with the development of serotonin syndrome.

Symptoms Listed by System	
Cardiovascular	Bradycardia, cardiac arrest (severe poisoning), decreased myocardial contractility (high-dose meperidine), dysrhythmias, flushing, hypertension (tramadol), hypotension, orthostatic hypotension, QTc prolongation (methadone), tachycardia (tramadol, tapentadol), torsades de pointes (loperamide)
Central nervous system	Agitation (tramadol), apathy, central nervous system stimulation (normeperidine), coma, confusion, delirium (normeperidine), depression, dizziness, drowsiness, euphoria, headache, hypothermia, lethargy, nonketotic hyperglycemic (methadone), psychosis, seizures (meperidine, tramadol), somnolence, stupor
Dermatologic	Cold, clammy skin; pruritus; urticaria
Endocrine & metabolic	Hyperglycemia (severe poisoning; methadone), hypothermia, serotonin syndrome (meperidine, tramadol)
Gastrointestinal	Constipation, decreased motility with ileus, nausea, vomiting
Genitourinary	Urinary retention
Hematologic	Thrombotic thrombocytopenic purpura (following IV abuse of oral oxymorphone)
Neuromuscular & skeletal	Muscular rigidity, muscle weakness, myoclonus (normeperidine), tremor (normeperidine)
Ocular	Miosis (less pronounced with meperidine), mydriasis (diphenoxylate/atropine)
Respiratory	Anaphylaxis (rare), apnea (severe poisoning), bronchospasm, cyanosis, pulmonary edema (noncardiogenic may occur with heroin or methadone), respiratory depression
Miscellaneous	Soft tissue injury (includes abscess, gangrene, large-scaled necrosis, thrombophlebitis, thrombosis)

Opioid intoxication physical findings: conscious, sedated, drowsy, slurred speech, "nodding" or intermittently dozing, memory impairment, pupillary constriction

Opioid overdose physical findings: unconscious, pinpoint pupils, slow, shallow respirations (respirations below 10 per minute)

Toxidrome	Agents	Mental Status	Eyes	Vital Signs	Other Manifestations
Anticholinergic	Antihistamines Antiparkinsonian agents Antispasmodics Atropine Belladonnas Cyclobenzaprine Diphenhydramine Promethazine Scopolamine TCAs	Agitation Coma Delirium Hallucinations Hyper-vigilance Mumbling speech	Mydriasis	Hypertension Hyperthermia Tachycardia Tachypnea	Decreased bowel sounds Dry mucous membranes Dry skin Flushed skin Myoclonus Picking behavior Seizures (rare) Urinary retention
Cholinergic	Bethanechol Donepezil (Aricept) Insecticides Nerve agents Nicotine Organophosphates Pilocarpine (ophthalmic)	Confusion Coma Lethargy Seizures	Miosis	Bradypnea or tachypnea Bradycardia Hypotension or hypertension	Bronchospasm *"SLUDGE"* **S**alivation **L**acrimation **U**rination **D**efecation/diarrhea **G**I distress **E**mesis
Hallucinogenic	DOM or STP Ecstasy (MDMA) Ketamine LSD MDA "Sally" "Sass" Mescaline Molly Phencyclidine (PCP) Psilocybin "psychedelic mushrooms"	Agitation Depersonalization Disassociation Distortions Hallucinations Perceptual distortions Synesthesia	Usually mydriasis Nystagmus	Tachypnea Tachycardia Hypertension Hyperthermia	Anger Disorientation Erratic behavior Impulsivity Increased sensuality Panic Paranoia Violence
	Ecstasy (MDMA)	Hyperactivity Hyperverbal Increased tactile and visual sensations		Cardiac arrhythmia Renal failure	Coma has been reported Dehydration Hyperthermia Water intoxication with low sodium rhabdomyolysis
Opioid	Fentanyl Heroin Hydromorphone Methadone Morphine Opioids	CNS Depression Coma	Miosis	Bradypnea Apnea Bradycardia Hypotension Hypothermia	Abscesses Acidosis Hyporeflexia Malnourished Pulmonary edema Track marks
Sedative/ Hypnotic	Alcohols Barbiturates Benzodiazepines Muscle relaxants Zolpidem	CNS depression Coma Confusion Stupor	Usually miosis	Apnea Bradycardia Bradypnea Hypotension Hypothermia	Agitation Combativeness Hyporeflexia Lethargy Somnolence

Toxidrome	Agents	Mental Status	Eyes	Vital Signs	Other Manifestations
Serotonin syndrome	Dextromethorphan (DXM) L-Tryptophan MAOIs Meperidine SSRIs TCAs	Confusion Agitation Coma	Mydriasis	Hypertension Hyperthermia Tachycardia Tachypnea	Diaphoresis Diarrhea Flushing Hyperreflexia Myoclonus Rigidity Tremor Trismus
Sympathomimetic	Amphetamines Caffeine Cathinones, Cocaine Ephedrine Methamphetamine Pseudoephedrine Synthetic cathinones ("bath salts") Theophylline	Agitation Anxiety Depression Drug craving Fatigue Hallucinations Hyper alert Hypersomnia or insomnia Paranoia Poor concentration Psychomotor retardation	Mydriasis (dilation)	Hypertension Hyperthermia Tachycardia Tachypnea Widened pulse pressure	Diaphoresis Hyperreflexia Seizures Tremors
	Marijuana Synthetic marijuana (K2, Spice)	Aggression Agitation Anxiety Blank stare Combativeness Hallucinations Paranoia Psychosis	Mydriasis Nystagmus Reddening	Bradycardia Hypotension Tachycardia Tachypnea	Ataxia Dystonia Inability to speak Short term memory loss
	Quetiapine	Agitation/ confusion Lethargy Slurred speech Drowsiness	Mydriasis (possible)	QTc prolongation	Anticholinergic effects possible: Decreased bowel sounds Dry mucous membranes Dry skin Urinary retention
Thank you to [redacted] for development of this table					

c. Frequently Abused Combinations and Common Reasons for Use[17]

Combination	Reasons
Heroin PLUS alcohol	Enhance a high; create euphoria or sedation
Heroin followed by alcohol	Medicate opioid withdrawal; medicate cocaine overstimulation (e.g., anxiety, paranoia)
Heroin PLUS cocaine ("speedball")	Enhance or alter cocaine euphoria
Heroin followed by cocaine	Medicate opioid withdrawal
Cocaine PLUS alcohol	Enhance high; reduce cocaine overstimulation (e.g., anxiety, paranoia)
Cocaine followed by heroin	Reduce cocaine overstimulation (e.g., anxiety, paranoia); modulate the cocaine "crash"
Methadone PLUS alcohol	Create a high; sedate
Methadone PLUS cocaine	Reduce cocaine overstimulation (e.g., anxiety, paranoia); moderate the cocaine "crash"
Methadone PLUS benzodiazepines	Create a high; sedate
Any opioid PLUS any nonbenzodiazepine sedative	Create a high; sedate
Any opioid followed by any nonbenzodiazepine sedative	Medicate opioid withdrawal
Any opioid PLUS amphetamine	Create a high

d. Physical Findings Suggestive of Addiction or its Complications[20]

System	Physical Finding/Complication
General	Odor of alcohol on breath, odor of marijuana on clothing, odor of nicotine or smoke on breath or clothing, poor nutritional status, poor personal hygiene
Neurologic	Sensory impairment, memory impairment, motor impairment, ophthalmoplegia, myopathy, neuropathy, tremor, cognitive deficits, ataxia, pupillary dilation or constriction
Behavior	Intoxicated behavior during exam, slurred speech, staggering gait, scratching
Head, Eyes, Ears, Nose, Throat (HEENT)	Conjunctival irritation or injection, inflamed nasal mucosa, perforated nasal septum, blanched nasal septum, sinus tenderness, gum disease, gingivitis, gingival ulceration, rhinitis, sinusitis, pale mucosa, burns in oral cavity
Cardiovascular	hypertension, tachycardia, cardiac arrhythmia, heart murmurs, clicks, edema, swelling
Pulmonary	Wheezing, rales, rhonchi, cough, respiratory depression
Gastrointestinal	Hepatomegaly, liver tenderness, positive stool hemoccult
Immune	Lymphadenopathy
Female reproductive/endocrine	Pelvic tenderness, vaginal discharge
Male reproductive/endocrine	Testicular atrophy, penile discharge, gynecomastia
Skin	Signs of physical injury, bruises, lacerations, scratches, burns, needle marks, skin abscesses, cellulitis, jaundice, palmar erythema, hair loss, diaphoresis, rash, puffy hands

Definition of Terms[27]

Misuse:

- Use of a medication (for a medical purpose) other than as directed or as indicated, whether willful or unintentional, and whether harm results or not

Abuse:

- Any use of an illegal drug.
- The intentional self-administration of a medication for a non-medical purpose such as altering one's state of consciousness (e.g. getting high)

Diversion:

- The intentional removal of a medication from legitimate and dispensing channels

Addiction:

- A primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestations.
- Behavioral characteristics include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, craving

Pseudoaddiction:

- Syndrome of abnormal behavior resulting from undertreatment of pain that is misidentified by the clinician as inappropriate drug-seeking behavior.
- Behavior ceases when adequate pain relief is provided.
- Not a diagnosis; rather a description of the clinical intention

e. Drug-drug interactions[13]

Most opioids are metabolized via CYP-mediated oxidation and have substantial drug interaction potential.

TABLE 1. **Metabolic Pathway/Enzyme Involvement**

Opioid	Phase 1 metabolism	Phase 2 metabolism	Comment
Morphine[12]	None	Glucuronidation via UGT2B7	
Codeine[13]	CYP2D6	None	
Hydrocodone[14]	CYP2D6	None	One of the metabolites of hydrocodone is hydromorphone, which undergoes phase 2 glucuronidation
Oxycodone[11]	CYP3A4 CYP2D6	None	Oxycodone produces a small amount of oxymorphone, which must undergo subsequent metabolism via glucuronidation
Methadone[15]	CYP3A4 CYP2B6 CYP2C8 CYP2C19 CYP2D6 CYP2C9	None	CYP3A4 and CYP2B6 are the primary enzymes involved in methadone metabolism; other enzymes play a relatively minor role
Tramadol[16]	CYP3A4 CYP2D6	None	
Fentanyl[10]	CYP3A4	None	
Hydromorphone[17]	None	Glucuronidation via UGT2B7	
Oxymorphone[18]	None	Glucuronidation via UGT2B7	

CYP = cytochrome P450; UGT2B7 = uridine diphosphate glucuronosyltransferase 2B7.

Enzyme inhibitors decrease buprenorphine and methadone metabolism (↑ effect)

- Antiretrovirals: delavirdine, indinavir, nelfinavir, ritonavir, saquinavir
- Azole antifungals: fluconazole, itraconazole, ketoconazole, miconazole
- Macrolides: clarithromycin, erythromycin
- SSRIs: Fluoxetine, fluvoxamine, paroxetine, sertraline
- Amiodarone, grapefruit juice, metronidazole, nefazadone, nicardipine, norfloxacin, omeprazole, verapamil, zafirlukast, zileuton

Enzyme inducers increase buprenorphine and methadone metabolism (↓ effect)

- Monitor for signs and symptoms of opioid withdrawal
- Atazanavir, carbamazepine, dexamethasone, efavirenz, ethosuximide, nevirapine, phenobarbital, phenytoin, primadone, rifampin

TABLE 2. **Cytochrome P450 3A4 Substrates, Inhibitors, and Inducers**

Substrates			Inhibitors			Inducers
CCBs	*Other psychiatric drugs*	*Antiretroviral agents*	*CCBs*	*Antibiotics*	*Chemotherapeutic agents*	*Statins*
Amlodipine	Aripiprazole	Indinavir	Amlodipine	Ciprofloxacin	4-Ipomeanol	Atorvastatin
Diltiazem	Bromocriptine	Lopinavir	Diltiazem	Clarithromycin	Imatinib	Fluvastatin
Felodipine	Buspirone	Nelfinavir	Felodipine	Erythromycin	Irinotecan	Lovastatin
Nicardipine	Carbamazepine	Nevirapine	Nicardipine	Josamycin	Tamoxifen	Simvastatin
Nifedipine	Donepezil	Ritonavir	Nifedipine	Norfloxacin	*Hormonal therapies*	*Antiretroviral agents*
Verapamil	Haloperidol	Saquinavir	Verapamil	Oleandomycin	Ethinyl estradiol	Efavirenz
Statins	Mirtazapine	Tipranavir	*Statin*	Roxithromycin	Levonorgestrel	Lopinavir
Atorvastatin	Nefazodone	*Chemotherapeutic agents*	Simvastatin	Telithromycin	Raloxifene	Nevirapine
Lovastatin	Pimozide	Cyclophosphamide	*Antiarrhythmic agents*	*Azole antifungal agents*	*Other drugs*	*Hypnotic agent*
Simvastatin	Reboxetine	Docetaxel	Amiodarone	Clotrimazole	Cimetidine	Pentobarbital
Other cardiovascular agents	Risperidone	Doxorubicin	Quinidine	Fluconazole	Disulfiram	*Anticonvulsant agents*
Amiodarone	Valproate	Etoposide	*Phosphodiesterase inhibitor*	Itraconazole	Methylprednisolone	Carbamazepine
Digoxin	Venlafaxine	Gefitinib	Tadalafil	Ketoconazole	Phenelzine	Oxcarbazepine
Ivabradine	Ziprasidone	Ifosfamide	*Psychiatric drugs*	Miconazole	*Foods*	Phenobarbital
Quinidine	*Sleep aids*	Paclitaxel	Bromocriptine	Voriconazole	Bergamottin (grapefruit juice)	Phenytoin
Warfarin	Zolpidem	Tamoxifen	Clonazepam	*Antiretroviral agents*	Star fruit	Primidone
Phosphodiesterase inhibitors	Zopiclone	Teniposide	Desipramine	Amprenavir		Valproic acid
Sildenafil	*Antibiotics*	Vinblastine	Fluoxetine	Atazanavir		*Food*
Tadalafil	Azithromycin	Vindesine	Fluvoxamine	Delavirdine		Cafestol (caffeine)
Benzodiazepines	Clarithromycin	*Hormonal therapies*	Haloperidol	Efavirenz		
Alprazolam	Erythromycin	Estradiol	Nefazodone	Indinavir		
Clonazepam	Oleandomycin	Ethinyl estradiol	Norclomipramine	Lopinavir		
Flunitrazepam	*Azole antifungal agents*	Levonorgestrel	Nortriptyline	Ritonavir		
Midazolam	Itraconazole	Raloxifene	Sertraline	Nelfinavir		
Triazolam	Ketoconazole	Testosterone		Nevirapine		
SSRIs				Saquinavir		
Citalopram				Tipranavir		
Fluoxetine						

CCB = calcium channel blocker; SSRI = selective serotonin reuptake inhibitor.
From *Ther Drug Monit*,[24] with permission.

Strategies to Prevent or Minimize Harmful Drug Interactions[22]

1. Obtain a thorough drug and medication history, including results of drug and other laboratory tests
2. When adding any drugs to a therapeutic regimen, start with low doses, increase slowly, and monitor patient reactions closely
3. Educate patient about the risks of drug interactions, potentially lethal drugs or medications during agonist-based pharmacotherapy, possible cardiovascular risks, and possible effects of deviating from dosage schedules and amounts
4. Substitute alternative medications that do not interact with opioid treatment medications or have the least potential for interaction
5. Consider whether administering other medications with or without food or altering dosing schedules might reduce the risk of drug interactions
6. Simplify the medication regimen to make it easier for patient to adhere to it
7. Adjust opioid medication dosage based on patient response to avoid drug interaction, but be vigilant for signs of withdrawal or sedation
8. Increase drug testing and monitoring of drug serum levels. Advise patient of the physical signs of adverse interactions, and explain what to do if these occur.
9. Be aware of concomitant diseases (e.g., liver disease) that might influence the potential for adverse drug interactions

[redacted]

f. Prescription Drug Monitoring Program (PDMP)

New Hampshire's Prescription Drug Monitoring program is an electronic system that facilitates the confidential sharing of information relating to the prescribing and dispensing of schedule II-IV controlled substances by providers and pharmacists (RSA 318-B:31-38).

The New Hampshire Prescription Drug Monitoring Program grants system access accounts to practitioners and pharmacists so that they may look up controlled substance dispensing information on their specific patients to identify drug interactions, drug-seeking behaviors or "doctor shopping."

The goal of NH's PDMP is to provide New Hampshire licensed prescribers and dispensers a valuable tool to improve clinical decision making and patient care in managing their health and prescriptions, to promote public health and safety through the prevention and treatment for misuse and abuse of controlled substances and to assist in the reduction of the diversion of controlled substances.

Recipient Query: This function is used by practitioners and pharmacists to create queries that can be used to report information about recipient usage of controlled substances.

Prescriber History Query: This function allows you to view an audit trail of all queries performed using your user ID, including queries performed by your delegates on your behalf, for a specified time frame.

Prescriber DEA Query: This function allows you to use your prescriber DEA number to view your prescribing history for a specified time frame.

Homepage: https://nhpdmp-ph.hidinc.com/nhlogappl/bdnhpdmqlog/pmqhome.html
Registration: http://www.nh.gov/pharmacy/prescription-monitoring/documents/pdmp_registration_info.pdf
Training guide: https://nhpdmp-ph.hidinc.com/NH_PDMP_Practitioners_Training_Guide.pdf

If you have any non-technical questions regarding the New Hampshire Controlled Drug Prescription Health and Safety Program please contact:

[redacted]

121 South Fruit Street
Concord, NH 03301-2412
Phone: 603-271-6980
Fax: 603-271-2856

[redacted]

[redacted]

g. Consent to Release of Information

The privacy and confidentiality of individually identifiable drug or alcohol treatment information is protected by SAMHSA confidentiality regulation Title 42, Part 2 of the Code of Federal Regulations (42 C.F.R. Part 2).

This regulation requires that healthcare professionals providing opioid addiction treatment obtain signed patient consent before disclosing individually identifiable addiction treatment information to any third party.

Use the attached form for Release/Request of Protected Health Information (differs from the standard CMC release form)

Authorization to
Release or Request P

The patient initials must initial the “drug or alcohol” line under sensitive information.
In the section “Authorization To,” check “Request Patient Information from” box then include the specific addiction recovery program’s (ARP) information
After completed, have the patient sign this form and fax to the ARP to request the information.
You can add instructions in the blank box for where to send the information (if applicable)

h. Medication Assisted Treatment (MAT)[3]

Three medications have received FDA-approval for treating opioid use disorders:

Methadone
Methadone prevents opioid withdrawal symptoms and reduces craving by centrally activating opioid receptors. Methadone maintenance has been shown to eliminate withdrawal symptoms of heroin and other opioids. Methadone can be dispensed only at an outpatient opioid treatment program (OTP) certified by SAMHSA and registered with the Drug Enforcement Administration (DEA) or to a hospitalized patient (refer to Methadone Safe Use policy in Policy Stat).
Available on formulary at CMC

Buprenorphine
Buprenorphine reduces or eliminates opioid withdrawal symptoms, including drug cravings, without producing the euphoria or dangerous side effects of heroin and other opioids by both activating and antagonizing opioid receptors in the brain. It is available for sublingual (under-the-tongue) administration both in a stand-alone formulation and in combination with another agent called naloxone. In the outpatient setting, the buprenorphine/naloxone combination is recommended to deter diversion or abuse of the medication by causing a withdrawal reaction if it is intravenously injected by individuals physically dependent on opioids.

Outpatient physicians with special certification may provide office-based buprenorphine treatment for detoxification and/or maintenance therapy. Refer to Buprenorphine Safe Use policy in Policy Stat for information regarding inpatient use at CMC.
Available on formulary at CMC

Naltrexone (Vivitrol, ReVia)
Naltrexone is FDA approved for the prevention of relapse in adult patients following complete detoxification from opioids. It acts as a competitive antagonist at opioid receptor sites, showing the highest affinity for mu receptors. Receptor antagonism blocks the opioid euphoria and withdrawal if recent opioid use has occurred. Naltrexone is available as a daily oral tablet or a monthly IM injection.

The half-life of naltrexone oral tablets is dose dependent and ranges from 24 hours for the 50 mg dose to 72 hours for the 150 mg dose. The effect of naltrexone extended release IM injection is approximately 4 weeks. When reversal of naltrexone is necessary in emergency situations, suggestions for pain management include regional analgesia or use of non-opioid analgesics. Refer to the Vivitrol Prescribing Information for additional information.

If opioid therapy is required to reverse the naltrexone blockade, patients should be continuously monitored in an anesthesia care setting by staff not involved in the conduct of the surgical or diagnostic procedure. The manufacturer recommends that opioid therapy be provided by individuals specifically trained in the use of anesthetic drugs and management of the respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation. The patient should be closely monitored by appropriately trained staff in a setting equipped and staffed for cardiopulmonary resuscitation
Non-formulary at CMC

i. Methadone[7, 17, 20, 23]

http://dpt.samhsa.gov/medications/methadone.aspx

Opioid agonist therapy[7]

- Withdrawal precipitated by an interruption in opioid use can be managed with either opioids or with non-opioid adjuncts.
- Iatrogenic withdrawal (due to naloxone or naltrexone) should be managed with adjunctive medications, not opioids.
- For patients who continue to score greater than 36 the COWS indicating severe withdrawal, after 24 hours on clonidine, consider use of methadone for management of acute withdrawal for patients on long acting opioids and those that require analgesia or buprenorphine for patients on short-acting opioids who do not require analgesia
- Consider methadone for management of acute withdrawal signs and symptoms refractory to adjunctive therapy and clonidine. Methadone is associated with a prolonged QT interval.
- Consider avoidance of full daily methadone maintenance dose for unfamiliar patients who have missed even a single dose. Some patients intentionally take reduced doses in order to save a portion, so their prescribed dose may be sold or abused.

Methadone for acute withdrawal

- Oral dose of 5 - 20 mg relieves acute withdrawal symptoms without producing intoxication
  - Use table below to determine initial dose based on patient presentation
  - For persistent signs/symptoms in 4-8 hours, administer an additional 5 to 10 mg one-time (limit 30 mg/day)
- Calculate the total methadone dose/24 hours and administer that dose on day #2
  - Daily doses of 30 or less are usually sufficient
  - Note: Methadone-related deaths have occurred almost exclusively at doses in excess of 30 mg/day
- Administer methadone can be given once daily then taper over 3 to 5 days in 5 to 10mg
- daily reductions (taper methadone dose by approximately 10 mg each day and by 5 mg on the final day)
- Considerations:
  - Higher methadone doses are utilized by outpatient maintenance programs in order to effectively block the euphoric effects of exogenous opioids
  - Remember , if the patient will NOT be transferred to a methadone maintenance program, methadone must be discontinued prior to discharge

Withdrawal Assessment using Narcotic Withdrawal Scale for Initial Methadone Dose[20]

Grade	Physical Findings	Initial Dose of Methadone
1	Diaphoresis, Insomnia, Lacrimation and/or rhinorrhea, Restlessness, Yawning	5 mg
2	Abdominal pain, Arthralgias, Dilated pupils, Muscle twitching and/or myalgia, Piloerection	10 mg
3	Anorexia or nausea, Extreme restlessness, Fever, Hypertension, Tachycardia, Tachypnea	15 mg
4	Curled-up position, Dehydration, Diarrhea and/or vomiting, Hyperglycemia, Hypotension	20 mg

Fultz and Senay (1975); (Table 1 page 816) used a grading scheme for hospitalized patients undergoing opiate withdrawal to determine initial methadone therapy as described above

j. Buprenorphine[17-20, 22, 23]

http://buprenorphine.samhsa.gov/

Pharmacology:
Buprenorphine exerts its analgesic effect via high affinity binding to mu-opiate receptors in the CNS; displays partial mu agonist and weak kappa antagonist activity. Due to it being a partial mu agonist, its analgesic effects plateau at higher doses and it then behaves like an antagonist.

Buprenorphine is an opioid partial agonist and can produce typical opioid agonist effects and side effects such as euphoria and respiratory depression, its maximal effects are less than those of full agonists like heroin and methadone. At low doses buprenorphine produces sufficient agonist effect to enable opioid-addicted individuals to discontinue the misuse of opioids without experiencing withdrawal symptoms. The agonist effects of buprenorphine increase linearly with increasing doses of the drug until at moderate doses they reach a plateau and no longer continue to increase with further increases in dose—the "ceiling effect." Thus, buprenorphine carries a lower risk of abuse, addiction, and side effects compared to full opioid agonists. In fact, in high doses and under certain circumstances, buprenorphine can actually block the effects of full opioid agonists and can precipitate withdrawal symptoms if administered to an opioid-addicted individual while a full agonist is in the bloodstream.

Under certain circumstances buprenorphine by itself can also precipitate withdrawal in opioid-addicted individuals. This is more likely to occur with higher levels of physical addiction, with short time intervals (e.g., less than 2 hours) between a dose of opioid agonist (e.g., methadone) and a dose of buprenorphine and with higher doses of buprenorphine.

For patients who continue to score greater than 36 on the COWS indicating severe withdrawal, after 24 hours on clonidine, consider use of methadone for patients on long acting opioids and those that require analgesia or buprenorphine for patients on short-acting opioids who do not require analgesia

Treatment Taper[18, 20, 23]:
Consider buprenorphine taper for patients addicted to short-acting opioids who will not be enrolled in a treatment program after discharge:
Those scoring greater than a 36 and have a positive Opioid drug screen who are not on chronic benzodiazepine therapy or sedative hypnotics may be treated with buprenorphine if clinically appropriate. Assess patients before each dose using the Clinical Opiate Withdrawal Scale (COWS).

Day 1: Buprenorphine 4 mg sublingual Daily x 1 dose
Buprenorphine 4 MG SL at bedtime PRN Clinical opiate withdrawal score ≥ 12
Day 2: Buprenorphine 4 mg sublingual Daily x 1 dose
Buprenorphine 2 MG SL at bedtime PRN Clinical Opiate withdrawal score ≥ 12
Day 3: Buprenorphine 2 mg sublingual Daily x 1 dose
Buprenorphine 2 MG SL at bedtime PRN Clinical Opiate withdrawal score ≥ 12
Day 4: Buprenorphine 2 mg sublingual Daily x 1 dose

At discharge patients will be provided with a list of physicians for continued outpatient treatment with Suboxone if necessary. The following induction and stabilization dosing is recommended for Medication Assisted Treatment with buprenorphine.

Off-label dosing recommendations (U.S. Department of Health and Human Services, 2004): Doses provided based on buprenorphine content.

- **Induction** (only administer combination product for induction in patients who are dependent on short-acting opioids and whose last dose of opioids was >12-24 hours prior to induction):
    - Day 1 induction dose: Initial: 4 mg; may repeat 4 mg dose after 2 or more hours if withdrawal symptoms not relieved; maximum daily dose on day 1: 8 mg daily
    - If withdrawal symptoms are still not relieved after a total of 8 mg of buprenorphine on Day 1, symptomatic relief with nonopioid medications should be provided
    - Day 2 induction dose: Previous dose from day 1 if no withdrawal symptoms present; if symptoms of withdrawal present, increase day 1 dose by 4 mg. If withdrawal symptoms not relieved after >2 hours, may administer 4 mg; maximum daily dose on day 2: 16 mg daily
    - Subsequent induction days: If withdrawal symptoms are not present, daily dose is established. If withdrawal symptoms are present, increase dose in increments of 2 mg or 4 mg each day as needed for symptom relief. Target daily dose by the end of the first week: 12 mg or 16 mg daily; maximum daily dose: 32 mg daily
- **Stabilization:** Usual dose: 16-24 mg daily; maximum dose: 32 mg daily

Because of its opioid agonist effects, buprenorphine is abusable, particularly by individuals who are not physically addicted to opioids. Naloxone is added to buprenorphine to decrease the likelihood of diversion and abuse of the combination product.

Adverse Effects:

- Cardiovascular: Vasodilatation (9%)
- CNS: Headache (30-36%), insomnia (21-25%), pain (24%), withdrawal syndrome (18-25%; placebo 37%), anxiety (12%), depression (11%); chills (6%), nervousness (6%), drowsiness (5%), dizziness (4%)
- Dermatologic: Diaphoresis (12-14%)
- Gastrointestinal: Nausea (10-14%), abdominal pain (12%), constipation (8-11%); Vomiting (5% to 8%)
- Infection: Infection (12% to 20%); Abscess (2%)
- Neuromuscular/Skeletal: Back pain (14%), weakness (14%)
- Respiratory: Rhinitis (11%); Flu-like symptoms (6%), cough (4%), pharyngitis (4%)

Autosubstitution for patients whose own supply is unavailable for inpatient use according to the dose equivalency table below:

Buprenorphine Dose	Buprenorphine/ naloxone (Suboxone®) sublingual tablet	Buprenorphine/ naloxone (Suboxone®) sublingual film	Buprenorphine/ naloxone (Zubsolv) sublingual tablets	Buprenorphine/ naloxone (Bunavail) sublingual film
2 mg	2 mg/0.5 mg	2 mg/0.5 mg	1.4 mg/0.36 mg	
4 mg		4 mg/1 mg		2.1 mg/0.3 mg
8 mg	8 mg/2 mg	8 mg/2 mg	5.7 mg/1.4 mg	4.2/0.7 mg
12 mg		12 mg/3 mg	8.6 mg/2.1 mg	6.3 mg/1 mg
16 mg			11.4 mg/2.9 mg	

k. Supportive Care[7-12]

Symptom	Treatment
Nausea & Vomiting	Promethazine 25 mg orally every 6 hours PRN Nausea/Vomiting Promethazine 12.5 mg IV every 6 hours PRN Nausea/Vomiting (if unable to take PO) Prochlorperazine 10 mg orally every 6 hours PRN Nausea/Vomiting *Ondansetron is not recommended due to QT prolongation*
Diarrhea	Loperamide 4 mg orally one-time then 2 mg orally PRN each loose stool (Max 16 mg in 24 hours) Bismuth subsalicylate 30 mL orally every 3 hours PRN loose stool
Myalgia	Acetaminophen 650 mg orally every 6 hours PRN myalgia, pain score 1-3 Ibuprofen 600 mg orally every 6 hours PRN pain score 4-10
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine 25 mg orally every 8 hours PRN anxiety, dysphoria, lacrimation, rhinorrhea
Insomnia	Trazodone 50 mg orally daily at bedtime
Spasms and twitching	Methocarbamol (Robaxin) 1000 mg orally every 6 hours PRN muscle spasms or twitching
Constipation	Milk of magnesia 30 mL orally daily PRN constipation
Seizure	Lorazepam 4 mg IV push every 5 minutes x 2-4 doses PRN Seizure Diazepam 5 mg IV push every 5 minutes x 4 doses PRN seizure Phenobarbital 10 mg/kg every 20 minutes x 3 doses PRN Propofol 1 mg/kg bolus (optional), then 30 to 75 mcg/kg/minute continuous infusion; titrate to desired effect (burst suppression on EEG). Midazolam 5 mg IM every 10 minutes PRN seizure
Abdominal cramping	Dicyclomine 20 mg orally every 6 hours PRN abdominal cramping

- Determine the stage or severity of opiate withdrawal using COWS score
- Consider clonidine for acute withdrawal for Clinical Opiate Withdrawal Scale (COWS) score greater than 12 indicating moderate withdrawal
- For patients who continue to score greater than 36 the COWS, indicating severe withdrawal, after 24 hours on clonidine, consider use of methadone for patients on long acting opioids or buprenorphine for patients on short-acting opioids

Clonidine for acute withdrawal

There are several advantages to treating opioid withdrawal using clonidine rather than methadone:

1. Clonidine does not produce opioid intoxication and is not reinforcing.
2. The FDA does not classify clonidine as having abuse potential, though some abuse has been reported.
3. Detoxification with clonidine occurs without opioids.
4. No special licensing is required for the dispensing of this medication.

Although clonidine alleviates some symptoms of opioid withdrawal (lacrimation, rhinorrhea, muscle pain, joint pain, restlessness, and gastrointestinal symptoms), it usually is less effective for insomnia, muscle aches and drug craving. Clonidine is administered orally, in three or four doses per day up to a maximum of 1 mg/day. Dizziness, sedation, and lethargy attributed to orthostatic hypotension and dry mouth were the primary adverse side effects.

Clonidine taper for symptoms of acute withdrawal

- Clonidine 0.1 mg one-time as a test dose (consider 0.2 mg for patients weighing over 90 kg)
    - Check blood pressure 1 hour after initial dose. If SBP less than 90 mmHg or DBP less than 60 mmHg, HR less than 60 or marked postural hypotension occurs, do not continue clonidine therapy
- If patient tolerates the clonidine test dose,
    - Clonidine 0.1 mg 4-day Taper for patients weighing 90 kg and less
        - Clonidine 0.1 mg orally every 6 hours x 7 doses
        - Clonidine 0.05 mg orally every 6 hours x 4 doses
        - Clonidine 0.025 mg orally every 6 hours x 4 doses
        - Check COWS score and BP before dose, hold for SBP <90 mmHg, DBP < 60 mmHg or HR < 60 bpm
    - Clonidine 0.2 mg 4-day Taper for patients weighing over 90 kg
        - Clonidine 0.2 mg orally every 6 hours x 3 doses
        - Clonidine 0.1 mg orally every 6 hours x 4 doses
        - Clonidine 0.05 mg orally every 6 hours x 4 doses
        - Clonidine 0.025 mg orally every 6 hours x 4 doses
        - Check COWS score BP before dose, hold for SBP <90 mmHg, DBP < 60 mmHg or HR < 60 bpm

I. Treating Patients in Recovery[2]

A thorough patient assessment provides information that allows the clinician to judge the stability of a patient's recovery from a Substance Use Disorder (SUD). Goals for treating chronic noncancer pain (CNCP) in patients who are in long-term recovery or whose SUD is in the distant past are as follows:

- Treat chronic noncancer pain with non-opioid analgesics as determined by pathophysiology.
- Recommend or prescribe nonpharmacological therapies (e.g., cognitive–behavioral therapy [CBT], exercises to decrease pain and improve function).
- Treat comorbidities.
- Assess treatment outcomes.
- Initiate opioid therapy only if the potential benefits outweigh risk and only for as long as it is unequivocally beneficial to the patient.

Analgesic	Addictive	Notes
Acetaminophen	No	Should normally not exceed 4 g/day; in adults with hepatic disease, the maximum dose is 2 g/day. Potentiates analgesia without potentiating respiratory and sedative side effects.
NSAIDs	No	Are used to relieve numerous types of pain, especially bone, dental, and inflammatory, and enhance opioid analgesia. May cause gastrointestinal bleeding and renal insufficiency.
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	No	Are used to relieve several nonstructural types of pain (e.g., migraine, fibromyalgia, low back pain) and probably others.
Tricyclic Antidepressants	No	Have demonstrated efficacy in migraine prophylaxis, fibromyalgia, many neuropathic pains, vulvodynia, and functional bowel disorders. Watch for anticholinergic side effects and orthostatic hypotension (fall risk in older people).
Anticonvulsants	No	Some have demonstrated efficacy in relieving fibromyalgia, migraine prophylaxis, and neuropathic pains.
Topical Analgesics	No	Comprise several unrelated substances (e.g., NSAIDs, capsaicin, local anesthetics). Work locally, not systemically, and therefore usually have minimal systemic side effects.
Antipsychotics	No	Have no demonstrated analgesic effect, except to abort migraine/cluster headache. Risks include extra-pyramidal reactions and metabolic syndrome.
Muscle Relaxants	Carisoprodol (Soma) is addictive	Have not been shown to be effective beyond the acute period. Some potentiate opioids and are not recommended. Some medications in this class have significant abuse potential.

TIP 54 Managing Chronic Pain in Adults

Alternative Therapies include:

Acupuncture

Heated pools

Mindfulness Bases Stress Reduction

Features to Distinguish Opioid Use in Patients with Pain from Opioid-addicted Patients[20]

Clinical Features	Patients with Pain	Opioid-addicted Patients
Compulsive drug use	Rare	Common
Crave drug (when not in pain)	Rare	Common
Obtain or purchase drugs from nonmedical sources	Rare	Common
Procure drugs through illegal activities	Absent	Common
Escalate opioid dose without medical instruction	Rare	Common
Supplement with other opioid drugs	Unusual	Frequent
Demand specific opioid agent	Rare	Common
Can stop use when effective alternate treatments are available	Usually	Usually not
Prefer specific routes of administration	No	Yes
Can regulate use according to supply	Yes	No

- If analgesia with opiates is necessary, consider use of oral liquid formulation to prevent diversion

m.Lab orders[6, 7, 14, 20, 22]

Patient should be treated for suspected overdoses/toxicities prior to laboratory test results. Although there may be minor differences in opioid toxicity between agents, it is more important to diagnose opioid toxicity than to determine the specific agent.

CMC Laboratory Testing

CMC Urine Tox Screen

- Usually collected in the ED; tests for the following: Amphetamine/Methamphetamine, Barbiturates, Benzodiazepine, Cocaine, Methadone, Opiates, PCP and THC. Test is resulted as negative and presumptive positive.
- May/may not detect meperidine, oxycodone.
- Confirmation testing can be sent to the reference lab.
- Will not detect tramadol, tapentadol or fentanyl and other substances not specified above.

Additional testing is available as a send out to Quest Diagnostics, the turn-around-time is 5 – 7 days.

Additional Tests:

In addition to the ED urine tox screen, consider the addition of the following tests:

- ABG
- Acetaminophen level
    - Acetaminophen is the most frequently ingested medication in the U.S. and is often seen in deliberate overdoses and accidental poisonings.
    - Toxicity manifests as liver necrosis and may be the most common form of acute liver failure.
- BMP or CMET
- Salicylate level
    - Aspirin is frequently included in opioid combinations

Patients presenting with suspected illicit opioid overdose

The CDC recommends performing an ELISA that includes fentanyl. If the fentanyl ELISA screen is positive, a gas chromatography-mass spectrometry (GC/MS) confirmatory test should be used to determine if the overdose was due to fentanyl or a synthetic fentanyl analog (eg, acetyl fentanyl) (CDC 2013).

Note: *This test is not available at CMC, but if necessary, may be requested as a send out to the reference lab. The turn-around-time is approximately 5 -7 days.*

Recommended Baseline Laboratory Evaluation of Patients Who Are Addicted to Opioids[20]

- Serum electrolytes
- BUN and creatinine
- CBC with differential and platelet count
- Liver function tests (GGT, AST, ALT, PT or INR, albumin)
- Lipid profile
- Urinalysis
- Pregnancy test (for women of childbearing age)
- Toxicology tests for drugs of abuse
- Hepatitis B and C screens

Drug Testing Guidelines[14]

Laboratory Evaluation: Testing for Alcohol and Substance Use (PDF, 279KB) - Resource listing important clinical considerations related to laboratory testing for alcohol and substance use.

Urine Drug Testing for Chronic Pain Management (PDF, 131KB) - Information tables outlining advantages, limitations, and other considerations for urine drug testing of opioids and other drugs.

Urine Drug Testing in Clinical Practice
http://www.pharmacomgroup.com/udt/udt5.pdf

Clinical Drug Testing in Primary Care. Technical Assistance Publication (TAP) 32
Substance Abuse and Mental Health Services Administration Publication
https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf

Cutoff Concentrations and Detection Times for Substances of Abuse[22]

Drug	Cutoff Concentrations (ng/mL) Initial Testing	Cutoff Concentrations (ng/mL) Confirmation	Analytes Tested in Confirmation	Urine Detection Time (Days)
Amphetamine	1,000	500	Amphetamine	2–4
Barbiturates	200	200	Amobarbital, secobarbital, other barbiturates	2–4 for short acting; up to 30 for long acting
Benzodiazepines	200	200	Oxazepam, diazepam, others	Up to 30 for long acting
Cocaine	300	150	Benzoylecgonine	1–3 for sporadic use; up to 12 for chronic use
Codeine	300	300, 300	Codeine, morphine	1–3
Heroin	300	300, 10	Morphine, 6-acetylmorphine	1–3
Marijuana	100, 50, 20	15	Tetra-hydro cannabinol (THC)	1–3 for casual use; up to 30 for chronic use
Methadone	300	300	Methadone	2–4
Methamphetamine	1,000	500, 200	Methamphetamine, amphetamine	2–4
Phencyclidine	25	25	Phencyclidine	2–7 for casual use; up to 30 for chronic use

Urine Drug Testing

- Urine drug screens are usually immunoassays
  - Relatively quick and inexpensive
  - Know what is in the testing panel (see above)
  - Risk of false negatives due to cut offs
  - Risk of false positives due to cross reactions
- Unexpected findings can be verified by conversation with the patient or use of Gas Chromatography/Mass Spectroscopy (GC/MS)
  - Identifies specific molecules
  - Levels are not a valid way of determining the amount ingested
  - Be aware of opioid metabolism to interpret

Major Opioid Metabolites[13, 26]

Opioid	Inactive Metabolites	Active Metabolites (pharmaceutical opioids)	Active Metabolites (not pharmaceutical opioids)
Morphine	Normorphine	Hydromorphone	Morphone-3-G glucuronide Morphone-6-G glucuronide
Hydromorphone	Minor metabolites	None	Hydromorphone-3-glucuronide
Hydrocodone	Norhydrocodone	Hydromorphone	None
Codeine	Norcodeine	Hydrocodone Morphine	None
Oxycodone	None	Oxymorphone	Noroxycodone
Oxymorphone	Oxymorphone-3-glucuronide	None	6-Hydroxy-oxymorphone
Fentanyl	Norfentanyl	None	None
Tramadol	Nortramadol	None	O-desmethyltramadol
Methadone	2-Ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine 2-Ethyl-5-methyl-3,3-diphenylpyrroline	None	None
Heroin	Normorphine	Morphine	6-Monoacetylmorphine
Modified from Table 4, Mayo Clinic Proceedings. 2009; 84(7):613-624. *Not comprehensive pathways, but may explain the presence of unprescribed drugs*			

n. Counseling

http://www.drugfreenh.org/

Counseling options include:

- Substance abuse referrals
- Individual Counseling
- Group Counseling
- Motivational Enhancement Therapy (MET)

Resource Guide for Alcohol and Drug Prevention and Treatment Services:
http://www.dhhs.nh.gov/dcbcs/bdas/guide.htm

Treatment Locator:
http://nhtreatment.org/
http://drugfreenh.org/get-help
http://www.samhsa.gov/treatment

o. Treatment

http://www.drugfreenh.org/
http://www.samhsa.gov/treatment

Tailor mental and substance use disorder treatments and supportive services to fit the needs of the individual patient.

Treatments and supportive services are provided in a variety of locations, including:

- Specialty community behavioral health centers
- Substance use disorder rehabilitation programs
- Independent providers
- Hospitals
- Community health centers
- Mutual support groups and peer-run organizations
- Community-based organizations
- Schools
- Jails and prisons
- At home through telebehavioral or home-based services
- Inpatient service providers
- Primary care programs with integrated behavioral health services

For available treatment services in our area visit:
Federal website: http://dpt2.samhsa.gov/treatment/directory.aspx
NH Drug Treatment Center Locator: www.nhtreatment.org
NH website: http://www.dhhs.nh.gov/dcbcs/bdas/treatment.htm
NH website: http://drugfreenh.org/get-help

Resource Guide for Alcohol and Drug Prevention and Treatment Services:
http://www.dhhs.nh.gov/dcbcs/bdas/guide.htm

National support and recovery programs:
National Support Groups: 1-800-662-HELP a 24/7 Treatment and Referral Hotline
Faces and Voices of Recovery: www.facesandvoicesofrecovery.org
Hope for NH Recovery: http://www.hopefornhrecovery.org/
Recovery is Everywhere: www.recoveryiseverywhere.com

Addiction Medication Specialist
Refer when the patient:

- is using illicit drugs
- is experiencing problems with other prescription medications
- abuses or is addicted to alcohol
- agrees they have an opioid addiction and wants help such as a referral to medication-assisted treatment (MAT)
- has dual or trio diagnosis of pain, addiction and psychiatric disease

p. Security

http://medweb01/home/cmc_security/default.asp

The safety of our staff, patients and visitors is of the utmost importance. CMC Security should be contacted at extension 2029. Dial x2111 for an Emergency.

Search

In order to provide a safe environment for patients, visitors and staff, Catholic Medical Center may conduct a search of a room or area, individual and/or personal belongings when there is a reasonable suspicion for a search in accordance with CMC's Search & Seizure of Patient Care Areas, Individuals, and/or Belongings policy. The policy may be found in Policy Stat. Contact Security to search patient belongings and remove ALL paraphernalia (lighters & cigarettes included).

Visitor restriction

Catholic Medical Center permits patient visitation 24 hours a day but reserves the right to restrict visitation for certain Justified Clinical Restrictions. Refer to CMC's policy, "Visitation Policy to Support a Healing Environment" in Policy Stat.

Patient Behavior Agreement

Educate patient at the point of entry about visitation and behaviors that will NOT be tolerated during their stay at CMC, and or behavior contract.

Behavior Care Plan

RN Safety

Contact security with concerns regarding patient or personal safety.
CMC's Patient Code of Conduct Policy is in development

Patient Safety

Under NO circumstances can the provider tell the patient they can go outside for fresh air or to smoke.

q. Manchester Area Resources

Treatment Locator

- The NH Center for Excellence website directory specific for locating alcohol and drug treatment service providers.
- www.nhtreatment.org

Narcotics Anonymous

- Granite State Area of Narcotics Anonymous; Seacoast Area of Narcotics Anonymous
  - http://gsana.org/
  - 24 Hour Helpline Number: 888-NA-HELP-U (888-624-3578)
  - Meeting List: http://www.gsana.org/download/Combined%20Meeting%20List.pdf
- Website: www.na.org

SMART Recovery

- http://www.smartrecovery.org/
- Meeting List: http://www.smartrecovery.org/meetings_db/view/showalpha_state.php?search=N

Suicide Prevention Hotline:

- **1-800-273-TALK**

New Hampshire support and recovery programs:

Celebrate Recovery: http://www.celebraterecovery.com/
Healthcare for the Homeless Program, Behavioral Health Team: 603-663-8718nts and activities.
Hope for NH Recovery: www.hopefornhrecovery.org
In the Rooms: www.intherooms.com
Keystone Hall: www.keystonehall.org
NH Alcoholics Anonymous, Inc.: www.nhaa.net
NH Families Sharing Without Shame:
NH Narcotics Anonymous: www.gsana.org
Serenity Place: www.serenityplace.org
Westbridge: www.westbridge.org
www.families-sharing-without-shame.com/Families_Sharing_Without_Sh.html

National support and recovery programs:

National Support Groups: 1-800-662-HELP for 24/7 Treatment and Referral Hotline
Faces and Voices of Recovery: www.facesandvoicesofrecovery.org
Recovery is Everywhere: www.recoveryiseverywhere.com

The Center for Substance Abuse Treatment (CSAT)

CSAT is a center within the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services (DHHS). CSAT promotes the quality and availability of community-based substance abuse treatment services for individuals and families who need them.
http://www.samhsa.gov/about-us/who-we-are/offices-centers/csat

r. Manchester Opioid Treatment Programs

https://findtreatment.samhsa.gov/locator?sAddr=03102&submit=Go

Substance Abuse Treatment Facility	Phone	Director	Treatment
Bresnahan and Ball Counseling Services Substance Abuse Outpatient 66 Prospect Street Manchester, NH 03104 www.bresnahanandballcounselingservices.com	603-965-6477	[redacted]	
Child and Family Services 464 Chestnut Street Manchester, NH 03101 www.cfsnh.org	603-518-4000 Intakes: 603-518-4000-4362	[redacted]	
Farnum Center 140 Queen City Avenue Manchester, NH 03103 http://www.EStreatment.org	603-622-3020 888-840-4243	[redacted]	Detoxification Buprenorphine
Habit OPCO 20 Market Street Manchester, NH 03101 www.habitopco.com	603-622-4747 603-622-9382	[redacted]	Detoxification Methadone Maintenance
Metro Treatment of New Hampshire LP Manchester Metro Treatment Center 5 Driving Park Road, Suite A Manchester, NH 03103 www.methadonetreatment.com	603-622-5005	[redacted]	Detoxification Buprenorphine Methadone maintenance
NH Div Alcohol/Drug Abuse Prevention and Recovery/Tirrell Halfway House 15 Brook Street Manchester, NH 03104 www.serenityplace.org	603-836-5145 603-836-5450	[redacted]	
Serenity Place NCADD Affiliate 101 Manchester Street Manchester, NH 03101 www.serenity-place.org	(603) 625-6980	[redacted]	Detoxification

s. Manchester Buprenorphine Prescribers

http://buprenorphine.samhsa.gov/bwns_locator/dr_facilitylocatordoc.htm

The Buprenorphine Treatment Physician Locator is available from Substance Abuse and Mental Health Services Administration (SAMHSA) at the above link to locate providers available to assist patients in need of medication assisted treatment for a substance use disorder.

Visit http://nhtreatment.org/ for the NH Alcohol and Drug Treatment Locator to find providers offering withdrawal management, outpatient counseling, residential treatment, recovery supports and other types of services for people experiencing problems with alcohol and other drug use, including addiction.

Additional resources for providers and patients can be found at www.drugfreenh.gov .

Provider	Address	Phone
[redacted]	Farnum Center 140 Queen City Avenue Manchester, NH 03101	(603) 622-3020
[redacted]	138 Coolidge Avenue Manchester, NH 03102	(603) 689-7890
[redacted]	718 Smyth Road Manchester, NH 03104	(603) 624-4366
[redacted]	718 Smyth Road Manchester, NH 03104	(603) 624-4366x6465
[redacted]	148 Coolidge Street Manchester, NH 03104	(603) 883-0005
[redacted]	753 Chestnut Street Manchester, NH 03104	(603) 860-2593
List developed from buprenorphine physician locator at http://buprenorphine.samhsa.gov. Please note there may be additional buprenorphine providers who have opted not to have their name published online.		
Pharmacists: To check on a physician's waivered status, please call the Buprenorphine Information Center at 1.866.287.2728.		

t. Manchester Mental Health Providers

http://buprenorphine.samhsa.gov/bwns_locator/dr_facilitylocatordoc.htm

Treatment Provider	Phone	Program Director	Patients
Mental Health Center of Greater Manchester 1555 Elm Street Manchester, NH 03101	603-668-4111	[redacted]	Adults Seniors Young Adults
WestBridge Community Services 1361 Elm Street, Suite 207 Manchester, NH 03101	603-634-4446 Intake: 800-889-7871	[redacted]	Adults Young Adults
Mental Health Center of Greater Manchester **Bedford Counseling Associates** 1228 Elm Street, Suite 201 Manchester, NH 03101	603-668-4111 Intake: 603-668-4111x1	[redacted]	Adults Children/ adolescents Seniors Young Adults
Mental Health Center of Greater Manchester 401 Cypress Street Manchester, NH 03103 http://MHCGM.org	603-668-4111 603-668-4111x1	[redacted]	Adults Seniors Young Adults
Elliot Hospital 1 Elliot Way Manchester, NH 03103 http://www.elliothospital.org/	603-669-5300 Intake: 603-668-4079	[redacted]	Adults Children/ adolescents Seniors Young Adults

u. Resources for Healthcare Team[3]

New Hampshire Epidemic and Response

Drug-related overdose deaths in New Hampshire
Website: http://wisdom.dhhs.nh.gov/wisdom/
Website: http://drugfreenh.org/images/FACTSheet_FINAL.pdf

Opioid Abuse Trends
Website: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w

NH Board of Medicine Emergency Rules for Patients with Acute and Chronic Pain
The emergency rules went into effect on November 6, 2015 and will remain in effect for 180 days or until new rules are promulgated. Although these rules are in effect for any licensee of the Board of Medicine, other prescribers governed by other licensing boards (Nursing, Dental, Veterinarian) are not covered under these rules at this time, but they should review them.
http://www.nh.gov/medicine/documents/emergencyrules_opioidprescribing_11-4-15.pdf
http://www.nh.gov/medicine/documents/pressrelease_emergencyrules.pdf

Joint Task Force (JTF) on Response to Heroin & Opioid Crisis
Governor Hassan announced that the NH Legislature will be called in for a special session starting on November 18th to deal with several issues pertaining to substance misuse.
http://governor.nh.gov/media/news/2015/pr-2015-11-04-substance-abuse.htm
On November 18th, both the House and Senate met in special session to create a Joint Task Force (JTF) on Response to Heroin & Opioid Crisis made up of 26 legislators (House and Senate). The JTF established a website which will contain all of the JTF meeting documents, meeting schedules, committee members, presentation materials, LSRs (Legislative Service Requests), etc. Legislation will be proposed as part of the 2016 legislative session. http://www.gencourt.state.nh.us/jtf/default.aspx

New Hampshire Regional Public Health Networks (RPHNs)
The RPHNs ensure coordinated and comprehensive delivery of essential public health services regionally. The thirteen agencies of the RPHNs are funded by NH DHHS and deliver regional support to provide appropriate and effective substance misuse prevention and related health promotion services. These regional plans complement the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment statewide five-year strategic plan, Collective Action – Collective Impact: New Hampshire's Strategy for Reducing the Misuse of Alcohol and Other Drugs and Promoting Recovery.
Website: http://nhphn.org/

New Hampshire Medical Society
Website: http://nhms.org/
New Hampshire Opioid Prescribing Resource: http://nhms.org/resources/opioid

Anyone Anytime
New Hampshire's "Anyone. Anytime" campaign is designed to to educate the public and professionals about addiction, emergency overdose medications, and support services for anyone experiencing opioid addiction.
Website: http://drugfreenh.org/anyoneanytime
Provider and Pharmacist Resources: http://drugfreenh.org/resources-for-prescribers-and-pharmacists

New Hampshire Center for Excellence
A NH resource to provide technical assistance, disseminate data and information, and promotes knowledge transfer in support of communities, practitioners, policymakers, and other stakeholders working to address alcohol and other drug misuse and related consequences.
Website: http://www.nhcenterforexcellence.org/

Assessment and Screening Tools

National Institute on Drug Abuse Drug Screening Tool
http://www.drugabuse.gov/nmassist/

Screening, Brief Intervention and Referral to Treatment (SBIRT)
http://sbirt.samhsa.gov/
TAP 33: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) – 2013 describes core elements of SBIRT programs for people with or at risk for substance use disorders.
White Paper on Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare – 2011 (PDF | 204 KB) report discusses the evidence supporting the effectiveness of SBIRT.

Pain, Enjoyment, General Activity (PEG) Scale Assessment
Use to assess pain over past week. Compare response to previous to assess treatment response over time

Screen for Depression
Assess for other mental illness using the PHQ2; administer the PHQ9 for score 3 points or more

Screen for Unhealthy Substance Abuse
The Clinician's Screening Tool for Drug Use in General Medical Settings from the National Institute for Drug Abuse (NIDA) guides clinicians through a series of questions to identify risky substance use in their adult patients.
Vital Signs: Communication Between Health Professionals and Their Patients About Alcohol Use — 44 States and the District of Columbia, 2011 from the Centers for Disease Control and Prevention reports on the number of patients discussing alcohol consumption with a health professional.

Opioid Risk Tool[25]
Administer this tool to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf

Substance Use Disorder Treatment References

Opioid Treatment Program Directory
Website: http://dpt2.samhsa.gov/treatment/directory.aspx
NH Drug Treatment Center Locator: www.nhtreatment.org
NH website: http://www.dhhs.nh.gov/dcbcs/bdas/treatment.htm
NH website: http://drugfreenh.org/get-help

Principles of Drug Addiction Treatment: A Research-based Guide (3rd Edition)
Presents research-based principles of addiction treatment for a variety of drugs, including nicotine, alcohol, and illicit and prescription drugs, that can inform drug treatment programs and services.
http://www.drugabuse.gov/publications/principles-drug-addiction-treatment

TAP 30: Buprenorphine: A Guide for Nurses
Gives nurses information about buprenorphine for medication-assisted treatment of addiction to opioids and guidelines for working with physicians to provide office-based screening, assessment, supervised withdrawal (detoxification), and maintenance treatment.
http://buprenorphine.samhsa.gov/bwns/TAP_30_Certified.pdf

TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction

Practice guidelines help physicians make decisions about using buprenorphine to treat opioid addiction. Includes information on patient assessment; protocols for opioid withdrawal; and the treatment of pregnant women, teens, and polysubstance users.
http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs
Gives a detailed description of medication-assisted treatment for addiction to opioids, including comprehensive maintenance treatment, detoxification, and medically supervised withdrawal. Discusses screening, assessment, and administrative and ethical issues.
http://buprenorphine.samhsa.gov/tip43_curriculum.pdf

General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders
Offers general principles to assist in the planning, delivery, and evaluation of pharmacologic approaches to support the recovery of individuals with co-occurring disorders. Covers engagement, screening, assessment, treatment planning, and continuity of care.
http://store.samhsa.gov/product/General-Principles-for-the-Use-of-Pharmacological-Agents-to-Treat-Individuals-with-Co-Occurring-Mental-and-Substance-Use-Disorders/SMA12-4689?WT.ac=EB_20120607_SMA12-4689

Principles of Adolescent Substance Use Disorders: A Research-Based Guide
Presents research-based principles of adolescent SUD treatment; covers treatment for a variety of drugs including, illicit and prescription drugs, alcohol, and tobacco; presents settings and evidence-based approaches unique to treating adolescents.
http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide

Neonatal Abstinence Syndrome
American Academy of Pediatrics Clinical Report: Neonatal Drug Withdrawal
http://pediatrics.aappublications.org/content/pediatrics/129/2/e540.full.pdf

Training, Education and Continuing Education References

Medication-Assisted Treatment For Opioid Addiction in Opioid Treatment Programs Inservice Training
Provides a training program for substance abuse treatment counselors and other clinicians on medication-assisted treatment for opioid addiction. Covers basic principles, best practices, history, and regulation. Includes scripted modules and handouts.
http://www.samhsa.gov/medication-assisted-treatment
http://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA09-4341
Mentoring and education is available through the Providers' Clinical Support System for Medication Assisted Treatment www.pcssmat.org

Prescribing opioids for chronic pain
Websites: http://www.opioidprescribing.com. Sponsored by the Boston University School of Medicine, with support from SAMHSA, this site presents course modules on various aspects of prescribing opioids for chronic pain. http://www.opioidprescribing.com/overview. CME credits are available at no charge.

FDA Physician Training and Patient Education on Use of Extended-release or Long-acting opioids
http://www.er-la-opioidrems.com/IwgUI/rems/home.action.
REMS site: http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm

The Role of Clinicians in Addressing the Opioid Overdose Epidemic [webinar]

Healthcare providers are encouraged to review prescribing practices due to the association between prescription opioid abuse/dependence and heroin abuse. The CDC's Clinician Outreach and Communication Activity (COCA) presented a webinar was presented entitled, "The Role of Clinicians in Addressing the Opioid Overdose Epidemic." The webinar can be viewed at: http://emergency.cdc.gov/coca/calls/2015/callinfo_092415.asp.

Providers' Clinical Support System
http://www.pcss-o.org or www.pcssmat.org. Sponsored by the **American Academy of Addiction Psychiatry** in collaboration with other specialty societies and with support from SAMHSA, the Prescriber's Clinical Support System offers multiple resources related to opioid prescribing and the diagnosis and management of opioid use disorders

National Institute on Drug Abuse – Two module Course
CME credits are available.
http://www.medscape.org/viewarticle/770687
http://www.medscape.org/viewarticle/770440.

US Department of Justice, DEA Publications and Manuals
http://www.deadiversion.usdoj.gov/pubs/index.html

Urine Drug Testing in Clinical Practice
http://www.pharmacomgroup.com/udt/udt5.pdf

Clinical Drug Testing in Primary Care. Technical Assistance Publication (TAP) 32
Substance Abuse and Mental Health Services Administration Publication
https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf

American Society of Addiction Medicine
ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.
Website: http://www.asam.org/
Education: http://www.asam.org/education
Research and Treatment: http://www.asam.org/research-treatment

The SCOPE of Pain
A continuing education series developed as part of the FDA mandated comprehensive Risk Evaluation and Mitigation Strategy (REMS) for extended release/long-acting (ER/LA) opioid analgesics.
Website: https://www.scopeofpain.com/
Resources: https://www.scopeofpain.com/tools-resources/

Opioid Overdose and Naloxone

Opioid Overdose Information for Pharmacists
The NH Board of Pharmacy has made the following information available to assist pharmacists with handling the Opioid Overdose Crisis in NH.
Opioid Overdose Prevention for Pharmacists
FAQ's on Naloxone for Opioid Overdose from Pharmacist's Letter
Naloxone Standing Order for Prescribers

Overdose Risk Reduction, Resources for health care providers
Compiled by prescribers, pharmacists, public health workers, lawyers, and researchers working on overdose prevention and naloxone access this privately funded site provides resources to help health care providers educate their patients to reduce overdose risk and provide naloxone rescue kits to patients.

http://prescribetoprevent.org.

NH Naloxone Access Information
Website: http://drugfreenh.org/resources-for-prescribers-and-pharmacists
Website: http://drugfreenh.org/images/Naloxone_FAQ.pdf
NH Board of Medicine [statement]: http://www.nh.gov/medicine/documents/naloxonestatement.pdf
In June, 2015, legislation was passed in New Hampshire to protects healthcare providers from criminal and civil liability for prescribing, dispensing, or distributing naloxone to patients and/or family and friends of patients who are at risk of opioid overdose. Refer to the websites listed above for information regarding naloxone access legislation. The NH Bureau of Drug and Alcohol Services is distributing naloxone kits across NH. Determine local access by visiting http://drugfreenh.org/find-out-where-to-get-naloxone-kits-in-your-community.
http://www.gencourt.state.nh.us/legislation/2015/HB0271.html

Opioid Overdose Prevention Toolkit
Equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. Addresses issues for first responders, treatment providers, and those recovering from opioid overdose
http://store.samhsa.gov/product/SMA13-4742?WT.mc_id=EB_20130828_SMA13-4742

v. Resources for Families

http://drugfreenh.org/families
http://drugfreenh.org/drug-guide

NH Resources:
A guide to New Hampshire resources including residential and outpatient treatment programs, recovery programs and support services for families
http://www.dhhs.nh.gov/dcbcs/bdas/documents/guide.pdf
Alcohol, Tobacco and Other Drug Clearinghouse and Lending Library:
http://www.dhhs.nh.gov/dcbcs/bdas/library.htm
NH Bureau of Drug and Alcohol Services: http://www.dhhs.nh.gov/dcbcs/bdas/

NH Alcohol and Drug Treatment Locator
Website: www.nhtreatment.org
Family Support Groups: http://nhtreatment.org/files/2015/05/flyer-family-peer-support-group.pdf
Naloxone Kit Finder: http://drugfreenh.org/find-out-where-to-get-naloxone-kits-in-your-community
Naloxone prescription access poster

211 Get Connected, Get Answers
Call 211 for information and referrals
Website: www.211nh.org

NH Alcohol, Tobacco, and Other Drug Resource Kiosks
An initiative of the NH DHHS' Bureau of Drug and Alcohol Services. Available to the general public to provide educational material about alcohol, tobacco, and other drug use, prevention, and treatment.
http://drugfreenh.org/resources/community-kiosks
Manchester City Public Library, 405 Pine Street, Manchester, NH 03104
Merrimack YMCA, 6 Henry Clay Drive, Merrimack, NH 03054

Anyone Anytime
New Hampshire's "Anyone. Anytime" campaign is designed to educate the public and professionals about addiction, emergency overdose medications, and support services for anyone experiencing opioid addiction.
Website: http://drugfreenh.org/anyoneanytime
Posters: Anyone anytime can save a life; Parent Seeking Help Poster

NH Al-Anon and Alateen:
www.nhal-anon.org for families and friends of alcoholics

DrugFreeNH.org
Sings of Misuse: http://drugfreenh.org/families/signs-of-abuse/warning-signs
Does my friend have a problem?
Pregnancy and Addiction: http://drugfreenh.org/families/healthy-mothers-and-babies
Neonatal Abstinence Syndrome: https://www.nlm.nih.gov/medlineplus/ency/article/007313.htm

Check the Stats NH
Resources to understand the issues the youth of NH are facing
Website: http://www.checkthestatsnh.org/

The American Chronic Pain Association
The Mission of the ACPA is "To facilitate peer support and education for individuals with chronic pain and their families so that these individuals may live more fully in spite of their pain"
www.theacpa.com

Drug Disposal

- FDA How to Dispose of Unused Medicines: http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm#1
  - Got Drugs? - National Prescription Drug Take-Back Day
  - FDA - How to Dispose of Unused Medicines
  - FDA - Disposal of Unused Medicines
- Drug Enforcement Agency (DEA)
  - Visit the DEA's website or call 1-800-882-9539 for more information and to find an authorized collector in your community.
- DOJ Prescription Drug Lock Box: http://doj.nh.gov/criminal/documents/prescription-drug-drop-box.pdf
- Environmental Protection Agency
  - EPA - How to Dispose of Medicines Properly
  - EPA - Disposal of Medical Sharps
- Alternative: If no disposal instructions are given on the prescription drug labeling and no take-back program is available in your area, throw the drugs in the household trash following these steps:
  1. Remove them from their original containers and mix them with an undesirable substance, such as used coffee grounds, dirt or kitty litter (this makes the drug less appealing to children and pets, and unrecognizable to people who may intentionally go through the trash seeking drugs).
  2. Place the mixture in a sealable bag, empty can or other container to prevent the drug from leaking or breaking out of a garbage bag.

CMC
CATHOLIC MEDICAL CENTER

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Title:	**Clinical Guidelines for Prescribing Opioids Prescription Drug Monitoring Program (PDMP)**
Original Date of Implementation:	02/02/17
Reviewed By Group/Committee:	Clinical Senior Management
Review Date(s):	
Revision Date(s):	
File in the Following Manual:	Patient Care Guidelines

Objective: To provide guidance to providers on the state requirements for prescribing opioids or narcotics for patients with acute and chronic pain.

Responsibility: Providers, Nurses and Medication Refill Coordinators
Guidelines:

1. All patients who are prescribed Opioids need to have a signed Opioid Agreement on file in their chart. This includes prescribing for both acute and chronic pain management. Opioid agreements are found in the Impression and Plan section of the chart. Click on 3rd tab →Protocol/Care Plan → Medical Condition → Chronic Opioid Use → Agreement Complete → opens up a summary of opiate meds and displays date of last agreement and allows you to open a new agreement prn. If there is no agreement in the system then the popup will be blank but will allow you to open a new agreement if you click "yes". Type in **".medagree**" to open the medication agreement directly.

2. When you open a new agreement, it will display a shortcut to the PDMP. The agreement should include the provider's signature, the patient or legal guardian's signature, name of pharmacy, the name of the contracted medication and the dispensing information.

3. The completed agreement will be scanned into the patient's clinical record and a copy is given to the patient.

4. All patients who are prescribed Opioids needs to have completed an Opioid Risk tool. One option for pulling up an Opioid Risk tool is to type in **".mhs".** This opens up the mental health screening tool and from there you click the 3rd tab to pull in the opioid risk tool. As directed by the provider, patients can be seen via a nurse visit or via a telephone encounter (phone note) to have an opioid risk assessment performed.`

5. The Opioid Risk Tool will autoscore and assign a "Low Risk", "Moderate Risk" and "High Risk" designation.

6. For Moderate or High Risk designations, the provider may elect to prescribe medication and/or perform more frequent UTOX (urine toxicology) screens. For those patients that may have been screened with this tool previously, the "Get Previous" button will pull in prior relevant data.

7. Patients prescribed with an Opioid (including Ultram/Tramadol) for an acute illness needs to have a PDMP query completed with results documented in the EMR. Type in ".**ctrmed"** to create a quick text that lists next visit, last PDMP, date of narcotic agreement, medication name and number on the narcotic agreement.

8. Patients on chronic narcotics need a UTOX done at a minimum of yearly and the PDMP checked a minimum of 2x/year with results documented in the chart.

9. Patients on chronic narcotics need the Opioid Agreement reviewed and signed annually.

10. Patients on chronic narcotics need to have the medication be included as part of their care plan/treatment plan. Provider should also clearly document other treatment modalities such as Physical Therapy, Pain Clinic, Acupuncture, NSAIDs, muscle relaxants, TCA's or Gabapentin that are included as part of the treatment plan for chronic pain.

2015-2016

Guidance Document on Best Practices: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire

An initiative of the Bureau of Drug and Alcohol Services (BDAS) at the New Hampshire Department of Health and Human Services, with technical assistance provided by the New Hampshire Center for Excellence

Compendium Panel:

[redacted]

NH Department of Health and Human Services, Bureau of Drug and Alcohol Services Team:

[redacted]

Community Health Institute/JSI NH Center for Excellence Technical Team:

[redacted]

NH DEPT. OF HEALTH AND HUMAN SERVICES
NHBDAS
BUREAU OF DRUG AND ALCOHOL SERVICES
Promoting Prevention and Recovery

NEW HAMPSHIRE CHARITABLE FOUNDATION

CENTER FOR EXCELLENCE | Addressing Alcohol & Drug Misuse in NH

A publication of the New Hampshire Department of Health and Human Services Bureau of Drug and Alcohol Services with funding and technical support from the U.S. Substance Abuse and Mental Health Services Administration.

ACRONYMS AND ABBREVIATIONS

42 C.F.R., Part 2 – Title 42, Part 2 of the Code of Federal Regulations
ASAM – American Society of Addiction Medicine
ASI – Addiction Severity Index
ATTC – Addiction Technology Transfer Center
AUD – Alcohol Use Disorder
BDAS – Bureau of Drug and Alcohol Services
CBT – Cognitive Behavioral Health
CHC – Community Health Center
COWS – Clinical Opioid Withdrawal Scale
DEA – Drug Enforcement Administration
DHHS – Department of Health and Human Services
DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DUR – Data Utilization Review
FDA – Food and Drug Administration
IM – Intramuscular
IOP – Intensive Outpatient Program
IV – Intravenous
LADC – Licensed Alcohol and Drug Counselor
MAT – Medication Assisted Treatment
MCO – Managed Care Organization
MET – Motivational Enhancement Therapy
MLADC – Master Licensed Alcohol and Drug Counselor
NCM – Nurse Care Manager
NHHPP – NH Health Protection Program
OBOT – Office-Based Opioid Treatment
OOWS – Objective Opioid Withdrawal Scale
OTP – Opioid Treatment Program
OUD – Opioid Use Disorder
PAP – Premium Assistance Program
PCP – Primary Care Provider
PDL – Preferred Drug List
PDMP – Prescription Drug Monitoring Program
PO – By Mouth
QHP – Qualified Health Plan
SAMHSA – Substance Abuse and Mental Health Services Administration
SES – Socioeconomic Status
SOWS – Subjective Opioid Withdrawal Scale
SUD – Substance Use Disorder
TAP – Technical Assistance Publication
TIP – Treatment Improvement Protocol
UDT – Urine Drug Testing

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I.

EXECUTIVE SUMMARY

In 2014, New Hampshire recorded 326 drug overdose deaths, and as of September 18, 2015, 232 more individuals were lost to drug overdoses. In the past year, 91% (211) of these deaths were related to opioids, the equivalent of twenty-seven deaths per month or on average one death per day. Specifically, in 2014, 70.3% (206) of the 293 opioid overdose deaths were caused by heroin or fentanyl; this has increased to 84.8% (179) of the 211 opioid overdose deaths in 2015 so far.[1]

In response to this opioid epidemic, NH has executed several activities including implementing screening, brief intervention and referral to treatment (SBIRT) in all community health centers to identify problem alcohol and drug use; passing legislation to allow physicians to prescribe naloxone (Narcan) to anyone who may be in a position to help someone experiencing an opioid-related overdose (House Bill 271) and providing protection from civil, criminal and professional liability to the prescriber, dispenser and administrator of naloxone, also known as the Good Samaritan Law (House Bill 270); making naloxone kits available to patients of ten community health centers at no cost; supporting community education and naloxone access events through the state's public health network system; and launching an opioid awareness and public education campaign. As a companion to these addiction prevention, early identification and overdose prevention initiatives, the state is making a concerted effort to expand the availability of addiction treatment through investment in and promotion of medication assisted treatment (MAT) for opioid use disorders (OUDs).

Similar to many other states across the country, MAT services are limited and desperately needed in NH. The need for expanded MAT is evident in the high rates of problem opioid use reflected in the sharp increases in emergency room visits and ambulance calls for opioid abuse, in opioid-related overdose deaths, and in the wait lists reported by all of the state's eight methadone clinics, with lengths of wait lists ranging from two weeks to two months.[2]

To address the evident lack of capacity to treat OUDs, the New Hampshire Department of Health and Human Services (DHHS) Bureau of Drug and Alcohol Services (BDAS) convened a panel of practitioners from health care, behavioral health, substance use disorder specialty treatment services, and the NH Medical Society to review existing practices in New Hampshire and other states and identified key components and best practice recommendations from the American Society for Addiction Medicine (ASAM) and other nationally-recognized resources.

This panel developed three core objectives to expand MAT for New Hampshire residents with an OUD:

1. Increase the number of waivered buprenorphine prescribers;
2. Increase awareness of and access to extended-release injectable (depot) naltrexone and other medications by prescription; and
3. Increase office-based access to MAT programs through multiple settings, including primary care offices and clinics, specialty office-based ("stand alone") MAT programs, and traditional addiction treatment programs offering medication assistance.

1 Data obtained from the NH Medical Examiner's Office

2 Substance Use Disorder Treatment and Other Service Capacity in New Hampshire, Community Health Institute/JSI, NH Center for Excellence, 2014

The panel also contributed to the development of this compendium of best practice recommendations and resources for implementing and delivering effective MAT. The goal is to provide expanded capacity to serve more people with OUDs with effective treatment across a variety of settings.

II.

INTRODUCTION

This compendium of best practice recommendations and resources has been developed in response to the desire for guidance and supports communicated by health care and behavioral health professionals in order to initiate or expand MAT services for OUDs for patient populations in a variety of service settings. Each component is described in the order in which it is most commonly implemented; however, the setting, and how prepared this specific setting is to implement office-based treatment services, will determine whether several components may be implemented simultaneously or a section of a component may be initiated during the planning phase with the remainder completed during the delivery of services. Providers may skip to the section of interest depending on where they are in the MAT implementation process. This document is not intended to replace best practice resources such as *ASAM's National Practice Guidelines For the Use of Medications in the Treatment of Addiction Involving Opioid Use* or the *Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocols (TIPs)* or *Technical Assistance Publications (TAPs),* but is rather a compilation of resources and recommendations identified from these sources.

The development of this compendium is based on several key principles:

- The disease of addiction is a complex biopsychosocial disease that is chronic in nature and is often characterized by periods of relapse and recovery;
- Medications such as methadone, buprenorphine and naltrexone have been determined by research to be highly effective in short-term withdrawal management and longer-term treatment for individuals experiencing addiction, particularly for those with opioid use disorders[3];
- Access to medication assistance for those experiencing addiction is extremely limited, as evidenced by a comprehensive assessment conducted in the state in 2014[4];
- Only 30% of treatment programs offer medications for opioid use disorder[5]; and
- Medical professionals from a range of primary care and specialty practices have expressed interest in delivering MAT to existing patient populations and/or to MAT-targeted patients provided they are able to access adequate training, technical assistance, and professional mentoring.

MAT can be delivered in a variety of service settings with the proper integration of specific components. This compendium has been designed to provide an overview of these essential components necessary for delivering MAT services with specific recommendations and resources highlighted relative to the following MAT setting types:

- Primary care based MAT delivery
- Behavioral health/specialty addiction treatment-based MAT delivery
- MAT-specific treatment programs

Each of these setting types exists in New Hampshire, and representatives from each were contacted to help the panel understand and consider the strengths, challenges, and opportunities that lay in each. Examples will be shared throughout the document to better describe the different models and components and are not intended for promotional purposes.

3 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
4 Substance Use Disorder Treatment and Other Service Capacity in New Hampshire, Community Health Institute/JSI, NH Center for Excellence, 2014.
5 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

III.

OVERVIEW OF OPIOID USE DISORDER MEDICATIONS

According to the SAMHSA's Addiction Technology Transfer Center (ATTC) Network, *MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.* MAT is linked to many positive outcomes including:[6,7]

- Decreasing mortality;
- Increasing retention in treatment;
- Reducing medical and substance use disorder (SUD) treatment costs;
- Reducing opioid overdose among patients in treatment;
- Increasing abstinence from opioids; and
- Lowering a person's risk of contracting HIV or hepatitis C.

Three medications are approved by the U.S. Food and Drug Administration (FDA) for treating OUDs -- methadone, buprenorphine, and naltrexone -- with several products/formulations available for each of these medications. While all three pharmacotherapies are approved options with different efficacies and contraindications, this compendium will focus primarily on the following:

- Buprenorphine (all products/formulations: Suboxone®, Subutex®, Zubsolv®, Bunavail®)
- Naltrexone (extended-release injectable/depot/xr-npx: Vivitrol®)

These medications were selected because they may be prescribed in an office-based setting, unlike methadone which must be dispensed at certified opioid treatment programs (OTPs). Additionally, this compendium focuses on depot naltrexone, specifically Vivitrol, the only commercial product currently available, rather than oral naltrexone (ReVia®, Depade®) because poorer medication adherence with the oral form has resulted in poorer retention rates compared to depot naltrexone.[8] However, prescribers are strongly advised to have a thorough understanding of each therapeutic medication, and the different products and formulations available, in an effort to, in conjunction with the patient, identify which pharmacotherapy will be the best treatment option. Another therapeutic formulation is a buprenorphine implant which is currently being investigated by the FDA with an anticipated action date of February 27, 2016 if approved. It is also important to note that several medications are available to treat alcohol use disorders (AUDs) and can be prescribed in an office-based setting. SAMHSA's *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*[9] provides more information.

Sampling of Research Findings Associated with Buprenorphine, Naltrexone and Methadone

Research outcomes relative to these medications are important to review as medication assistance approaches are considered. For example, in an examination of buprenorphine maintenance versus placebo or methadone

6 Retrieved from Substance Abuse and Mental Health Services Administration (SAMHSA), Addiction Technology Transfer Center (ATTC) Network - http://attcnetwork.org/regional-centers/content.aspx?rc=northwest&content=STCUSTOM3.

7 Connery, H. Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. 2015. *Harv Rev Psychiatry.* 23(2):63-75.

8 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

9 Substance Abuse and Mental Health Services Administration and National Institute on Alcohol Abuse and Alcoholism, Medication for the Treatment of Alcohol Use Disorder: A Brief Guide. HHS Publication No. (SMA) 15-4907. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

maintenance, which included 31 trials and 5,430 participants, findings indicated that buprenorphine retains fewer people than methadone when dose intervals are flexible and at low fixed doses. However, at medium to high doses no differences are seen. Additionally, based on the literature reviewed, no difference was observed between methadone and buprenorphine for reducing criminal activity or mortality rates. Specifically, this research found the following:

- Low fixed-dose studies indicated that methadone (≤ 40 mg) was more likely to retain participants than low-dose buprenorphine (2 - 6 mg), (3 studies, 253 participants, RR 0.67; 95% CI: 0.52 to 0.87);
- No difference in retention was observed between medium-dose buprenorphine (7 - 15 mg) and medium-dose methadone (40 - 85 mg), (7 studies, 780 participants, RR 0.87; 95% CI 0.69 to 1.10); and
- No difference in retention was observed between high-dose buprenorphine (≥ 16 mg) and high-dose methadone (≥ 85 mg), (RR 0.79; 95% CI 0.20 to 3.16).[10]

Another study looked at the long-term (18-month) outcomes of office-based buprenorphine/naloxone maintenance therapy and the impact of socioeconomic status (SES) and other characteristics. Of the 176 opioid-dependent patients who were on buprenorphine/naloxone and receiving intensive outpatient counseling (IOP), 110 completed the follow-up interview with 77% of those who reported remaining on the medication. Individuals who were still on buprenorphine/naloxone were more likely to report abstinence, involvement with recovery programs, and to be employed. No differences were observed between high and low SES groups.[11]

Limited research is available comparing outcomes of depot naltrexone to buprenorphine and/or methadone. According to a 24-week, placebo-controlled, randomized trial of patients (n=250) who were either completing or recently completed detoxification and were receiving biweekly psychosocial support, the percentage of opioid-free weeks, negative urine drug results for opioids, was greater among the depot naltrexone group compared to the placebo group. Complete abstinence was sustained by 23% of the placebo group compared to 36% between weeks 5 and 24 for the depot naltrexone group.[12]

Depot naltrexone has been increasingly used with incarcerated and criminal justice-involved populations. In a retrospective study involving parolees and probationers (N=3,135), among those who identified opioids as a problem, individuals stayed in treatment longer (an average of 97 days) if treated with depot naltrexone (n=136) compared to those treated with oral naltrexone (63 days, n=34) or psychosocial treatment only (63 days, n=866). Those treated with buprenorphine/naloxone (69 days, n=163) showed no significant difference compared to depot naltrexone.[13]

According to the results of a retrospective, longitudinal study comparing patients who received MAT vs. those who did not receive medication to support recovery, of 10,513 patients who received one of the four approved medications for the treatment of opioid dependence (depot naltrexone, n=156, 1.5%; oral naltrexone, n=845, 8.3%; buprenorphine, n=7,596, 72% or methadone, n=1,916, 18.2%), the per-patient mean cost associated with treatment

10 Mattick RP, Breen C, Kimber J, Davoli M. *Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review).* Copyright © 2014. The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
11 Parran et. al. Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy. *Drug and Alcohol Dependence.* 106 (2010) 56–60.
12 Vivitrol Prescribing Information and Medication Guide. July 2013. Alkermes, Inc.
13 Data obtained from Alkermes, Inc. Lundy C, Stringer M, Crits-Cristoph P, et al. Extended-Released Naltrexone (XR-NTX) in St. Louis Parolees and Probationers. Poster Presented at: Research Society on Alcoholism (RSA) annual meeting. June 21-25, 2014.

including inpatient, outpatient and pharmacy costs was $10,710 vs. $6,791 for patients receiving no drug treatment; however, six-month risk-adjusted outcomes indicated lower total healthcare costs by 29% for patients who received a medication for their opioid dependence. Specifically, treatment with depot naltrexone was associated with significantly fewer opioid and non-opioid related hospitalizations and fewer emergency department visits than patients who received methadone. It is important to note that the cost of depot naltrexone is much higher in comparison to other medications for opioid dependence. However, in looking at total costs, this medication is not significantly different compared to oral naltrexone or buprenorphine, but is significantly lower than methadone.[14]

The following chart highlights the differences among the three medications.

DIFFERENCES AMONG OPIOID USE DISORDER MEDICATIONS [15,16,17,18]			
PRESCRIBING CONSIDERATIONS	**METHADONE**	**BUPRENORPHINE**	**NALTREXONE**
Product/Formulation		All products/formulations; Suboxone,* Subutex, Zubsolv,* Bunavail*	Extended-release injectable/depot/xr-npx; Vivitrol
Mechanism of Action	Full Agonist: Binds to and activates receptors. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Partial Agonist: Binds to and partially activates opioid receptor. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Antagonist: Binds and competitively blocks opioid reward effects.
Uses of Medication	Withdrawal and Treatment	Withdrawal and Treatment	Treatment
Route of Administration	Oral tablet or liquid	Sublingual tablet or sublingual or buccal film	Intramuscular (IM) Injection
Dose	PO: 5 mg, 10 mg tablets; 10/mg/mL liquid	PO: 2 mg, 4 mg, 8 mg, 12 mg film and 8 mg tablet	IV/IM: 380 mg in 4cc

14 Data obtained from Alkermes, Inc. Baser O, Chalk M, Fiellin DA, Gastfriend DR. Cost and utilization outcomes of opioid dependence treatments *Am J Manage Care.* 2011;17:S235-248.
15 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
16 National Council for Behavioral Health. Webinar: Making the Case: How MAT Improves Mental Health Care for those with OUDs held by Dr. Hilary Connery on October 6, 2015.
17 Retrieved from Substance Abuse and Mental Health Services Administration (SAMHSA). An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence. Winter 2012. Volume 11. Issue 1, http://www.integration.samhsa.gov/Intro_To_Injectable_Naltrexone.pdf.
18 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

PRESCRIBING CONSIDERATIONS	METHADONE	BUPRENORPHINE	NALTREXONE
Product/Formulation		All products/formulations; Suboxone,* Subutex, Zubsolv,* Bunavail*	Extended-release injectable/depot/xr-npx; Vivitrol
Frequency of Administration	Daily	Daily	Monthly
Dosage	Initial dose: 10 – 30 mg (titration is slow and monitored) Typical daily dose: 60 – 120 mg	Initial: 2 – 4 mg (increase by 2 – 4 mg) Daily: ≥ 8 mg (typically started at 8 or 16mg/day) Maximum: 24 mg/day	1 Injection (380 mg and 4cc) every 4 weeks
Regulatory Context	May only be dispensed at a certified opioid treatment program (see He-A 300 rules, part 304).[19]	Any licensed physician with a DEA registration and a buprenorphine waiver may prescribe (see pages 17-19).	Any healthcare provider who has a license to prescribe (e.g., physician, nurse practitioner, physician assistant).
Typical Visit Requirement	Initial: daily Progressing to maximum of thirteen doses within 14 days	Initial: weekly Interval increases based on patient progress	Monthly injection
Cost of Medication	Low	Medium	High
Cost of Treatment	Varies		
Controlled Substance Schedule	Schedule II	Schedule III	Not a scheduled medication
Overdose Potential	High	Moderate	None
Diversion Value	High	High	Low
Level of Engagement	All patients diagnosed with a substance use disorder can benefit from recovery support programs		
Discontinuation of Medication	Tapering Required	Tapering Required	No Tapering Required
Retention Rate	See pages 8-10 for data		

** Suboxone, Zubsolv, and Bunavail contain both buprenorphine and naloxone. Naloxone is an antagonist and is used to avoid the use of this drug intravenously. If intravenous abuse occurs, the person will experience immediate withdrawal compared to taking medication as prescribed.*

19 He-A 300 Certification and Operation of Alcohol and Other Drug Disorder Treatment Programs, Part He-A 304 Operational Requirements for Opioid Detoxification and Methadone Maintenance, Treatment, and Rehabilitation Programs, http://www.gencourt.state.nh.us/rules/state_agencies/he-a300.html

IV.

SERVICE DELIVERY AND CLINICAL CONSIDERATIONS

A high-level overview of each of the elements of an optimally organized office-based MAT program for the treatment of OUDs will be described in the following sections. Specific best practice recommendations and resources will be promoted throughout this guidance document to assist with the initiation or expansion of office-based MAT services for each of the various service delivery models: primary care based MAT delivery, behavioral health/specialty addiction treatment-based MAT delivery, and MAT-specific treatment programs as appropriate (see chart below).

Overview of Buprenorphine/Naltrexone Service Delivery Models				
			MAT-Specific Treatment Programs	
	Primary Care Clinic or Office	Behavioral Health/ Specialty Addiction Treatment Program	Free-Standing Buprenorphine Clinic	Opioid Treatment Program (OTP)/ Methadone Maintenance Clinic
General Description	Engages existing PCP to become waivered, prescribes buprenorphine/ naltrexone and arranges psychosocial treatment and recovery support services	Provides psychosocial treatment and recovery support services Either employs or contracts with waivered physician to prescribe buprenorphine/ naltrexone	Establishes clinic specifically to provide buprenorphine/ naltrexone Engages prescriber, psychosocial treatment provider and care coordination Either engages or refers to recovery support providers	Methadone clinic expands services to include prescribing of buprenorphine/ naltrexone Engages waivered physicians and utilizes existing psychosocial treatment provider and care coordination Either engages or refers to recovery support providers
Prescriber *Roles* • Diagnoses opioid dependence • Induces onto MAT • Prescribes • Provides routine follow-up visits	Waivered PCP or other waivered MD May link to other waivered physicians for cross coverage	Medical/Psychiatric Director or other medical staff become waivered Partner with waivered physician in community	Employed & waivered staff physician	Employed & waivered staff physician

Overview of Buprenorphine/Naltrexone Service Delivery Models				

Counselor
Roles
• Provides addiction counseling
  • Group
  • Individual as needed
• Engages in self-help and recovery support
• Therapy for co-occurring disorders requiring attention
	Embedded addiction counselor
	
	Contract with outside counseling provider
	
	Prescriber provides counseling
		Designated counseling staff	Designated counseling staff	Designated counseling staff

Care Coordinator ***Roles*** • Facilitates communication between prescriber & counselor • Phone contact with patient as needed • UDTs • Pill/film counts • Links with recovery support services	Nurse Medical assistant Prescriber	Case manager Counselor	Case manager Counselor	Case manager Counselor

Office-based MAT must aim to find the balance between maximizing access to life-saving medications and supporting recovery from opioid addiction, while minimizing unintended negative consequences such as diversion and misuse of treatment medications. The simplest form of MAT with buprenorphine which meets federal and state regulations involves a waivered physician writing a prescription for patients who meet criteria for opioid dependence, providing regular office visits, documenting care properly and ensuring capacity to refer patients for appropriate counseling and other appropriate ancillary services.

In addition to these requirements, there are other best practices that this guidance document promotes. They include querying the Prescription Drug Monitoring Program (PDMP) each time a prescription is written, routine and random urine drug testing (UDTs) and pill/film counts and timely communication among the prescriber, the patient and external providers. This model can be successful for some providers and patients.[20] Formal structuring of office systems to support best practices in MAT is strongly encouraged to facilitate efficient patient care and reduce system

20 Weiss, et al. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence. Archives of General Psychiatry. 68(12):1238-1246. 2011.

stress, especially if a provider treats more than a few patients with MAT. These processes would apply to all MAT.

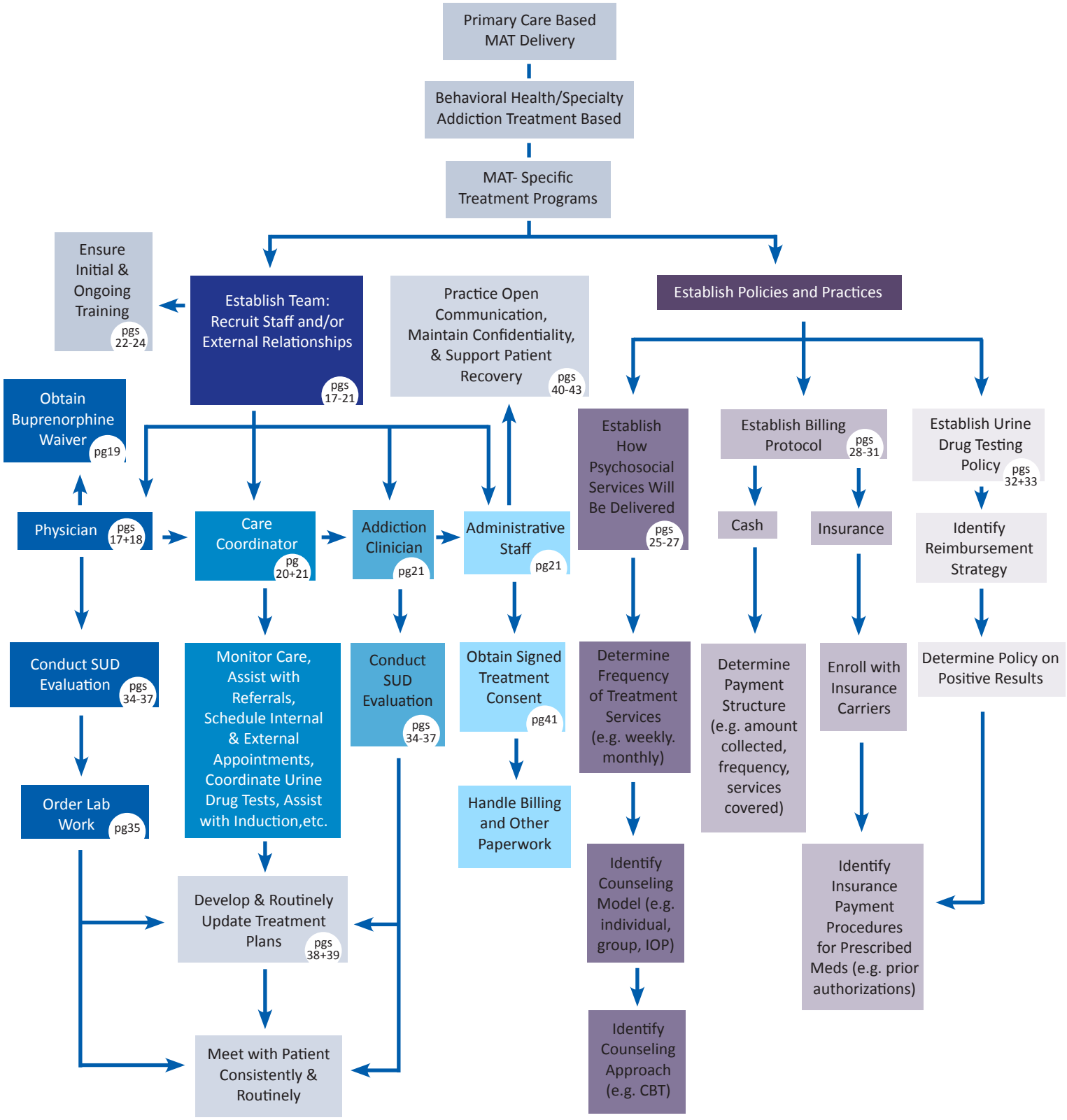
The following chart distinguishes federal and state requirements and the best practices (highlighted in blue) which New Hampshire is strongly promoting for its office-based opioid treatment (OBOT) programs to actively employ.

Federal Regulatory Requirements	State of New Hampshire Regulatory Requirements	New Hampshire Best Practices
• Physician to obtain buprenorphine waiver to prescribe (8 hours CME and exam) • Verify that patients meet criteria for opioid dependence • Determine patients are deemed appropriate for MAT level of care and medication • Conduct full evaluation and medical exam • Provide regular office visits • Document care properly (e.g., treatment plans, confidentiality) • Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services.	• Physician to obtain buprenorphine waiver to prescribe (8 hours CME and exam) • Verify that patients meet criteria for opioid dependence • Determine patients are deemed appropriate for MAT level of care and medication • Conduct full evaluation and medical exam • Provide regular office visits • Document care properly (e.g., treatment plans, confidentiality) • Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services.	• Physician to obtain buprenorphine waiver to prescribe (8 hours CME and exam) • Verify that patients meet criteria for opioid dependence • Determine patients are deemed appropriate for MAT level of care and medication • Conduct full evaluation and medical exam • Provide regular office visits • Document care properly (e.g., treatment plans, confidentiality) • Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services. • Query the PDMP each time a prescription is written • Identify additional qualified staff to include care coordinator • Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers • Perform routine and random UDT checks • Perform routine and random pill/film counts • Practice timely communication among the prescriber, the patient and external providers • Provide initial and on-going training and resources

Each of the components mentioned in the above chart is described in further detail in the following document in the order by which these tasks are most commonly implemented; however, the setting, and how prepared this specific setting is to implement office-based treatment services, will determine whether several components may be implemented simultaneously or a section of a component may be initiated during the planning phase with the remainder completed during the delivery of services. Providers may skip to the section of interest depending on where they are in the MAT implementation process.

Additionally, the MAT program should identify specific program goals before the implementation phase. These goals should be realistic and flexible. It should be anticipated that the first one to two years after implementation will involve identifying problems and adjusting programming and service delivery as necessary.

The following is a visual representation of the recommended best practices and tasks for the implementation of an OBOT program across multiple service delivery settings.


Primary Care Based MAT Delivery
Behavioral Health/Specialty Addiction Treatment Based
MAT- Specific Treatment Programs
Ensure Initial & Ongoing Training pgs 22-24
Establish Team: Recruit Staff and/or External Relationships pgs 17-21
Practice Open Communication, Maintain Confidentiality, & Support Patient Recovery pgs 40-43
Establish Policies and Practices
Obtain Buprenorphine Waiver pg19
Physician pgs 17+18
Care Coordinator pg 20+21
Addiction Clinician pg21
Administrative Staff pg21
Establish How Psychosocial Services Will Be Delivered pgs 25-27
Establish Billing Protocol pgs 28-31
Establish Urine Drug Testing Policy pgs 32+33
Cash
Insurance
Identify Reimbursement Strategy
Conduct SUD Evaluation pgs 34-37
Monitor Care, Assist with Referrals, Schedule Internal & External Appointments, Coordinate Urine Drug Tests, Assist with Induction,etc.
Conduct SUD Evaluation pgs 34-37
Obtain Signed Treatment Consent pg41
Determine Frequency of Treatment Services (e.g. weekly. monthly)
Determine Payment Structure (e.g. amount collected, frequency, services covered)
Enroll with Insurance Carriers
Determine Policy on Positive Results
Order Lab Work pg35
Handle Billing and Other Paperwork
Identify Counseling Model (e.g. individual, group, IOP)
Identify Insurance Payment Procedures for Prescribed Meds (e.g. prior authorizations)
Develop & Routinely Update Treatment Plans pgs 38+39
Identify Counseling Approach (e.g. CBT)
Meet with Patient Consistently & Routinely

IV.

A. STAFFING: Establish a Core Team

Establishing a core team dedicated to patient care and service coordination specific to MAT is fundamental for an organized MAT setting.[21] This team may be made up exclusively of clinic staff or may include partnering providers/ organizations in the community to provide comprehensive treatment services to meet patient needs.

To establish an effective team, it is important to identify or recruit interested and qualified staff who encompass the attitudes, values, and competence associated with treating opioid misuse. It is recommended that the team consist of, at a minimum, a prescriber, a care coordinator, a licensed alcohol and drug counselor (LADC) or behavioral health provider with addiction training, and non-clinical/administrative staff. The following describes each of the positions necessary for delivering effective MAT.

1. Prescriber

For either buprenorphine or naltrexone, a medical professional who is licensed to prescribe medications is necessary to provide patients with medicines to assist with their treatment program.

Buprenorphine (Suboxone/Subutex/Zubsolv/Bunavail): A buprenorphine prescriber must be a physician (MD or DO) who has received a buprenorphine waiver through the DEA (Drug Enforcement Administration). Waivered physicians can prescribe for up to 30 patients in the first year and can then apply to increase the limit to a maximum of 100 patients.

Physicians have been able to prescribe buprenorphine since October 2002 when the FDA approved buprenorphine for clinical use in treating opioid dependency; however, very few physicians in NH have obtained the waiver compared to other states. According to SAMHSA, as of October 7, 2015, eighty-four physicians have been waivered to treat at the 30-patient limit and fifty-nine physicians at the 100-patient limit. Of those 143 waivered physicians, only sixty-six have listed their contact information on SAMHSA's Buprenorphine Treatment Physician Locator[22] (see Appendix I: *Map of Buprenorphine Prescriber Locations*). Some may not be currently practicing, some may be at capacity, or some have chosen not to be listed for other reasons.

Naltrexone (Vivitrol): This medication may be prescribed by any healthcare provider (e.g., nurse practitioners, physician assistants) who is licensed to prescribe medications. There is no limit on the number of patients for whom this medication may be prescribed.

This extended-release injectable medication is the most recent drug, approved in October of 2010, for the treatment of opioid addiction. Despite the less restrictive rules regarding who can prescribe naltrexone, and the allowable number of patients, NH has very few providers. According to Alkermes, Inc.,[23] as of November 16, 2015, twenty-one health care providers are current Vivitrol prescribers (see Appendix II: *Map of Vivitrol Prescriber Locations*).

21 Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
22 Retrieved from the Substance Abuse and Mental Health Services Administration (SAMHSA) Buprenorphine Treatment Physician Locator, http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
23 Retrieved from Pamela O'Sullivan, Director of Government Affairs and Policy of Alkermes, Inc. on November 16, 2015.

Methadone: While methadone can be prescribed for pain treatment by any prescriber with a DEA registration, for purposes of addiction treatment it can only be dispensed at a licensed opioid treatment program (OTP)/ methadone clinic. For patients for whom methadone is determined to be the most appropriate option, primary care, behavioral health-based, and specialty addiction treatment programs can work with one of the eight licensed OTPs to coordinate integrated primary care, behavioral health, and opioid treatment services. New Hampshire has three organizations with a total of eight sites across the state certified to dispense methadone (see Appendix III: Ma*p of Opioid Treatment Program (OTP)/ Methadone Clinic Locations*).

The following table provides recommendations for identifying a prescriber by medication and setting type.

OVERVIEW OF MAT PRESCRIBER OPTIONS BY SETTING			
	PRIMARY CARE based MAT delivery	**BEHAVIORAL HEALTH / SPECIALTY ADDICTION TREATMENT** based MAT delivery	**MAT-SPECIFIC** treatment programs
Buprenorphine (Suboxone, Subutex, Zubsolv, Bunavail)	Have interested physician(s) in practice obtain buprenorphine waiver, prescribe medication, and oversee patient care.	Have staff physician obtain buprenorphine waiver. Establish a working relationship with a physician in the community waivered to prescribe buprenorphine.	Have staff physician obtain buprenorphine waiver. Hire physician(s) waivered to prescribe buprenorphine.
Naltrexone (Vivitrol)	Identify existing healthcare providers to prescribe naltrexone and oversee patient care.	Have staff physician prescribe naltrexone. Establish a working relationship with a healthcare provider in the community to prescribe naltrexone.	Have staff physician prescribe naltrexone. Hire or subcontract with a medical professional to prescribe naltrexone and to participate in oversight of patient care.
If methadone is determined to be the most appropriate medication for patients, providers can establish care coordination plans with one of the state's eight methadone clinics to support effective, integrated primary care, behavioral health care, and addiction treatment.			

Buprenorphine Waiver Training Information

TO QUALIFY FOR A BUPRENORPHINE WAIVER, A PHYSICIAN MUST:

1. Be a licensed physician (M.D. or D.O.)
2. Meet and verify any one or more of the following criteria:
   a. Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
   b. Hold an addiction certification from the American Society of Addiction Medicine (ASAM)
   c. Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association
   d. Complete an eight-hour addiction course on the management and treatment of patients with opioid use disorders as provided by an approved vendor.
   e. Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment.
   f. Have other training or experience that the state medical licensing board or Health and Human Services considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.
3. Submit notification of intent to SAMHSA.
   http://buprenorphine.samhsa.gov/pls/bwns/waiver

The DEA will send a letter within 45-60 days with approval status. If approved, an identification number will be provided to treat up to 30-patients for the first year.

After the first year of prescribing, a physician can submit a second letter of intent to treat up to 100 patients.
http://buprenorphine.samhsa.gov/pls/bwns/additional_notification_form?prefilled_or_online=ONLINE

For more information: *http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver*

BUPRENORPHINE WAIVER TRAININGS

(must be obtained from an approved organization)

American Academy of Addiction Psychiatry (AAAP)

http://www.aaap.org/education-training/buprenorphine/

- Half-and-Half Training - FREE
  3.75-hour online training
  4.25-hour in-person training
- Live training via computer on the 2nd Saturday (east coast morning) and 4th Wednesday (west coast evening) – FREE

American Society of Addiction Medicine (ASAM)

http://www.asam.org/education/live-and-online-cme/buprenorphine-course

- Half-and-Half Training - cost varies
  4-hour online training
  4-hour in-person training
- Blended course (online training and live webinar) - $75

American Osteopathic Academy of Addiction Medicine (AOAAM)

http://www.aoaam.org/?page=PCSSMAT&hhSearchTerms=%22PCSS-MAT%22

- Online training only – FREE

American Psychiatric Association (APA)

http://www.apaeducation.org/ihtml/application/student/interface.apa/index.htm

- Online training only

Resident/Fellow – FREE
Medical Student - $100
Member - $100
Non-Member - $200

2. Care Coordinator

Aside from the need for a prescriber to be involved in MAT programs in any setting, care coordination is the most critical component for effective addiction treatment and patient care. How care coordination is provided often varies from program to program, but there are components of effective care coordination that are consistent across different styles, approaches, and practice settings.

The most central component of successful MAT models is care coordination for patients.

Care coordination often involves a range of tasks and responsibilities specific to medication assistance, including coordinating induction, administering urine/lab screens and monitoring results, collaborating with external providers in compliance with Title 42, Part 2 of the Code of Federal Regulations (42 C.F.R., Part 2), and assisting patients with accessing social services (housing, medical care, legal services, childcare, employment support, etc.). Depending on the structure and capacities of the MAT setting, a case manager, medical assistant, physician's assistant, nurse, or another staff member may assume the role of care coordinator for a MAT program.

Example: Using Nurses to Coordinate Patient Care

In 2003, Boston Medical Center (BMC) created the Collaborative Care Model of Office-Based Opioid Treatment also known as the Massachusetts Model in an effort to expand access to buprenorphine treatment. The model utilizes Nurse Care Managers (NCMs) to provide clinical support to waivered physicians. Specifically, the NCM is the initial contact for patients and serves as the main liaison between the patient and physician throughout treatment. The NCM is responsible for conducting the initial patient assessment to better understand the patients' medical, social, and psychiatric history, supports the patient through the induction process, provides support and education through weekly appointments and telephone check-ins, conducts urine toxicology screens and verifies behavioral health counseling. Since the program's inception, BMC has grown to serve over 500 patients with twenty-four waivered primary care physicians.

In 2007, this model was implemented in community health centers through support provided by the Massachusetts Bureau of Substance Abuse Services (BSAS). By 2013, fourteen CHCs were enrolled in the State OBOT-B Program and the number of waivered physicians increased from 24 to 114. Since the grant was disseminated across the Commonwealth over 8,000 patients have been served. Each NCM has a caseload of 125 patients (8-12 patients per day) and receives assistance from a medical assistant. Seven out of the fourteen CHCs have expanded the size of their program and have hired an additional NCM to support the program. Additionally, as of 2013, 67% of the patients stayed in treatment for more than twelve months and 50% for more than five years.[24]

Information obtained from Colleen LaBelle, B.S.N., RN – B.C., C.A.R.N., Boston Medical Center on September 18, 2015.

24 Labelle, C. et. al. Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. *Journal of Substance Abuse Treatment.* (2015).

Most essential for care coordinators is not a specific set of credentials as much as an understanding of the nature of addiction, and of the behaviors associated with people experiencing addiction, in combination with a caring and problem solving approach to challenges.

It is important to note that many existing MAT programs may tend to divide responsibilities across available staff; however, treatment retention and compliance can be vastly improved through identifying one position to coordinate care for all MAT patients. Also, for MAT settings in which all services are not co-located, care coordination becomes even more critical.

3. Behavioral Health/Addiction Clinician

Effective MAT combines medication assistance with behavioral health and/or addiction-specific counseling and recovery support services such as recovery coaching and community support groups. Studies have found that programs providing regular, structured, substance use disorder-focused counseling had better outcomes than programs providing little or no counseling.[25] Having an on-site Licensed Alcohol and Drug Counselor (LADC), Master Level Alcohol and Drug Counselor (MLADC) or a behavioral health specialist with addiction training will help to encourage behavior change but will also ensure that patients are attending sessions and, therefore, receiving the support they will need to recover. If the MAT program does not have an addiction specialist on-site to deliver treatment services it will be crucial that a formal agreement be established with several treatment providers offering different levels of care in an effort to support a patients' recovery. Additionally, it will be important for the care coordinator to consistently monitor treatment attendance based on program expectations and routinely provide and obtain updates from the external clinician. Please refer to Section C: Psychosocial Treatment Services and Recovery Supports (pg 25-27) which describes the levels of care and suggested programming.

4. Administrative Staff

Non-clinical and administrative staff can be considered the glue of the program. These staff members are often responsible for obtaining intake information from patients, handling the billing and other accounting procedures, and most importantly they are the first person the patient comes in contact with. Thus, it is important that these personnel receive the same education and training as clinical staff to include addiction pharmacotherapy with a specific emphasis on stigma of drug addiction. If the patient has a negative experience right upon entering the program, this could influence their treatment. Staff should also receive on-going record keeping and confidentiality training.

INCENTIVES & SUPPORTS FOR RECRUITING AND RETAINING STAFF:

- Establish shared collegial patient care
- Pay training and registration fees
- Provide on-going supervision
- Encourage refresher and on-going training
- Ensure for practical caseloads
- Increase wages

25 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

IV.

B. TRAINING & RESOURCES: Provide Initial and On-Going Training & Resources

> *How . . . interactions [between OTP staff and patients] are conducted, and particularly the attitude of staff members, is probably the next most important determinant of treatment effectiveness after an adequate dose of methadone.*
>
> *(Bell 1998, p. 168)*

Patient outcomes are largely influenced by staff. It is important to ensure that the attitudes, values, and competence around MAT and interactions with patients among all staff are effective for delivering MAT services. All staff should have on-going access to training and supervision, resources and research. The following provides general resources and literature and training by discipline.

GENERAL RESOURCES	
MEDICATION ASSISTED TREATMENT	**The ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use** *http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf?sfvrsn=22* **Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options** The New England Comparative Effectiveness Public Advisory Council, Final Report, 2014. *http://cepac.icer-review.org/adaptations/opioid-dependence/* **CMS, SAMHSA, CDC, NIH Informational Bulletin** *http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf* **SAMHSA TIP 43: Medication Assisted Treatment For Opioid Addiction in Opioid Treatment Programs** *http://store.samhsa.gov/shin/content//SMA12-4214/SMA12-4214.pdf* **Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition), NIH** *http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface* **National Alliance for Medication Assisted Recovery** *http://methadone.org/* **Screening & Assessment Tools** *http://www.ncbi.nlm.nih.gov/books/NBK64244/*

RESOURCES BY MEDICATION	
BUPRENORPHINE	**SAMHSA TIP 40 - Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction** *http://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/Bookshelf_NBK64245.pdf* **National Alliance of Advocates for Buprenorphine** *http://www.naabt.org* **Clinical Opiate Withdrawal Scale (COWS) Flowsheet** *http://www.naabt.org/documents/cows_induction_flow_sheet.pdf* **Objective Opiate Withdrawal Scale (OOWS)** *http://www.ncbi.nlm.nih.gov/books/NBK143183/* **Subjective Opioid Withdrawal Scale (SOWS)** *http://www.buppractice.com/node/5775*
NALTREXONE	**An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence** SAMHSA Advisory, Winter 2012. Volume 11. Issue 1 *http://store.samhsa.gov/shin/content//SMA12-4682/SMA12-4682.pdf* **Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide** *http://store.samhsa.gov/shin/content//SMA14-4892R/SMA14-4892R.pdf*
METHADONE	**Methadone Overview** *http://www.samhsa.gov/medication-assisted-treatment/treatment/methadone*

RESOURCES BY DISCIPLINE	
PHYSICIAN	**Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT)** Mentoring from a physician, webinars & learning modules, tools & resources *http://pcssmat.org/* **One-hour refresher training for buprenorphine waivered physicians** *http://pcssmat.org/new-updated-buprenorphine-waiver-training-advanced-review-module/*
NURSE PRACTITIONER/ NURSE	**TAP 30 – Buprenorphine: A Guide for Nurses** *http://store.samhsa.gov/product/TAP-30-Buprenorphine-A-Guide-for-Nurses/SMA09-4376*
BEHAVIORAL HEALTH/ ADDICTION CLINICIAN	**Six-hour training for multidisciplinary addiction professionals** *http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/buptx/*
NON-CLINICAL & ADMINISTRATIVE PERSONNEL	**Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs In-service Training** Covers basic principles, best practices, history, and regulation. Includes scripted modules and handouts *http://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-OpioidTreatment-Programs/SMA09-4341*

WEBSITES

Anyone.Anytime.NH Campaign - *anyoneanytime.org*
Public education and awareness campaign designed to help anyone affected by opioid addiction, including people experiencing addiction, families, healthcare, safety and other systems.

NH Alcohol and Drug Treatment Locator - *nhtreatment.org*
An on-line directory for locating alcohol and drug treatment service providers in New Hampshire who offer evaluation services, withdrawal management, outpatient counseling, residential treatment, recovery supports and other services by location, service type, population/specialties served, and/or payer.

The Hungry Heart - *Thehungryheartmovie.org*
Documentary of a pediatrician who prescribes Suboxone to his patients from varied SES backgrounds struggling with prescription drug addiction and the challenges in treating this disease.

IV.

C. PSYCHOSOCIAL TREATMENT SERVICES & RECOVERY SUPPORTS: Identify What and How Substance Use Disorder Services Will Be Delivered

There are three important parts to MAT: medication, counseling and care coordination. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.[26] Additionally, when a patient is started on MAT, many third-party payers and the DEA require that the prescriber is capable of referring the patient to supportive psychosocial therapy or the patient has already started to receive behavioral therapy services along with their medication. These services can either be delivered on-site or off-site.

The following chart highlights what is needed depending on how psychosocial supports are delivered.

DELIVERY OF PSYCHOSOCIAL SERVICES	
ON-SITE	**OFF-SITE**
• Already have or hire a behavioral health/addiction clinician • Identify the type of treatment that will be provided (e.g., individual, group, intensive outpatient counseling) • Identify the psychosocial approaches that will be used (e.g., CBT, MET) • Determine the frequency of services • Review psychosocial treatment expectations and responsibilities with patient	• Establish a strong working relationship with several treatment providers offering different levels of treatment • Review psychosocial treatment expectations and responsibilities with patient • Obtain signed consent form from patient to approve open communication • Routinely provide and obtain updates from the external clinician (see Section A: Staffing; pg 20) to consistently monitor treatment attendance and progress

The most common counseling models used include individual, group, and family counseling.

- **Individual Outpatient Counseling** – *Service provided by a clinician to assist an individual in achieving treatment objectives through the exploration of SUDs and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug-related problems.*
- **Group Outpatient Counseling** – *Service provided by a clinician to assist two or more individuals and/or their families/significant others in achieving treatment objectives through the exploration of SUDs and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug-related problems.*
- **Family Counseling** – *Provides education, allows family members to express their feelings and concerns, and helps secure the family's support for the person in recovery.*

26 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Group medical visits have been used in some MAT practices as another therapeutic option. These involve the prescriber and behavioral health/addiction clinician co-facilitating a group with a ten-minute individual medical appointment preceding or following the group. Advantages of group counseling over individual counseling include the opportunity for patients to interact and problem solve with their peers[27] and more efficient provision of counseling services.

Example: Utilizing Group Medical Visits to Provide Substance Use Disorder Treatment

An independent OBOT program uses a group medical visit approach for delivering psychosocial and medical treatment. Each week patients are required to participate in a group visit which is facilitated by an addiction clinician. A prescriber is, at times, present during the group to answer and discuss any medical-related questions. Each group consists of no more than fifteen people to ensure adequate opportunity for everyone to share. Before or after the group, the prescriber meets with each patient for a ten-minute check-in to review treatment plan goals, discussing medication adherence, side effects, treatment progress and concerns. This treatment model provides patients with the opportunity to problem solve and gain support from their peers while also being able to discuss medical concerns directly with the prescriber. Additionally, patients are required to attend group in order to receive a prescription to obtain their medication.

Information obtained from Heather Prebish, Recover Together Program Coordinator, on September 18, 2015.

It is important to note that MAT can be provided during any level of care. The following describes additional treatment options available in NH.

- **Intensive Outpatient Program (IOP) –** *Structured individual and group alcohol and/or drug treatment services and activities that are provided at least three hours a day and at least three days a week according to an individualized treatment plan.*
- **Partial Hospitalization –** *Combination of 20 or more hours per week of group and individual sessions in conjunction with, either directly or through referral, medical and psychiatric services, psychopharmacological services, addiction medication management, recovery support services and 24-hour crisis services.*
- **Residential Services –** *Program providing 24-hour support and services where an individual lives full time at the program and receives individual and/or group counseling, educational sessions and introduction to self-help groups.*
- **Recovery Support Services –** *Services provided to individuals and/or their families to help stabilize and support recovery. Services may include employment services, anger management, recovery mentoring/relapse prevention management, peer recovery coaching, care coordination, childcare, transportation, sober housing, and other supports.*

27 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

In addition to identifying the type of treatment that will be provided, the program will need to determine which psychosocial treatment approaches will be used to initiate behavior change. Some approaches utilize positive reinforcement while others capitalize on readiness to change. The table to the right lists some of the more commonly used psychosocial treatment approaches.

Regardless of the type of treatment or approaches used, several topics should be covered including:[28]

- Education about addiction and the effects of substances of abuse;
- Education about relapse prevention strategies to learn skills to attain and maintain abstinence;
- Education on opioid-related health issues (e.g., HIV, Hepatitis);
- Providing linkages to existing family support systems; and
- Providing referrals to community supports.

Examples of Psychosocial Treatment Approaches:

- Cognitive behavioral therapy
- Motivational enhancement therapy
- Contingency management/ motivational incentives
- Community reinforcement approach
- Behavioral couples counseling

NH Alcohol and Drug TREATMENT LOCATOR

To locate service providers, visit the NH Alcohol and Drug Treatment Locator, www.nhtreatment.org an on-line directory for locating alcohol and drug treatment service providers in New Hampshire who offer evaluation services, withdrawal management, outpatient counseling, residential treatment, recovery supports and other services by location, service type, population/specialties served, and/or payer.

Example: Supporting Patient Needs by Offering Multiple Pharmacotherapy and Psychosocial Treatment Options

One OTP offers a full array of SUD services to include most products and formulations of methadone, buprenorphine, and naltrexone and a variety of psychosocial treatments including residential treatment. These services are made available to patients depending on multiple factors including physiological aspects, socioeconomic factors, setting (e.g., more structure, frequency of visits), and medication adherence. Patients are mandated to one group session per month, brief psychosocial counseling with a physician monthly, and are encouraged to participate in recovery support groups.

Information obtained from Stephen Straubing MD, DABAM, Meridian Behavioral Healthcare, Gainesville, FL. on October 8, 2015.

28 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

D. BILLING: Determine How Services Will Be Paid

Services can be covered through a variety of payer/payment mechanisms to include cash and third-party payers. While cash can be collected to cover the services that are delivered, it is recommended that office-based opioid treatment programs credential with third-party payers in an effort to better support patients and their ability to access available services.

1. **If services will be reimbursed via a non-insurance payment model:** Establish a payment structure to identify how much will be collected, how often and what services this payment will cover. Additionally, determine how late fees will be handled and how the practice will assist individuals who may not be able to pay for services in full.

Example: MAT-Specific Treatment Program Using a Non-Insurance Payment Model

On-site counseling, consultation with a prescriber, urine drug screens and pill counts are provided at one OBOT program. This program does not accept insurance for its clinical services. Patients pay for services on a weekly basis via money order, credit or debit card. This fee covers weekly group counseling, consultation with a prescriber, and weekly prescriptions. The program will help the patient cover the cost of medication through insurance. A patient can carry over one week's worth of payment if needed.

Information obtained from Heather Prebish, Recover Together Program Coordinator, on September 18, 2015.

2. **If services will be reimbursed through third-party payers:** Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers. It is important to understand the various parts of the NH Health Insurance Marketplace to include the NH Health Protection Program (NHHPP) and the Premium Assistance Program (PAP). For more information please visit: *http://www.dhhs.state.nh.us/ombp/pap/, http://www.nh.gov/insurance/consumers/mp_plans.htm, and http://www.dhhs.nh.gov/ombp/nhhpp/.* Please take into consideration that enrolling with an MCO, QHP or other insurer takes time.

The following chart highlights the various insurers that are available in NH and the substance use disorder services that are covered by each payer.

COVERED SUBSTANCE USE DISORDER SERVICES BY PAYER		
Insurance Type	**Payer**	**SUD Service Coverage**
Managed Care Organizations	• Cenpatico/NH Healthy Families • Well Sense/Beacon Health Strategies	Screening; assessment; withdrawal management (detoxification) within acute care settings; treatment with methadone in Opioid Treatment Programs; individual, group and family counseling; crisis intervention; screening, brief intervention and referral to treatment (SBIRT); treatment with buprenorphine in Opioid Treatment Programs; office-based, medication-assisted treatment with a primary care provider; intensive outpatient services; partial hospitalization services; residential rehabilitative services; medically-monitored withdrawal management-residential and ambulatory; individual and group peer and non-peer recovery supports; and continuous recovery monitoring.
Qualified Health Plans & Other Insurers	• Ambetter (Cenpatico/NH Healthy Families) • Maine Community Health Options • Harvard Pilgrim • Anthem • Minuteman Health Plan • Tricare • Other Insurers	Service array varies depending on payer and plan

The MCOs and other third-party carriers use specific strategies to help manage the prescribing of addiction medicines. It is important to be aware of the requirements of each carrier, and the time it takes to meet them, prior to prescribing medication, to ensure that the patient does not become responsible for unpaid claims. For example, some insurers require a prior authorization which must include a written statement that the patient is receiving addiction counseling from a qualified counselor. Approval of prior authorization may take up to 48 hours.

INSURANCE STRATEGIES FOR MANAGING MEDICATION ASSISTED TREATMENT [29]		
Preferred Drug List (PDL)	**Prior Authorization**	**Medical Necessity: Quantity and Duration Limits**
Identify if a medication is on the PDL.	*If a prescribed medication is not on the PDL, the provider will need to obtain a prior authorization before the medication will be paid for.*	*A provider should be aware of utilization guidelines for each medication prescribed in that restrictions may be placed on the amount prescribed and the frequency of the prescription.*

The following chart highlights the strategies that should be identified for each MCO and third-party payer.

INSURANCE STRATEGIES					
Medication	**Is the medication covered?**	**Is the med on the PDL?**	**Frequency of prior authorizations?**	**Quantity limits?**	**Duration limits?**
Buprenorphine					
Suboxone					
Suboxone MIS 12/3mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 2/0.5mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 4/1mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 8/2mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 2/0.5mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Suboxone MIS 8/2mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Subutex					
Subutex SUB 8mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv					
Zubsolv SUB 1.4/0.36mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 2.9/0.71mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 5.7/1.4mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 8.6/2.1 mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 6.3/1mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Bunavail					
Bunavail MIS 2.1/0.3mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Bunavail MIS 4.2/0.7mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Bunavail MIS 6.3/1mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Naltrexone					
Vivitrol					
Vivitrol IM 380mg	Yes/No	Yes/No	Per month/year	# of injections	# of days

29 Retrieved from CMS, SAMHSA, CDC, NIH Informational Bulletin - http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf.

It is essential that all prescribers utilize NH's prescription drug monitoring program (PDMP) to monitor and analyze prescribing and dispensing data prior to prescribing medication in an effort to ensure appropriate prescribing. The PDMP grants practitioners access to system accounts to look up and view controlled substance dispensing information on specific recipients. Individuals with a NH license and a DEA registration (from any state) are required to register with the PDMP. Prescribers are encouraged to register with the PDMP in contiguous states, if possible.

Drug utilization reviews (DURs) may be initiated by a MCO or third-party carrier in which claims documentation is reviewed against a clinical database to identify patient prescribing discrepancies (e.g., duplication of prescriptions, incompatibility with other prescriptions).

To register in the NH Prescription Drug Monitoring Program (NH PDMP):

1. Open an Internet browser window and navigate to the following URL: *www.newhampshirepdmp.com*
   - Click the Practitioner/Pharmacist link located on the left menu
   - Click Registration Site (a login window is displayed)
   - Type "newacct" in the user name field
   - Type "welcome" in the password field
   - Click OK
   - Complete the fields on this form:
     Account Type: Select "Master"
     License line: Put the following if you are a:
     Physician Assistant, please put PA(license#) example: PA1234
     Optometrist, please put OD(license #) example: OD1234
     Podiatrist, please put P(license#) example: P1234
     Dentist – please just put D(license#) example: D1234
     Veterinarian – please just put V(license #) example: V1234
     MD, DO, APRN – please just put (license #) example:1234
     Pharmacist please put (license#) – If you have an "R" before your license be sure to include this. example:1234 or R1234
   - Click submit

If information is incomplete or missing, a message is displayed indicating which fields must be corrected before your account request form can be submitted. Required fields are indicated with an asterisk (*).

If all information has been properly supplied, a completed account request form is displayed along with a registration number and a prompt to print the form.

2. Email registration number to Michelle Ricco-Jonas at *Michelle.RiccoJonas@nh.gov* to activate account.

3. If you are approved for an account, you will be notified via two separate e-mails. The first e-mail will contain your approval notification and user name information. The second e-mail will contain your temporary password, your personal identification number (PIN) that you will use to identify yourself if you need assistance from the Help Desk, and the steps to follow to log in to the system. You will be required to change the temporary password immediately when you first attempt to access the system.

4. While waiting for confirmation, submit your registration form to your respective regulatory board as "proof" of your registration when sending in your license application.

For any other questions, please call the NH Help Desk at 855-353-9903.

E. URINE DRUG TESTING: Establish a Policy

Urine drug testing (UDT) is used in SUD treatment to confirm adherence to a prescribed medication as well as detect illicit or licit drugs that may interfere with a treatment and recovery program. It is an objective measure of treatment and a tool for monitoring patient progress. It is recommended that standard testing be integrated into the initial evaluation process and conducted throughout treatment.

Two types of tests are available:

> ***Qualitative drug testing*** determines the presence or absence of a drug or drug metabolite. The test result is expressed in non-numerical terms.
>
> ***Quantitative drug testing*** determines the specific quantity of a drug or drug metabolite. The test result is expressed in numerical terms.

The panel recommends, at a minimum, qualitative UDT during each visit, as well as random drug testing. More or less frequent drug testing may be needed, with more testing early in treatment or during periods of relapse, depending on several factors:

- stability of the patient;
- type of treatment;
- treatment setting; and
- half-life of medication taken.[30]

Drug screens may be conducted in-house or via a lab. A number of drug testing companies and hospitals are available to conduct these tests. Several factors should be taken into consideration when selecting a vendor:

- panels offered;
- cost (prices can vary and depend on the substances that the company tests for); and
- turn-around time of results.

Additionally, it is recommended that when utilizing UDT in clinical/confirmation settings (and not just screening situations) to have a resource to which to refer questions. This may be a toxicologist or another colleague with training in drug testing interpretation. Some reference labs offer free telephone consultation with their pathologist.

30 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015

The following table summarizes the main steps recommended to implement a UDT policy.

URINE DRUG TESTING (UDT) POLICY		
UDT Guidelines	Reimbursement Strategy	Response to Results
Determine how tests will be conducted and frequency	Determine how each test will be paid for (cash vs. insurance)	Establish policy on drug screens: presence of unexpected substance and absence of prescribed medication.

While UDT is a management tool necessary in the care of patients with addictive disorders, insurers vary in benefits where insurer payment denials have been reported. Before ordering any testing, prescribers should become familiar with the type of test offered (i.e., immunoassay, LC/MS, GC/MS), which drugs are on the testing panel, and the cost. Having this information will help avoid patients being charged substantial fees and/or unpaid claims.

The following UDT information should be identified for each insurer.

- Panel
- Test Performed
- Need and Frequency of Prior Authorizations
- Quantity Limits
- Duration Limits
- Cost

IV.

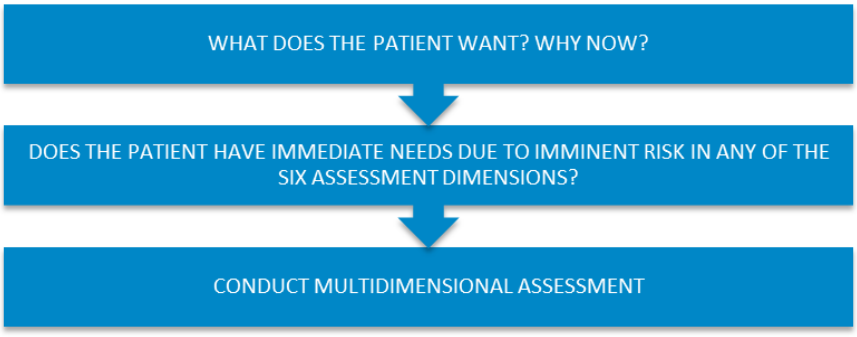
F. EVALUATION: Establish a Process for Assessing the Patient

Prior to prescribing medication a thorough evaluation should be conducted with the patient to identify if he/she is an appropriate candidate for MAT and, if so, the type of medication that would be most suitable.

A clinical and medical assessment should be conducted with both specifically focusing on the six dimensions of an individual as described by the ASAM. Understanding the patient's medical history, past and current use of alcohol and/or drugs, family background, environment and other factors, will help identify which medication and psychosocial treatment would be most appropriate.

It is recommended that the alcohol and drug counselor and prescriber be involved with the evaluation process. On average, a thorough evaluation can take up to three hours to complete. The following indicates the steps for conducting a thorough evaluation.[31]

1. **Conduct Patient Assessment:** Evaluate the patient's physical, mental and emotional health, past and current substance use, medical history -- identification of medications, allergies, pregnancy, family medical history, history of infectious diseases such as hepatitis, HIV, and TB -- and social and environmental factors, to identify barriers to addiction treatment and other circumstances. Evidence-based tools such as the Addiction Severity Index (ASI)[32], a semi-structured assessment tool available on the public domain, can be used to evaluate an individual. Additionally, it is critical to engage the patient in the treatment process by asking open-ended questions to identify what his/her treatment goals are and why.[33]



Sample Evaluation Questions:

- How long have you been taking the opioid drug?
- Are you taking other drugs?
- How often do you use these substances?
- Have you been in treatment before? What were the outcomes?
- Do you have any other health problems?
- Are you taking any prescribed medications?
- Have you ever had a reaction to a medication?
- Are you pregnant?
- What are your goals for recovery?
- Do you have family and friends who are supportive of your recovery?

31 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.
32 Retrieved from the Treatment Research Institute - http://www.tresearch.org/tools/download-asi-instruments-manuals/.
33 Substance Abuse and Mental Health Services Administration. *Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends.*

Rate the severity of each dimension, based on the information gathered from the evidence-based assessment and additional questions asked, to determine an appropriate level of care for the patient.

The table below lists appropriate observations for each ASAM dimension that would qualify an individual for needing opioid pharmacotherapy as a component of overall treatment.

ASAM Dimensions	Observation
DIMENSION 1: Alcohol Intoxication and/or Withdrawal Potential	Physiologically dependent on opiates and requires opioid maintenance therapy to prevent withdrawal
DIMENSION 2: Biomedical Conditions and Complications	None or manageable with outpatient medical monitoring
DIMENSION 3: Emotional/Behavioral/Cognitive Conditions and Complications	None or manageable in an outpatient structured environment
DIMENSION 4: Readiness to Change	Ready to change the negative effects of opiate use, but not ready for total abstinence
DIMENSION 5: Relapse/Continued Use/Continued Problem Potential	At high risk of relapse/continued use without opioid maintenance therapy and structured treatment to promote treatment progress
DIMENSION 6: Recovery Environment	Has supportive recovery environment and/or skills to cope

2. **Conduct Physical Exam:** An exam should be performed by either the prescribing physician or another healthcare provider prior to prescribing medication. The exam should include identifying physical signs of opioid intoxication or withdrawal (e.g., restlessness, sweating, needle tracks) and signs of a substance use disorder (e.g., abscesses, cellulitis).

3. **Conduct Laboratory Tests/Urine Screens:** The following labs/urine drug screens should be considered at the time of initial evaluation:

   a. infectious disease (tuberculosis, hepatitis A, B, C, sexually transmitted diseases and HIV);
   b. pregnancy test;
   c. blood count;
   d. urine drug screen; and
   e. liver function test.

Depending on the results of these tests further follow up may be required.

Opioid Use Disorder Severity Classifications:

Mild: 2 – 3 symptoms

Moderate: 4 – 5 symptoms

Severe: 6 – 11 symptoms

4. **Determine Diagnosis:** A diagnosis for OUD must be identified before prescribing a medication. The assessment, physical exam, urine drug screen, and other information gathered during the evaluation process should be used to help determine the diagnosis. A patient must be diagnosed with at least a "mild" opioid use disorder, two of eleven criteria indicated in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) met by the patient within the last twelve months. A non-medical clinician can determine this diagnosis; however the prescribing physician should verify this determination.

5. **Other Evaluation Tools:** Several opioid withdrawal scales are available to help a clinician identify and quantify OUDs. These include:

   a. Objective Opiate Withdrawal Scale (OOWS)[34] – Tool for determining level of withdrawal (see Appendix IV: *Objective Opiate Withdrawal Scale (OOWS)).*

   b. Subjective Opioid Withdrawal Scale (SOWS)[35] – Self-reporting tool for identifying opioid withdrawal (see Appendix V: *Subjective Opioid Withdrawal Scale (SOWS)).*

   c. Clinical Opioid Withdrawal Scale (COWS)[36] – Tool for identifying signs and symptoms which integrates subjective and objective items (see Appendix VI: *Clinical Opioid Withdrawal Scale (COWS)).*

34 Retrieved from the National Institutes of Health - http://www.ncbi.nlm.nih.gov/books/NBK143183/.
35 Retrieved from buppractice - http://www.buppractice.com/node/5775.
36 Retrieved from The National Alliance of Advocates for Buprenorphine Treatment - http://www.naabt.org/documents/cows_induction_flow_sheet.pdf.

The following table summarizes when and by whom each evaluation component should be initiated.

Evaluation Components	Staff Responsible for Component	Initiation of Evaluation Component
Assessment	• Behavioral Health/Addiction Clinician • Strongly recommended that prescriber conduct an abbreviated assessment	Completion of the assessment may be completed over a period of a few sessions; however, a shortened version should be conducted at intake to identify information necessary to prescribe the appropriate pharmacotherapy.
Physical Exam	Prescriber or other health care provider	Prior to prescribing pharmacotherapy
Lab Tests	• Prescriber or other healthcare provider may order • May be conducted in-house or an outside lab may be used	Prior to prescribing pharmacotherapy
Diagnosis	• Behavioral Health/Addiction Clinician • Prescriber must verify diagnosis	Prior to prescribing pharmacotherapy

Example: Promoting Individualized Care through Comprehensive Evaluation

A wide array of services to include primary care, addiction medicine and psychiatry are offered at one practice. The addiction program offers individual and group counseling and office-based opioid treatment. Prior to prescribing medication, an evaluation of the patient is conducted which takes approximately three hours. The patient meets with the intake and project coordinator who conducts a 1.5 – two hour assessment, a half hour is spent with the addiction medicine physician who also performs a physical exam, and a one-hour psychiatric consult is provided. This comprehensive evaluation allows the care team to identify the appropriate treatment needed. The model this practice utilizes, in which all services are available, assists with the evaluation process, and also allows for patients to receive specialized and coordinated care.

Information obtained from Dr. Mark Logan, Green Mountain Family Practice Medicine, Rutland, VT in September 2015.

G. TREATMENT PLANNING: Monitor Patient Progress

After the patient has been evaluated, the prescriber and clinician will need to determine appropriate medication and psychosocial treatment. The plan should be the result of shared decision-making with the patient, and the conversation may include supportive family and friends if the patient chooses. Several factors will need to be taken into consideration when determining which medication and addiction treatment will be the best option. These include:

- physiological aspects;
- setting (e.g., more structure, frequency of visits);
- socioeconomic factors (e.g., transportation, child care, employment/education schedule); and
- medication adherence.

If the prescriber and clinician are not considerate of these factors, medication and psychosocial treatment adherence may be adversely affected and the patient's recovery compromised.

Two respective treatment plans, one for monitoring MAT and one for addiction treatment, will need to be developed. One inclusive plan is acceptable for settings that provide both services, medication and psychosocial treatment. Treatment plans should be developed following a M.A.T.R.S.[37] (measurable, attainable, time-limited, realistic, sensitive) approach. Appendix VII: *Treatment Planning M.A.T.R.S. Checklist* highlights specific questions that should be considered for each section of the treatment plan including the goals, objectives, and interventions.

The M.A.T.R.S. Test

Measurable?	*Can change be documented (include dates, types and frequency of services, number of days drug free)?*
Attainable?	*Achievable within the active treatment phase?*
Time-limited?	*Is time frame specified (include dates and time frames)? Will staff be able to review within a specific period of time?*
Realistic?	*Is it reasonable to expect the client will be able to take steps on his/her own behalf (identify actions that can be attained based on client environment, supports, diagnosis, level of functioning)? Is it agreeable to client and staff?*
Specific?	*Will client understand what is expected and how program/staff will assist in reaching goals?*

37 Retrieved from the Addiction Technology Transfer Center Network (ATTC), Treatment Planning M.A.T.R.S. - http://attcnetwork.org/projects/txplanning.aspx.

The following highlights recommended items to include in the medication and psychosocial treatment plans.

Medication Assisted Treatment Plan

- Goals of treatment
- Treatment objectives over a defined period of time
- Medication and dose level
- Frequency and type of treatment (in-person visits/check-in calls)
- Counseling plan
- Consequences for non-adherence to the plan

Psychosocial Treatment Plan

- Goals of treatment
- Treatment objectives over a defined period of time
- Frequency and type of treatment
- (individual and/or group counseling or higher level of care)
- Linkages to existing family support systems
- Referrals to community-based services
- (e.g. housing, employment assistance, legal services)
- Referrals to recovery support services (e.g. 12 step faith-based programs, recovery coaching)
- Medication plan
- Consequences for non-adherence to the plan

Appendix VIII: *Sample Treatment Plan Form* provides a template that can be used/modified to document patient progress.

Usually providers have a patient sign a treatment agreement to clarify treatment goals, help patients understand what is expected of them and promote compliance. The agreement should not be presented as potentially punitive. In the event that a patient does not follow the plan and/or relapses, it is recommended that the prescriber and clinician review and revise treatment plans accordingly, rather than summarily discharging a patient. There will be circumstances, of course, when discharge is necessary. A sample treatment agreement[38] for the prescribing of opioid medications is provided in Appendix IX: *Sample Treatment Agreement*. This agreement can be modified for use in a psychosocial treatment setting.

A person can be on opioid medication for an undefined amount of time, short- or long-term. During this time whether for a few months, a year, several years or longer, the prescriber and clinician should work collaboratively, consistently and routinely evaluating the patient to ensure he/she is receiving appropriate medication and the right level of treatment.

38 Center for Substance Abuse Treatment.*Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

V.

OTHER CONSIDERATIONS

In addition to the components described, there are others to consider when providing office-based MAT. It is important that practices looking to have a successful model of care consider the recommendations discussed in the following sections.

V.

A. Confidentiality/42 C.F.R., Part 2

A patient's confidentiality and privacy related to alcohol and drug treatment is protected by SAMHSA confidentiality regulation *Title 42, Part 2 of the Code of Federal Regulations* (42 C.F.R. Part 2). The following is an overview of 42 C.F.R., Part 2. For more information visit *http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl.* Addiction treatment providers are required to handle patient information with increased confidentiality compared to other providers. To disclose information with another provider (e.g., pharmacist, primary care provider) written informed consent must be obtained from the patient. Consent should be obtained from the patient for anyone with whom the provider may discuss their treatment. It is recommended that consent forms be signed upon admission to avoid any issues during the course of treatment. There are some instances in which there may be exceptions to this policy, including:

1. a patient is in imminent danger of harming himself/herself or others;
2. crimes on agency/program property;
3. child abuse or neglect;
4. abuse, neglect, exploitation, or self neglect of incapacitated adults; and
5. other medical emergency.

Third-Party Consent Examples (if applicable):

- ✓ Families
- ✓ Friends
- ✓ Employers
- ✓ Allied Healthcare Providers
- ✓ Third-Party Payers
- ✓ Law Enforcement Officers
- ✓ Pharmacists
- ✓ Social Service Agencies

Consent Form Components

1. Name of patient
2. Name of provider
3. Type and amount of information to be disclosed
4. Name or title of the individual or organization to which disclosure is to be made
5. Purpose of disclosure
6. Date (on which this consent is signed)
7. Signature of patient
8. Signature of parent or guardian (if applicable)
9. Signature of individual authorized to sign in lieu of the patient (if applicable)
10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate on: (specific date, event, or condition).

Disclosure Language (must be included on consent):
This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

B. Communications

Essential to a MAT program is effective, timely communication among the prescriber, the patient and a variety of providers, both internal and external. The communication must be well documented, confidential, and consistent with SAMHSA confidentiality regulation *Title 42, Part 2 of the Code of Federal Regulations* (42 C.F.R. Part 2). Policies and practices should be established for each level of communication to ensure that care is well coordinated and aligned with patient needs.

The chart below highlights several factors to consider.

Patient Communication	Intra-office Communication	External Communication
• Establish and review program guidelines, expectations and responsibilities during first visit • Discuss frequency of face-to-face visits with prescriber • Review how to communicate with prescriber and prescriber's office outside of scheduled visits	• Identify care coordinator and responsibilities (e.g. nurse, addiction clinician, other office staff) • Document care plan in electronic record • Document office visits and UDT results • Establish routine meeting times for practice stakeholders to discuss patient progress, challenges and administrative issues	• Establish protocol for written and oral communication between prescriber and primary care provider (PCP) and counselor/therapist (if not located in practice) and incorporation into electronic medical record • Determine responsibility for monitoring adherence to program, need for increase in intensity of therapy or discharge • Collaborate with other health care providers who are managing concurrent health problems that are complicated by the patient's MAT (e.g., pregnancy, surgical procedures requiring pain control)

C. Stigma

Addiction is highly stigmatized on many fronts. Similarly, MAT can be a controversial issue. Some professionals in the field, as well as individuals in recovery, do not support the use of medication and consider methadone, buprenorphine and naltrexone as "replacing one drug for another." It is important for all staff to recognize that:

1. addiction is a chronic, relapsing disease;
2. on-going support will be needed to help a person stop using alcohol and/or drugs;
3. treatment may require the use of medications, low- or high-intensity addiction treatment and/or recovery support services;
4. the use of medication in conjunction with treatment and recovery supports is most often the best choice for treating opioid addiction; and
5. people are at a higher risk of addiction because of their genes, temperament, or personal situation.[39]

If patients express concerns about stigma, reassure them that they have a disease in the same way that others may have diabetes, hypertension or other chronic conditions. In each of these cases, a treatment plan is developed which may include the use of medications. Commend efforts to seek help and participate in the necessary treatment to reach recovery goals.

39 Substance Abuse and Mental Health Services Administration. Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends.

VI.

APPENDICES

Appendix I: Map of Buprenorphine Prescriber Locations

Appendix II: Map of Vivitrol Prescriber Locations

Appendix III: Map of Opioid Treatment Program (OTP)/ Methadone Clinic Locations

Appendix IV: Objective Opiate Withdrawal Scale (OOWS)

Appendix V: Subjective Opioid Withdrawal Scale (SOWS)

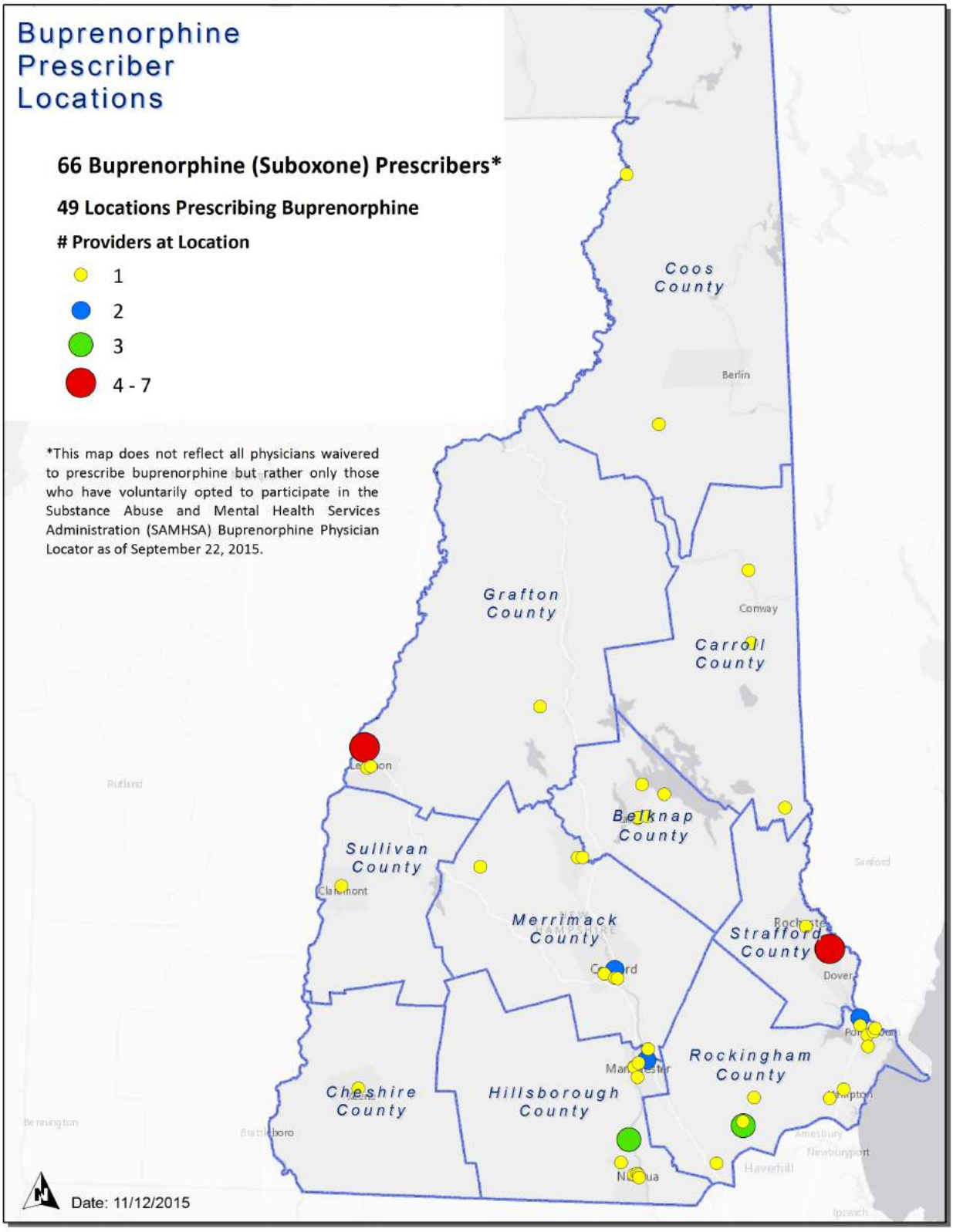
Appendix VI: Clinical Opioid Withdrawal Scale (COWS)

Appendix VII: Treatment Planning M.A.T.R.S. Checklist

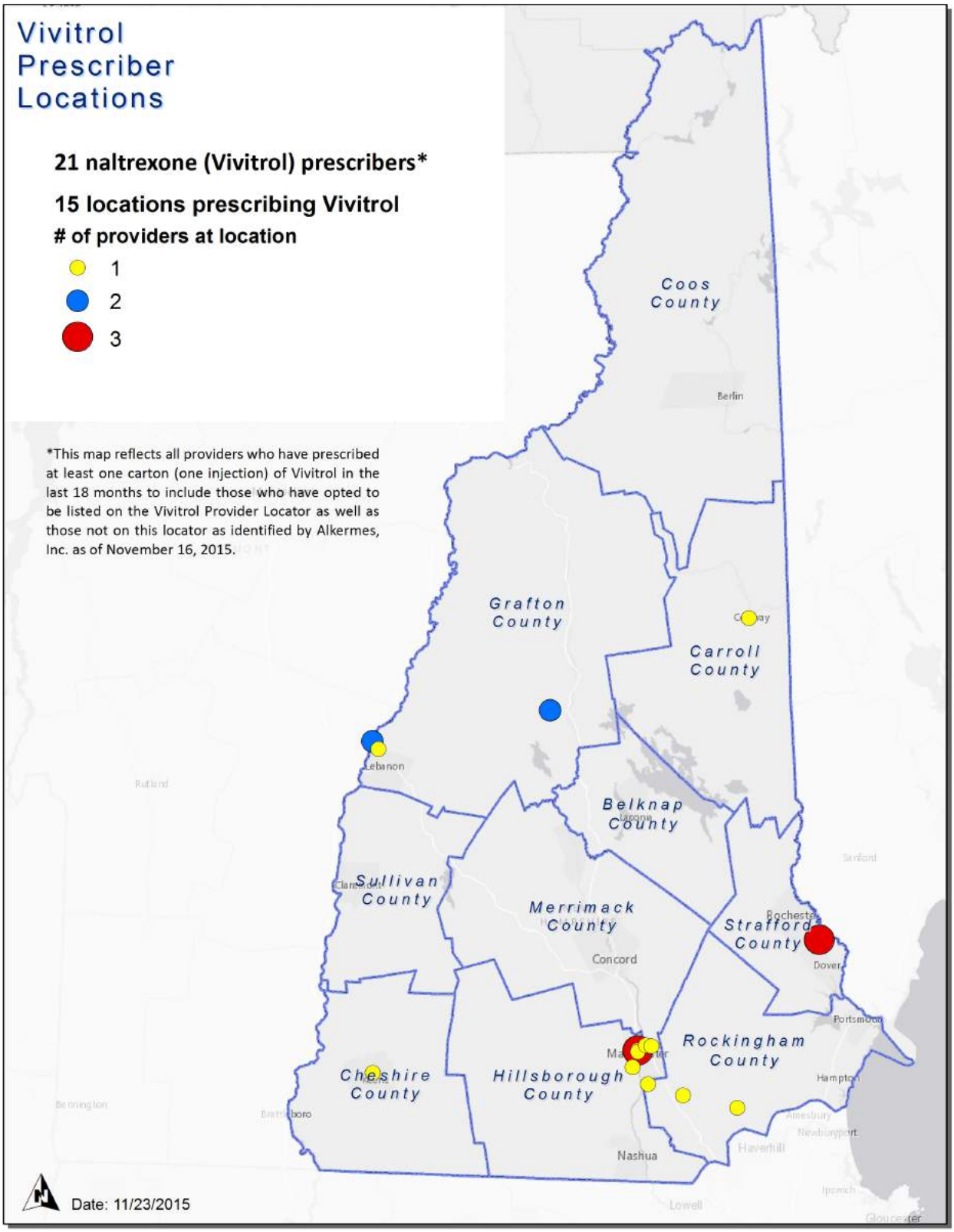
Appendix VIII: Sample Treatment Plan Form

Appendix IX: Sample Treatment Agreement

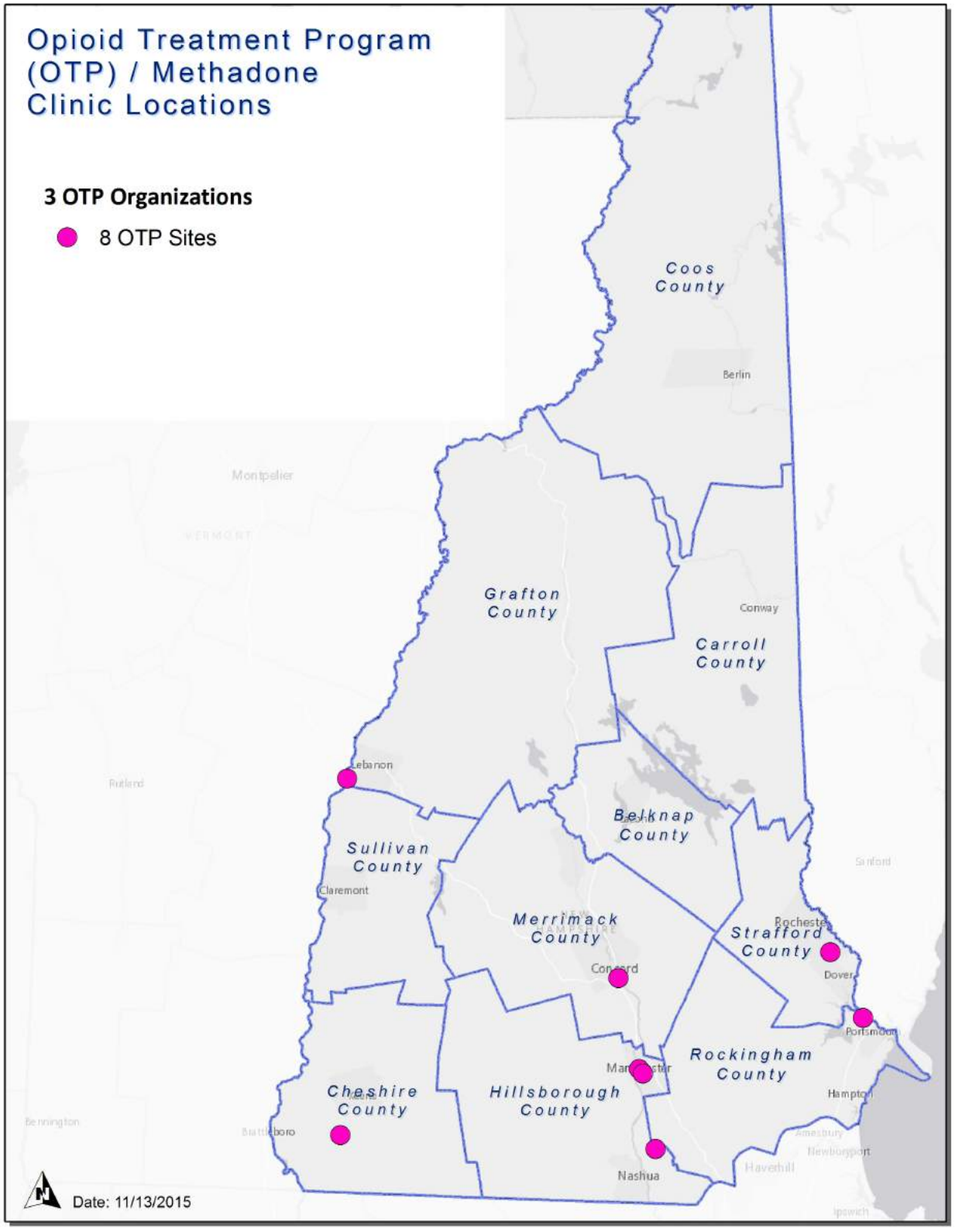
APPENDIX I: Map of Buprenorphine Prescriber Locations



APPENDIX II: Map of Vivitrol Prescriber Locations



APPENDIX III: Map of Opioid Treatment Program (OTP)/ Methadone Clinic Locations



APPENDIX IV: Objective Opiate Withdrawal Scale (OOWS)

Observe the patient during a 5 minute observation period then indicate a score for each of the opioid withdrawal signs listed below (items 1-13).
Add the scores for each item to obtain the total score

DATE							
TIME							

1	**Yawning** 0 = no yawns 1 = ≥ 1 yawn							
2	**Rhinorrhoea** 0 = < 3 sniffs 1 = ≥ 3 sniffs							
3	**Piloerection** (observe arm) 0 = absent 1 = present							
4	**Perspiration** 0 = absent 1 = present							
5	**Lacrimation** 0 = absent 1 = present							
6	**Tremor** (hands) 0 = absent 1 = present							
7	**Mydriasis** 0 = absent 1 = ≥ 3 mm							
8	**Hot and cold flushes** 0 = absent 1 = shivering / huddling for warmth							
9	**Restlessness** 0 = absent 1 = frequent shifts of position							
10	**Vomiting** 0 = absent 1 = present							
11	**Muscle twitches** 0 = absent 1 = present							
12	**Abdominal cramps** 0 = absent 1 = Holding stomach							
13	**Anxiety** 0 = absent 1 = mild - severe							
	TOTAL SCORE							

Source: Handelsman et. al, 1987

APPENDIX V: Subjective Opioid Withdrawal Scale (SOWS)

Please indicate if you are having any of the following withdrawal symptoms by **rating its severity.**							How long **AFTER** your last dose did you begin to feel this symptom?	
	Symptom	Not at all	A Little	Moderate	Quite a bit	Extremely	Onset (hrs)	
1	**Anxious/Nervous**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
2	**Body Aches & Pains**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
3	**Constipation**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
4	**Diarrhea**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
5	**Drug Hunger/Craving**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
6	**Goosebumps**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
7	**Hot/Cold Flashes**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
8	**Muscle Twitching**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
9	**Nausea**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
10	**Restlessness**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
11	**Runny Nose**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
12	**Sedation/Sleepiness**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
13	**Shaking**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
14	**Stomach Cramps**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
15	**Sweating**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
16	**Teary Eyes**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
17	**Vomiting**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
18	**Yawning**	0	1	2	3	4	☐3-4 ☐8 ☐16 ☐24	
	Total							

Mild withdrawal is considered to be a score of 1-10.
Moderate withdrawal is considered to be a score of 11-20.
Severe withdrawal is considered to be 21-30.

Adapted from: Handelsman, L., Cochrane, K.J., Aronson, M.J. et al. (1987) Two New Rating Scales for Opiate Withdrawal, American Journal of Alcohol Abuse, 13, 293-308

APPENDIX VI: Clinical Opioid Withdrawal Scale (COWS)

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Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal.
For example: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____ Date: _____

Buprenorphine Induction: _____

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Times of Observation:			
Resting Pulse Rate: Record Beats per Minute				
Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below • 2 = pulse rate 101-120 1 = pulse rate 81-100 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity				
0 = no report of chills or flushing • 3 = beads of sweat on brow or face 1 = subjective report of chills or flushing • 4 = sweat streaming off face 2 = flushed or observable moistness on face				
Restlessness Observation During Assessment				
0 = able to sit still • 3 = frequent shifting or extraneous movements of legs/arms 1 = reports difficulty sitting still, but is able to do so • 5 = Unable to sit still for more than a few seconds				
Pupil Size				
0 = pupils pinned or normal size for room light • 2 = pupils moderately dilated 1 = pupils possibly larger than normal for room light • 5 = pupils so dilated that only the rim of the iris is visible				
Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored				
0 = not present • 2 = patient reports severe diffuse aching of joints/muscles 1 = mild diffuse discomfort • 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies				
0 = not present • 2 = nose running or tearing 1 = nasal stuffiness or unusually moist eyes • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour				
0 = no GI symptoms • 3 = vomiting or diarrhea 1 = stomach cramps • 5 = multiple episodes of diarrhea or vomiting 2 = nausea or loose stool				
Tremor Observation of Outstretched Hands				
0 = no tremor • 2 = slight tremor observable 1 = tremor can be felt, but not observed • 4 = gross tremor or muscle twitching				
Yawning Observation During Assessment				
0 = no yawning • 2 = yawning three or more times during assessment 1 = yawning once or twice during assessment • 4 = yawning several times/minute				
Anxiety or Irritability				
0 = none • 2 = patient obviously irritable/anxious 1 = patient reports increasing irritability or anxiousness • 4 = patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh Skin				
0 = skin is smooth • 5 = prominent piloerection 3 = piloerection of skin can be felt or hairs standing up on arms				
Score: 5-12 = Mild 13-24 = Moderate 25-36 = Moderately Severe More than 36 = Severe Withdrawal	Total score			
	Observer's initials			

The National Alliance of Advocates for Buprenorphine Treatment
PO Box 333 • Farmington, CT 06034 • MakeContact@naabt.org
naabt.org

*Source: Wesson et al. 1999.

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APPENDIX VI: Clinical Opioid Withdrawal Scale (COWS)

naabt.org

The National Alliance of Advocates for Buprenorphine Treatment

Precipitated Withdrawal. What it is. How to avoid it.

What Is Precipitated Withdrawal?

It is a ***rapid and intense onset*** *of withdrawal symptoms initiated by a medication.* In the case of Buprenorphine, because it has a higher binding strength at the opioid receptor, it competes for the receptor, "kicks off" and replaces existing opioids. If a significant amount of opioids are expelled from the receptors and replaced, the opioid physically dependent patient will feel the rapid loss of the opioid effect, initiating withdrawal symptoms.

More precisely, precipitated withdrawal can occur when an antagonist (or partial agonist, such as Buprenorphine) is administered to a patient who is physically dependent on full agonist opioids. Due to the high *affinity* but low *intrinsic activity* of Buprenorphine at the μ-receptor, the partial agonist displaces full agonist opioids from the μ-receptors, but activates the receptor to a *lesser* degree than full agonists which results in a net *decrease* in agonist effect, thereby precipitating withdrawal.[1]

Full Agonist Opioid. Perfect receptor fit. Maximum intrinsic activity (opiate effect).

Partial Agonist Opioid (Buprenorphine). Imperfect Fit. Less intrinsic activity (opiate effect).

A common misconception is that the naloxone in the buprenorphine/naloxone combination medication initiates precipitated withdrawal. Naloxone may only initiate withdrawal if *injected* into a person physically dependent on opioids. Taken sublingually, as directed, naloxone is clinically insignificant and has virtually no effect. (Except in rare cases of an allergic reaction or naloxone hypersensitivity.[2])

Avoiding Precipitated Withdrawal

Patient education and developing realistic expectations are essential before beginning treatment.

To **avoid** precipitated withdrawal, physically dependent patients must no longer be experiencing the agonist effects of an opioid. One way to gauge this is to observe objective symptoms of withdrawal sufficient to score a minimum of 5 to 6 on the COWS (Clinical Opioid Withdrawal Scale). Scores of >10 are preferable. Due to patient individuality, required abstinent times may vary considerably from patient to patient. Only use the time since last use as an estimate to anticipate the onset of withdrawal symptoms.[4]

The **induction begins** by assessing last use of all opioids, short and long acting, objective and subjective symptoms and a COWS score calculation. If not in sufficient withdrawal (mild to moderate: COWS of 5 to 24), it is in the patient's best interest to wait. Long-acting opioids will require a longer period of abstinence, than short-acting opioids.

Short-acting Opioids

(Heroin, Crushed OxyContin®, Percocet®, Vicodin®, Oxycodone and others)

Prior to induction, patients must abstain from all short-acting opioids for 12 to 24 hours ***and***/or have objective withdrawal symptoms sufficient to produce a score of 5 to 24 on the COWS.[1]

Long-acting Opioids

OxyContin® (Taken Orally)

Discontinue use for at least 24 hours prior to induction. A minimal score of at least 5 on the COWS is recommended, although some physicians prefer scores of 15 or higher.[5]

Methadone

It is recommended that patients transitioning from methadone to Buprenorphine slowly taper to 30 mg./day of methadone, for at least one week. Last dose must be no less than 36 hours prior to induction, and may be 96 hours or more. A minimal score of at least 5 on the COWS is recommended, although some physicians prefer scores of 15 or higher.[5]

Patients transferring from methadone or another long-acting opioid to Buprenorphine may experience discomfort for several days and dysphoria for up to 2 weeks.[3]

The **goal of induction** is to safely suppress opioid withdrawal as rapidly as possible with adequate doses of Buprenorphine. Failure to do so may cause patients to use opioids or other medications to alleviate opioid withdrawal symptoms or may lead to early treatment dropout.[3] To achieve this, some physicians have found they may need to dose as high as 32 mgs. the first day with some methadone to Buprenorphine transfers.[5]

[1] Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40.* DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. http://naabt.org/links/TIP_40_PDF.pdf

[2] FDA. Full Prescribing Information on Subutex® (buprenorphine)/ Suboxone® (buprenorphine/naloxone) www.fda.gov/cder/foi/label/2002/20732bl.pdf

[3] *Dosing Guide Maintenance therapy for Opioid Dependence.* Suboxone®/Subutex® www.suboxone.com/pdfs/DosingGuides.pdf

[4] *Practical Considerations for the use of Buprenorphine* Hendrée E. Jones, Ph.D., Johns Hopkins University School of Medicine, Baltimore, MD

[5] Physician Clinical Support System: www.pcssmentor.org *Transfer from Methadone to Buprenorphine,* Paul P. Casadonte, MD, PCSS guidance paper. 8/9/2006 http://www.pcssmentor.org/pcss/documents2/PCSS_MethadoneBuprenorphineTransfer.pdf

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APPENDIX VII: Treatment Planning M.A.T.R.S. Checklist

Treatment Planning M.A.T.R.S. Checklist

Problem Statements	Check if addressed
1. Do problem statements reflect the 6 problem domains? (e.g., 1. Medical status; 2. Employment and support; 3. Drug/Alcohol Use; 4. Legal status; 5. Family/social status; 6. Psychiatric Status)	
2. Are problem statements written in behavioral terms?	
3. Are problem statements written in a non-judgmental and jargon free manner?	
4. Are problem statements based on priority needs?	
Goals *What does the client want to achieve during treatment?*	
5. Do goals address the problem statements?	
6. Are the goals attainable during the active treatment phase?	
7. Would the client be able to understand the goals as written?	
8. Would both the client and the treatment program find these goals acceptable?	
9. Has the client's stage of *readiness to change* been considered in the goal statements?	
Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*	
10. Do objectives address the goals?	
11. **M**easurable—Can change or progress toward meeting the objectives be documented/evaluated?	
12. **A**ttainable—Can the client take steps toward meeting the objectives?	
13. **T**ime-Limited—Is the time frame specified for the objectives?	
14. **R**ealistic—Can the client meet the objectives given their current situation?	
15. **S**pecific—Are specific activities included? Could the client understand what is expected?	
16. Has the client's stage of *readiness to change* been considered in the objectives?	
Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	
17. Do interventions address the objectives?	
18. **M**easurable—Will the counselor/treatment program be held accountable for the service(s)?	
19. **A**ttainable—Do interventions reflect the level of care available or are outside referrals used when needed?	
20. **T**ime-limited—Is the time frame specified for the interventions?	
21. **R**ealistic—Do the interventions reflect the level of functioning or functional impairment of the client?	
22. **S**pecific—Are specific staff persons responsible for assisting client/providing service?	
23. Has the client's stage of *readiness to change* been considered in the interventions?	
General Checklist	
24. Is this treatment plan individualized to fit the client based on their unique abilities, goals, lifestyle, socio-economic status (SES), work history, educational background, and culture?	
25. Are client strengths incorporated in the treatment plan?	
26. Has the client (and significant others) participated in developing this treatment plan?	
27. Is the plan dated and signed by all who participated in developing this treatment plan?	

Retrieved from: Addiction Technology Transfer Center (ATTC) http://attcnetwork.org/projects/txplanning.aspx

APPENDIX VIII: Sample Treatment Plan Form

Client Name: **Counselor Name:**

Date	Problem Statement

Goals

D/C Criteria	Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	Service Codes	Target Date	Resolution Date

Participation in Treatment Planning Process

Participation by Others in the Treatment Planning Process

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

Service Codes

I=Individual	G=Group	F=Family	C=Couples	P=Psychoeducational	H=Homework
R=Reading	M=Media	V=Videotape	A=Audiotape	R=Referral	

Retrieved from: Addiction Technology Transfer Center Network (ATTC) http://attcnetwork.org/projects/txplanning.aspx

APPENDIX IX: Sample Treatment Agreement

TREATMENT AGREEMENT

As a participant in the **[NAME OF PROGRAM]** for the treatment of opioid abuse and dependence with **[TYPE OF MEDICATION]**, I freely and voluntarily agree to accept this treatment agreement, as follows:

- I agree to keep, and be on time to, all my scheduled appointments with the doctor.
- I agree to conduct myself in a courteous manner in the physician's office.
- I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.
- I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
- I agree not to deal, steal, or conduct any other illegal or disruptive activities in the doctor's office.
- I agree that my medication (or prescriptions) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
- I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
- I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.
- I agree to take my medication as the doctor has instructed and not to alter the way I take my medication without first consulting the doctor.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.

Patient:

Printed Name: _____ Signature: _____ Date: _____

Prescriber:

Printed Name: _____ Signature: _____ Date: _____

Center for Substance Abuse Treatment. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Manchester Community Health Center
Patient Guide for Home Induction

MAT Nurse **603-792-5064**
General number 603-626-9500

Please read the entire pamphlet before you start your Subutex, Suboxone or Buprenorphine for the first time.

Follow all directions precisely as described in this pamphlet.

If you expect that you may run out of medication, call the MAT Nurse immediately.

[redacted]

603-792-5064 (direct line)

Please inform us of any problems in a timely manner. If you feel bad or have severe withdrawal symptoms, come to the office or go to the Emergency Room immediately.

Plan to stay in touch by telephone with the MAT Nurse for day 1 and day 2 when you are starting treatment.

Manchester Community Health Center
Patient Guide for Home Induction

MAT Nurse **603-792-5064**
General number 603-626-9500

You will be seen in the Hollis Street Office by your MAT (Medication Assisted Treatment) Provider the morning you are to start on your medication. You **must** be demonstrating symptoms of withdrawal to start on the medication. This means you will be feeling sick. If you are not feeling sick, the start of your medication may be postponed. You should not have taken or used any substances for 24 hours prior to starting on the medication, longer if you are converting from Methadone.

Symptoms of withdrawal that we will be looking for are:

Rapid heart rate	Runny nose, teary eyes, nasal congestion
Chills and/or sweating	Yawning
Anxious or irritable	Goose pimples
Restlessness	Bone and joint aching

Stomach cramps, nausea, vomiting or diarrhea

You will be asked about these symptoms once you go home and start your medicine as well.

You will need to have scissors available at home.

You will be seen by the provider, who will decide if you are ready to start treatment. If you are ready, you will be given a prescription for Buprenorphine, Subutex or Suboxone to take to your pharmacy and have filled. From there, you should go home. Do not plan to drive anywhere after you have started your medication.

Manchester Community Health Center
Patient Guide for Home Induction

MAT Nurse **603-792-5064**
General number 603-626-9500

Do not open your medication until you have called 603-792-5064 to indicate that you are ready to start. If no one is available to take your call, leave a message and someone will call you back in a few minutes.

Your first dose of medication will usually be 4 mg. If you have Suboxone films, this is usually one half of a film. Use your scissors to cut it in half. **Save** the other half in the package for later use.

Take a sip of water or another drink to wet your mouth. The medication should be placed on the underside of your tongue and held in place until it fully dissolves. Try not to swallow while the medication is dissolving. If you are having difficulty holding onto the saliva, try tipping your head forward so the saliva is not irritating your throat. Once the film is completely dissolved you can either swallow your saliva or spit it out.

Buprenorphine takes between 30 minutes to 2 hours to be fully absorbed into your system. You should start to feel a little better during the first 30 minutes. We cannot fully assess how well this medication dose worked for you for until 2 hours after it was taken.

When it has been two hours you will either receive a call from the nurse, or you can call in to 603-792-5064 to discuss whether to take more Suboxone. If you are going to take more, it will be the other half of the film you cut when you started, which is also 4 mg.

Do not take more than 8 mg on the first day.

Please check in one more time with the nurse 2 hours after taking the second dose. If you are still feeling sick or anxious, you can use the other medications you may have been prescribed. Those may be a combination of any of the following: Clonidine, Hydroxyzine, Cyclobenzaprine, Trazadone, Ibuprofen, Immodium, and Phenergan.

Day 2 You will call the nurse for dose instructions after 8:30 am.

Manchester Community Health Center
Patient Guide for Home Induction

MAT Nurse **603-792-5064**
General number 603-626-9500

Call the Nurse at 603-792-5064 when you are at home with your medication.
Call anytime if you are feeling more sick or have questions.

Day 1	Time	Amount taken	Symptoms and next step
1 hour later		none	Note how you feel
2 hours later			Call Nurse for second dose 603-792-5064 note how you feel
4 hours after first dose		none	Note how you feel. Call Nurse to plan for next day, 603-792-5064

Day 2	Time	Amount taken	Symptoms and next step
			Call nurse 603-792-5064 to discuss first dose of day after 8:30 am. Note how you feel
2 hours later			Call nurse 603-792-5064 to discuss if more medication is needed. Please write down how you feel.

You will be scheduled to see your doctor within the next 7 days. If you have any questions or concerns before that appointment, please call the nurse at 603-792-5064.

Manchester Community Health Center

DRAFT

Policies and Procedures

Title:	**Progressive Response Plan for Managing Patients in Treatment of Opioid Addiction**
Original Date of Implementation:	
Written By:	
Approved By:	
Reviewed By Group/Committee:	
Review Date(s):	
Revision Date(s):	
File in the Following Manual:	Patient Care Procedures

Objective: To outline guidelines for the Medication Assistance Treatment (MAT) Program in managing patients stability with routine monitoring, support, inquiries and communicating by identifying potential problems and intervening to resolve them.

Procedure:

1. Staff will be alert for early signs of destabilization that can manifest themselves in a variety of ways. Observable behavioral changes, including missing or being late for appointments, losing medication, not following through on the current treatment plan, showing changes in affect or appearing disheveled or impaired

2. Concrete findings such as toxicology report summaries and the patient results history, may test positive for illegal drugs or test negative for the prescribed opioid treatment medication may signify a threat to stability or that the patient has relapsed.

3. MCHC MAT Provider and Staff will clarify whether there is a threat to stability. Techniques include discussion with the patient. Does the patient have a reasonable explanation for the missed appointment, the lapse or the positive drug test?

4. When the provider and/or MAT team has determined that a threat to stability exists, more intensive interventions would be indicated. This includes more frequent office visits with counseling and urine testing and fewer doses prescribed.

5. When the toxicology results are negative for the prescribing opioid treatment medication, the patient will be queried to determine if he/she missed a dose(s), is not taking the medication or admits to providing someone else's urine specimen. Missing doses, not taking the medication or substituting someone else's urine specimen suggests that the patient is not appropriate for the program and should be referred to a more intensive level of care.

6. The provider and MAT Team will respond promptly when it is clear that the patient is using illicit drugs. As is the case with non-adherence to Buprenorphine dosages, if the patient admits drug use, the provider/MAT Team and patient will initiate a discussion about the reasons for the lapse and what steps need to be taken to ensure it does not occur. If increased monitoring and counseling do not resolve the problem promptly, more intensive

References:
Physicians Guide: Opioid Agonist Medical Maintenance Treatment Guidelines: Office of Pharmacologic and Alternative Therapies; (OPAT) Center for Substance Abuse Treatment (CSAT)and Substance Abuse and Mental Health Services Administration (SAMHSA) and Department of Health and Human Services (DHHS)
Federal Guidelines For Opioid Treatment Programs: SAMHSA
Buppractice DATA 2000 Qualifying Buprenorphine Training

intervention would be indicated to include discharge from the Buprenorphine program and referral to a higher level of care.

7. Inform patients of their responsibility to inform the provider and/or MAT staff of the use of any psychoactive substances. This means the use of consciousness altering drugs including narcotics, euphorants, hallucinogens, marijuana, 'designer drugs' whether illicit or licit. If patients are discovered to have not disclosed the use of psychoactive substances, Provider/MAT staff will inform the patients of the policy for the first instance and increase the frequency of Urine Drug Testing. Subsequent instances of non-disclosure of use of psychoactive substances will result in discontinuation from the program and a referral for a higher level of care.

8. The consequences of problematic urine drug testing results include increased frequency of urine drug testing for the first episode, possible dose adjustment for opioid use, increased counseling/support group sessions and discussion of the problem with the patient. Further instances of problematic urine drug testing results will result in discontinued treatment in the program and referral for a higher level of care.

9. Patients are required to take medication as instructed by the provider and avoid crushing or injecting the medication. If the patients take medication other than as instructed, discuss the problem with the patient for the first episode and discontinue treatment with 2nd episode and refer the patient to a higher level of care.

10. Patient's dose changes are not permitted without consulting with the provider. If patients change their dosage on their own, remind the patient of the policy for the first episode and discontinue treatment if there is a 2nd episode.

11. Patients must agree to safe storage and non-sharing of medications. Patients who share medications will have treatment discontinued immediately. Patients who lose medication due to unsafe storage will be reminded of the policy for the first instance and have treatment discontinued if there is a second instance.

12. Patient relapse to using opioids will not be grounds for stopping treatment the first time, but treatment structure will be increased, including more frequent appointments.

13. A second episode of using opioids will result in the addition of further additional treatment structure. A pattern of non-compliance with treatment/continued use of opioids will result in discontinued treatment.

14. If the patient stops taking Buprenorphine, they would need to be scheduled with BHC who will consult with provider to determine if they meet the eligibility criteria for re-admission to the program. Treatment agreements will need to be re-signed.

15. Patients who have been dismissed from treatment and return with new motivation may be considered for one second chance with increased treatment structure.

16. Periodic pill counts are required of patients who are described as high risk at the initial or subsequent appointments. MAT staff will schedule two pill counts unannounced in a 12 month period of time. If the results of the pill count are problematic or if the patient fails to comply, discuss the problem with patient for the 1st episode and discontinue treatment if there is a 2nd episode.

17. Counseling and other treatment participation is required for patients particularly with psychiatric diagnoses. Consequences of not participating in recommended counseling or other treatment is warning for the 1st three instances and discontinue treatment on the 4th instance.

18. Behaviors that will result in permanent dismissal from the program include violence, stealing at the health center, dealing drugs and carrying weapons. Other behaviors that will not be tolerated include: arriving impaired/intoxicated for appointments and disruptive behavior. Consequences for these behaviors include not seeing the patient until the next regularly scheduled appointment for the first episode and discontinue treatment at the 2nd instance.

References:

Physicians Guide: Opioid Agonist Medical Maintenance Treatment Guidelines: Office of Pharmacologic and Alternative Therapies; (OPAT) Center for Substance Abuse Treatment (CSAT)and Substance Abuse and Mental Health Services Administration (SAMHSA) and Department of Health and Human Services (DHHS)
Federal Guidelines For Opioid Treatment Programs: SAMHSA
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ASAM

THE NATIONAL PRACTICE GUIDELINE

For the Use of Medications in the Treatment of Addiction Involving Opioid Use

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

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Disclosure information for **Guideline Committee Members,** the **ASAM Quality Improvement Council,** and **External Reviewers** is available respectively in Appendices III, IV, and V.

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EXECUTIVE SUMMARY

Purpose

The American Society of Addiction Medicine (ASAM) developed this *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* to provide information on evidence-based treatment of opioid use disorder. (Hereafter, in this document, this National Practice Guideline will be referred to as ''*Practice Guideline*.'')

Background

Opioid use disorder is a chronic, relapsing disease, which has significant economic, personal, and public health consequences. Many readers of this *Practice Guideline* may recognize the term ''opioid use disorder'' as it is used in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5), developed by the American Psychiatric Association; others may be more familiar with the term ''opioid dependence,'' as used in previous editions of the DSM.[1]

The American Society of Addiction Medicine defines addiction as ''a primary, chronic disease of brain reward, motivation, memory, and related circuitry,'' with a ''dysfunction in these circuits'' being reflected in ''an individual pathologically pursuing reward and/or relief by substance use and other behaviors.'' In this context, the preferred term by ASAM for this serious bio-psycho-social-spiritual illness would be ''addiction involving opioid use.'' ASAM views addiction as a fundamental neurological disorder of ''brain reward, motivation, memory, and related circuitry,'' and recognizes that there are unifying features in all cases of addiction, including substance-related addiction and nonsubstance-related addiction. It is clear that a variety of substances commonly associated with addiction work on specific receptors in the nervous system and on specific neurotransmitter systems. Specific pharmacological agents used in the

treatment of addiction exert their effects via their actions on specific receptors. Hence, the medications used in the treatment of addiction have specific efficacy based on their own molecular structure and the particular neurotransmitters affected by that medication. Medications developed for the treatment of addiction involving opioid use may have benefits in the treatment of addiction involving an individual's use of other substances. For instance, naltrexone, which is approved by the US Food and Drug Administration (FDA) for the treatment of opioid dependence using DSM, 4th Edition (DSM-IV) terminology, is also US FDA-approved for the treatment of alcohol dependence as per the DSM-IV guidelines.[2]

The American Society of Addiction Medicine recognizes that research is yet to be done to confirm the specificity of its conceptualization of addiction as a medical and a psychiatric illness. Both the American Medical Association, as noted in various policy and position statements, and the *International Classification of Diseases* (ICD), recognize addiction as both a medical and a psychiatric disorder.[3,4] ASAM encourages clinicians, researchers, educators, and policy makers to use the term ''addiction'' regardless of whether the patient's condition at a given point in its natural history seems to more prominently involve opioid use, alcohol use, nicotine use, or engagement in addictive behaviors such as gambling. Given the widespread North American application of the DSM's categorization of disorders, this *Practice Guideline* will, for the sake of brevity and convention, use the term ''opioid use disorder.''

According to the 2013 National Survey on Drug Use and Health (NSDUH), 4.5 million individuals in the United States were current (past month), nonmedical users of prescription opioids. Nonmedical use of opioids and other prescription drugs constitute hazardous and risky behavior which should be discouraged, given the potential that unauthorized use of such substances has for harm (to the user). Medication therapy related to opioids focuses not only on nonmedical use but also on an attempt to treat the medical illness, addiction. The 2013 NSDUH further found that 1.9 million persons in America met DSM-IV criteria for opioid use disorder associated with their use of prescription opioids, and that more than 0.5 million additional individuals have met DSM-IV criteria for opioid use disorder associated with their use of heroin.[5]

Opioid use is associated with increased mortality. The leading causes of death in people using opioids for nonmedical purposes are overdose and trauma.[6] The injection route use (intravenous or even intramuscular [IM]) of opioids or other drugs increases the risk of being exposed to HIV, viral hepatitis, and other infectious agents.

Scope of Guideline

This *Practice Guideline* was developed for the evaluation and treatment of opioid use disorder and for the management of opioid overdose. The medications covered in this guideline are mainly, but not exclusively, those that have been US FDA-approved for the treatment of opioid dependence, as defined in prior versions of the DSM, and not necessarily the most recent version of the manual, the DSM-5.[7] DSM-5 combined the criteria for opioid abuse and opioid dependence from prior versions of the DSM in its new diagnosis of opioid use disorder; therefore, pharmacologic treatment may not be appropriate for all patients along the entire opioid use disorder continuum. In a study comparing opioid dependence from DSM-IV and opioid use disorder from DSM-5, optimal concordance occurred when four or more DSM-5 criteria were endorsed (ie, the DSM-5 threshold for moderate opioid use disorder).[8] Other medications have been used off-label to treat opioid use disorder (clearly noted in the text); however, the Guideline Committee has not issued recommendations on the use of those medications. As a final note related to references to medications, whether US FDA-approved or off-label, cost and/or cost effectiveness were not considerations in the development of this *Practice Guideline*.

Intended Audience

This *Practice Guideline* is primarily intended for clinicians involved in evaluating patients and providing authorization for pharmacological treatments at any level. The intended audience falls into the broad groups of physicians; other healthcare providers (especially those with prescribing authority); medical educators and faculty for other healthcare professionals in training; and clinical care managers, including those offering utilization management services.

Qualifying Statement

This ASAM *Practice Guideline* is intended to aid clinicians in their clinical decision- making and patient management. The *Practice Guideline* strives to identify and define clinical decision-making junctures that meet the needs of *most patients* in *most circumstances*. Clinical decision-making should involve consideration of the quality and availability of expertise and services in the community wherein care is provided. In circumstances in which the *Practice Guideline* is being used as the basis for regulatory or payer decisions, improvement in quality of care should be the goal. Finally, prescribed courses of treatment contained in recommendations in this *Practice Guideline* are effective only if the recommendations, as outlined, are followed. Because lack of patient understanding and adherence may adversely affect outcomes, clinicians should make every effort to promote the patient's understanding of, and adherence to, prescribed and recommended pharmacological and psychosocial treatments. Patients should be informed of the risks, benefits, and alternatives to a particular treatment, and should be an active party to shared decision-making whenever feasible. Recommendations in this *Practice Guideline* do not supersede any federal or state regulation.

Overview of Methodology

This *Practice Guideline* was developed using the RAND Corporation (RAND)/University of California, Los Angeles (UCLA) Appropriateness Method (RAM) – a process that combines scientific evidence and clinical knowledge to determine the appropriateness of a set of clinical procedures. The RAM is a deliberate approach encompassing review of existing guidelines, literature reviews, appropriateness ratings, necessity reviews, and document development. For this project, ASAM selected an independent committee to oversee guideline development, to participate in review of

treatment scenarios, and to assist in writing. ASAM's Quality Improvement Council, chaired by Margaret Jarvis, MD, oversaw the selection process for the independent development committee, referred to as the Guideline Committee.

The Guideline Committee was comprised of 10 experts and researchers from multiple disciplines, medical specialties, and subspecialties, including academic research, internal medicine, family medicine, addiction medicine, addiction psychiatry, general psychiatry, obstetrics/gynecology, pharmacology, and clinical neurobiology. Physicians with both allopathic and osteopathic training were represented in the Guideline Committee. The Guideline Committee was assisted by a technical team of researchers from the Treatment Research Institute (TRI) affiliated with the University of Pennsylvania (see page 2), and worked under the guidance of Dr. Kyle Kampman who led the TRI team as Principal Investigator in implementing the RAM.

Summary of Recommendations

Part 1: Assessment and Diagnosis of Opioid Use Disorder

Assessment Recommendations

(1) First clinical priority should be given to identifying and making appropriate referral for any urgent or emergent medical or psychiatric problem(s), including drug-related impairment or overdose.
(2) Completion of the patient's medical history should include screening for concomitant medical conditions, including infectious diseases (hepatitis, HIV, and tuberculosis [TB]), acute trauma, and pregnancy.
(3) A physical examination should be completed as a component of the comprehensive assessment process. The prescriber (the clinician authorizing the use of a medication for the treatment of opioid use disorder) may conduct this physical examination him/herself, or, in accordance with the ASAM Standards, ensure that a current physical examination is contained within the patient medical record before a patient is started on a new medication for the treatment of his/her addiction.
(4) Initial laboratory testing should include a complete blood count, liver function tests, and tests for hepatitis C and HIV. Testing for TB and sexually transmitted infections should also be considered. Hepatitis B vaccination should be offered, if appropriate.
(5) The assessment of women presents special considerations regarding their reproductive health. Women of childbearing age should be tested for pregnancy, and all women of childbearing potential and age should be queried regarding methods of contraception, given the increase in fertility that results from effective opioid use disorder treatment.
(6) Patients being evaluated for addiction involving opioid use, and/or for possible medication use in the treatment of opioid use disorder, should undergo (or have completed) an assessment of mental health status and possible psychiatric disorders (as outlined in the ASAM Standards).
(7) Opioid use is often co-occurring with other substance-related disorders. An evaluation of past and current substance use and a determination of the totality of substances that surround the addiction should be conducted.
(8) The use of marijuana, stimulants, or other addictive drugs should not be a reason to suspend opioid use disorder treatment. However, evidence demonstrates that patients who are actively using substances during opioid use disorder treatment have a poorer prognosis. The use of benzodiazepines and other sedative hypnotics may be a reason to suspend agonist treatment because of safety concerns related to respiratory depression.
(9) A tobacco use query and counseling on cessation of tobacco products and electronic nicotine delivery devices should be completed routinely for all patients, including those who present for evaluation and treatment of opioid use disorder.
(10) An assessment of social and environmental factors should be conducted (as outlined in the ASAM Standards) to identify facilitators and barriers to addiction treatment, and specifically to pharmacotherapy. Before a decision is made to initiate a course of pharmacotherapy for the patient with opioid use disorder, the patient should receive a multidimensional assessment in fidelity with *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occuring Conditions* (the "ASAM Criteria"). Addiction should be considered a bio-psycho-social-spiritual illness, for which the use of medication(s) is but only one component of overall treatment.

Diagnosis Recommendations

(1) Other clinicians may diagnose opioid use disorder, but confirmation of the diagnosis by the provider with prescribing authority, and who recommends medication use, must be obtained before pharmacotherapy for opioid use disorder commences.
(2) Opioid use disorder is primarily diagnosed on the basis of the history provided by the patient and a comprehensive assessment that includes a physical examination.
(3) Validated clinical scales that measure withdrawal symptoms, for example, the Objective Opioid Withdrawal Scale (OOWS), the Subjective Opioid Withdrawal Scale (SOWS), and the Clinical Opioid Withdrawal Scale (COWS), may be used to assist in the evaluation of patients with opioid use disorder.
(4) Urine drug testing during the comprehensive assessment process, and frequently during treatment, is recommended. The frequency of drug testing is determined by a number of factors including the stability of the patient, the type of treatment, and the treatment setting.

Part 2: Treatment Options

(1) The choice of available treatment options for addiction involving opioid use should be a shared decision between clinician and patient.
(2) Clinicians should consider the patient's preferences, past treatment history, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone in the treatment of addiction involving opioid use. The treatment setting described as level 1 treatment in the

ASAM Criteria may be a general outpatient location such as a clinician's practice site. The setting described as level 2 in the ASAM Criteria may be an intensive outpatient treatment or partial hospitalization program housed in a specialty addiction treatment facility, a community mental health center, or another setting. The ASAM Criteria describes level 3 or level 4 treatment, respectively, as a residential addiction treatment facility or hospital.

(3) The venue in which treatment is provided is as important as the specific medication selected. Opioid treatment programs (OTPs) offer daily supervised dosing of methadone, and increasingly of buprenorphine. In accordance with the Federal law (21 CFR §1306.07), office-based opioid treatment (OBOT), which provides medication on a prescribed weekly or monthly basis, is limited to buprenorphine.[9] Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe any medication. Clinicians should consider a patient's psychosocial situation, co-occurring disorders, and risk of diversion when determining whether OTP or OBOT is most appropriate.

(4) OBOT may not be suitable for patients with active alcohol use disorder or sedative, hypnotic, or anxiolytic use disorder (or who are in the treatment of addiction involving the use of alcohol or other sedative drugs, including benzodiazepines or benzodiazepine receptor agonists). It may also be unsuitable for persons who are regularly using alcohol or other sedatives, but do not have addiction or a specific substance use disorder related to that class of drugs. The prescribing of benzodiazepines or other sedative-hypnotics should be used with extreme caution in patients who are prescribed methadone or buprenorphine for the treatment of an opioid use disorder.

(5) Methadone is recommended for patients who may benefit from daily dosing and supervision in an OTP, or for patients for whom buprenorphine for the treatment of opioid use disorder has been used unsuccessfully in an OTP or OBOT setting.

(6) Oral naltrexone for the treatment of opioid use disorder is often adversely affected by poor medication adherence. Clinicians should reserve its use for patients who would be able to comply with special techniques to enhance their adherence, for example, observed dosing. Extended-release injectable naltrexone reduces, but does not eliminate, issues with medication adherence.

Part 3: Treating Opioid Withdrawal

(1) Using medications for opioid withdrawal management is recommended over abrupt cessation of opioids. Abrupt cessation of opioids may lead to strong cravings, which can lead to continued use.

(2) Patients should be advised about risk of relapse and other safety concerns from using opioid withdrawal management as standalone treatment for opioid use disorder. Opioid withdrawal management on its own is not a treatment method.

(3) Assessment of a patient undergoing opioid withdrawal management should include a thorough medical history and physical examination, focusing on signs and symptoms associated with opioid withdrawal.

(4) Opioid withdrawal management in cases in which methadone is used to manage withdrawal symptoms must be done in an inpatient setting or in an OTP. For short-acting opioids, tapering schedules that decrease in daily doses of prescribed methadone should begin with doses between 20 and 30 mg per day, and should be completed within 6–10 days.

(5) Opioid withdrawal management in cases in which buprenorphine is used to manage withdrawal symptoms should not be initiated until 12–18 hours after the last dose of a short-acting agonist such as heroin or oxycodone, and 24–48 hours after the last dose of a long-acting agonist such as methadone. A dose of buprenorphine sufficient to suppress withdrawal symptoms is given (this can be 4–16 mg per day) and then the dose is tapered. The duration of the tapering schedule can be as brief as 3–5 days or as long as 30 days or more.

(6) The use of combinations of buprenorphine and low doses of oral naltrexone to manage withdrawal and facilitate the accelerated introduction of extended-release injectable naltrexone has shown promise. More research will be needed before this can be accepted as standard practice.

(7) The Guideline Committee recommends, based on consensus opinion, the inclusion of clonidine as a practice to support opioid withdrawal. Clonidine is not US FDA-approved for the treatment of opioid withdrawal, but it has been extensively used off-label for this purpose. Clonidine may be used orally or transdermally at doses of 0.1–0.3 mg every 6–8 hours, with a maximum dose of 1.2 mg daily, to assist in the management of opioid withdrawal symptoms. Its hypotensive effects often limit the amount that can be used. Clonidine can be combined with other non-narcotic medications targeting specific opioid withdrawal symptoms such as benzodiazepines for anxiety, loperamide for diarrhea, acetaminophen or non-steroidal anti-inflammatory medications (NSAIDs) for pain, and ondansetron or other agents for nausea.

(8) Opioid withdrawal management using anesthesia UROD is not recommended due to high risk for adverse events or death. Naltrexone-facilitated opioid withdrawal management can be a safe and effective approach, but should be used only by clinicians experienced with this clinical method, and in cases in which anesthesia or conscious sedation are not being employed.

Part 4: Methadone

(1) Methadone is a treatment option recommended for patients who are physiologically dependent on opioids, able to give informed consent, and who have no specific contraindications for agonist treatment when it is prescribed in the context of an appropriate plan that includes psychosocial intervention.

(2) The recommended initial dose for methadone ranges from 10 to 30 mg, with reassessment in 3–4 hours, and a second dose not to exceed 10 mg on the first day if withdrawal symptoms are persisting.

(3) The usual daily dosage of methadone ranges from 60 to 120 mg. Some patients may respond to lower doses and some patients may need higher doses. Dosage increases

in 5–10-mg increments applied no more frequently than every 7 days (depending on clinical response) are necessary to avoid oversedation, toxicity, or even iatrogenic overdose deaths.
(4) The administration of methadone should be monitored because unsupervised administration can lead to misuse and diversion. OTP regulations require monitored medication administration until the patient's clinical response, and behavior demonstrates that the prescribing of nonmonitored doses is appropriate.
(5) Psychosocial treatment, though sometimes minimally needed, should be implemented in conjunction with the use of methadone in the treatment of opioid use disorder.
(6) Methadone should be reinstituted immediately if relapse occurs, or when an assessment determines that the risk of relapse is high for patients who previously received methadone in the treatment of opioid use disorder, but who are no longer prescribed such treatment.
(7) Strategies directed at relapse prevention are an important part of comprehensive addiction treatment and should be included in any plan of care for a patient receiving active opioid treatment or ongoing monitoring of the status of their addictive disease.
(8) Switching from methadone to another medication for the treatment of opioid use disorder may be appropriate if the patient experiences intolerable side effects or is not successful in attaining or maintaining treatment goals through the use of methadone.
(9) Patients switching from methadone to buprenorphine in the treatment of opioid use disorder should be on low doses of methadone before switching medications. Patients on low doses of methadone (30–40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort in switching medications.
(10) Patients switching from methadone to oral naltrexone or extended-release injectable naltrexone must be completely withdrawn from methadone and other opioids, before they can receive naltrexone. The only exception would apply when an experienced clinician receives consent from the patient to embark on a plan of naltrexone-facilitated opioid withdrawal management.
(11) Patients who discontinue agonist therapy with methadone or buprenorphine and then resume opioid use should be made aware of the risks associated with opioid overdose, and especially the increased risk of death.

Part 5: Buprenorphine

(1) Opioid-dependent patients should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6–12 hours after the last use of heroin or other short-acting opioids, or 24–72 hours after their last use of long-acting opioids such as methadone.
(2) Induction of buprenorphine should start with a dose of 2–4 mg. Dosages may be increased in increments of 2–4 mg.
(3) Clinicians should observe patients in their offices during induction. Emerging research, however, suggests that many patients need ''not'' be observed and that home buprenorphine induction may be considered. Home-based induction is recommended only if the patient or prescribing physician is experienced with the use of buprenorphine. This is based on the consensus opinion of the Guideline Committee.
(4) Buprenorphine doses after induction and titration should be, on average, at least 8 mg per day. However, if patients are continuing to use opioids, consideration should be given to increasing the dose by 4–8 mg (daily doses of 12–16 mg or higher). The US FDA approves dosing to a limit of 24 mg per day, and there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion.
(5) Psychosocial treatment should be implemented in conjunction with the use of buprenorphine in the treatment of opioid use disorder.
(6) Clinicians should take steps to reduce the chance of buprenorphine diversion. Recommended strategies include frequent office visits (weekly in early treatment), urine drug testing, including testing for buprenorphine and metabolites, and recall visits for pill counts.
(7) Patients should be tested frequently for buprenorphine, other substances, and prescription medications. Accessing Prescription Drug Monitoring Program (PDMP) data may be useful for monitoring.
(8) Patients should be seen frequently at the beginning of their treatment. Weekly visits (at least) are recommended until patients are determined to be stable. There is no recommended time limit for treatment.
(9) Buprenorphine taper and discontinuation is a slow process and close monitoring is recommended. Buprenorphine tapering is generally accomplished over several months. Patients should be encouraged to remain in treatment for ongoing monitoring past the point of discontinuation.
(10) When considering a switch from buprenorphine to naltrexone, 7–14 days should elapse between the last dose of buprenorphine and the start of naltrexone to ensure that the patient is not physically dependent on opioids before starting naltrexone.
(11) When considering a switch from buprenorphine to methadone, there is no required time delay because the addition of a full mu-opioid agonist to a partial agonist does not typically result in any type of adverse reaction.
(12) Patients who discontinue agonist therapy and resume opioid use should be made aware of the risks associated with an opioid overdose, and especially the increased risk of death.

Part 6: Naltrexone

(1) Naltrexone is a recommended treatment in preventing relapse in opioid use disorder. Oral formula naltrexone may be considered for patients in whom adherence can be supervised or enforced. Extended-release injectable naltrexone may be more suitable for patients who have issues with adherence.

(2) Oral naltrexone should be taken daily in 50-mg doses, or three times weekly in two 100-mg doses followed by one 150-mg dose.
(3) Extended-release injectable naltrexone should be administered every 4 weeks by deep IM injection in the gluteal muscle at a set dosage of 380 mg per injection.
(4) Psychosocial treatment is recommended in conjunction with treatment with naltrexone. The efficacy of naltrexone use in conjunction with psychosocial treatment has been established, whereas the efficacy of extended-release injectable naltrexone without psychosocial treatment ''has not'' been established.
(5) There is no recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. Duration depends on clinical judgment and the patient's individual circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms.
(6) Switching from naltrexone to methadone or buprenorphine should be planned, considered, and monitored. Switching from an antagonist such as naltrexone to a full agonist (methadone) or a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist because there is no physical dependence associated with antagonist treatment and thus no possibility of precipitated withdrawal. Patients being switched from naltrexone to buprenorphine or methadone will not have physical dependence on opioids and thus the initial doses of methadone or buprenorphine used should be low. Patients should not be switched until a significant amount of the naltrexone is no longer in their system, about 1 day for oral naltrexone or 30 days for extended-release injectable naltrexone.
(7) Patients who discontinue antagonist therapy and resume opioid use should be made aware of the increased risks associated with an opioid overdose, and especially the increased risk of death.

Part 7: Psychosocial Treatment in Conjunction With Medications for the Treatment of Opioid Use Disorder

(1) Psychosocial treatment is recommended in conjunction with any pharmacological treatment of opioid use disorder. At a minimum, psychosocial treatment should include the following: psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services.
(2) Treatment planning should include collaboration with qualified behavioral healthcare providers to determine the optimal type and intensity of psychosocial treatment and for renegotiation of the treatment plan for circumstances in which patients do not adhere to recommended plans for, or referrals to, psychosocial treatment.
(3) Psychosocial treatment is generally recommended for patients who are receiving opioid agonist treatment (methadone or buprenorphine).
(4) Psychosocial treatment should be offered with oral and extended-release injectable naltrexone. The efficacy of extended-release injectable naltrexone to treat opioid use disorder has not been confirmed when it has been used as pharmacotherapy without accompanying psychosocial treatment.

Part 8: Special Populations: Pregnant Women

(1) The first priority in evaluating pregnant women for opioid use disorder should be to identify emergent or urgent medical conditions that require immediate referral for clinical evaluation.
(2) A medical examination and psychosocial assessment is recommended when evaluating pregnant women for opioid use disorder.
(3) Obstetricians and gynecologists should be alert to signs and symptoms of opioid use disorder. Pregnant women with opioid use disorder are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, or exhibit signs of withdrawal or intoxication.
(4) Psychosocial treatment is recommended in the treatment of pregnant women with opioid use disorder.
(5) Counseling and testing for HIV should be provided in accordance with state law. Tests for hepatitis B and C and liver function are also suggested. Hepatitis A and B vaccination is recommended for those whose hepatitis serology is negative.
(6) Urine drug testing may be used to detect or confirm suspected opioid and other drug use with informed consent from the mother, realizing that there may be adverse legal and social consequences of her use. State laws differ on reporting substance use during pregnancy. Laws that penalize women for use and for obtaining treatment serve to prevent women from obtaining prenatal care and worsen outcomes.
(7) Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine monoproduct rather than withdrawal management or abstinence.
(8) Care for pregnant women with opioid use disorder should be comanaged by an obstetrician and an addiction specialist physician. Release of information forms need to be completed to ensure communication among healthcare providers.
(9) Treatment with methadone should be initiated as early as possible during pregnancy.
(10) Hospitalization during initiation of methadone and treatment with buprenorphine may be advisable due to the potential for adverse events, especially in the third trimester.
(11) In an inpatient setting, methadone should be initiated at a dose range of 20–30 mg. Incremental doses of 5–10 mg are given every 3–6 hours, as needed, to treat withdrawal symptoms.
(12) After induction, clinicians should increase the methadone dose in 5–10-mg increments per week. The goal is to maintain the lowest dose that controls withdrawal symptoms and minimizes the desire to use additional opioids.
(13) Twice daily dosing is more effective and has fewer side effects than single dosing, but may not be practical because methadone is typically dispensed in an outpatient clinic.

(14) Clinicians should be aware that the pharmacokinetics of methadone are affected by pregnancy. With advancing gestational age, plasma levels of methadone progressively decrease and clearance increases. Increased or split doses may be needed as pregnancy progresses. After child birth, doses may need to be adjusted.
(15) Buprenorphine monoproduct is a reasonable and recommended alternative to methadone for pregnant women. Whereas there is evidence of safety, there is insufficient evidence to recommend the combination buprenorphine/naloxone formulation.
(16) If a woman becomes pregnant while she is receiving naltrexone, it is appropriate to discontinue the medication if the patient and doctor agree that the risk of relapse is low. If the patient is highly concerned about relapse and wishes to continue naltrexone, she should be informed about the risks of staying on naltrexone and provide her consent for ongoing treatment. If the patient wishes to discontinue naltrexone, but then reports relapse to opioid use, it may be appropriate to consider treatment with methadone or treatment with buprenorphine.
(17) Naloxone is not recommended for use in pregnant women with opioid use disorder except in situations of life-threatening overdose.
(18) Mothers receiving methadone and buprenorphine monoproduct for the treatment of opioid use disorders should be encouraged to breastfeed.

Part 9: Special Populations: Individuals With Pain

(1) For all patients with pain, it is important that the correct diagnosis be made and that a target suitable for treatment is identified.
(2) If pharmacological treatment is considered, non-narcotic medications such as acetaminophen and NSAIDs should be tried first.
(3) Opioid agonists (methadone or buprenorphine) should be considered for patients with active opioid use disorder who are not under treatment.
(4) Pharmacotherapy in conjunction with psychosocial treatment should be considered for patients with pain who have opioid use disorder.
(5) Patients on methadone for the treatment of opioid use disorder will require doses of opioids in addition to their regular daily dose of methadone to manage acute pain.
(6) Patients on methadone for the treatment of opioid use disorder and who are admitted for surgery may require additional short-acting opioid pain relievers. The dose of pain relievers prescribed may be higher due to tolerance.
(7) Temporarily increasing buprenorphine dosing may be effective for mild acute pain.
(8) For severe acute pain, discontinuing buprenorphine and commencing on a high-potency opioid (such as fentanyl) is advisable. Patients should be monitored closely and additional interventions such as regional anesthesia should also be considered.
(9) The decision to discontinue buprenorphine before an elective surgery should be made in consultation with the attending surgeon and anesthesiologist. If it is decided that buprenorphine should be discontinued before surgery, this should occur 24–36 hours in advance of surgery and restarted postoperatively when the need for full opioid agonist analgesia has passed.
(10) Patients on naltrexone will not respond to opioid analgesics in the usual manner. Therefore, it is recommended that mild pain be treated with NSAIDs, and moderate to severe pain be treated with ketorolac on a short-term basis.
(11) Oral naltrexone should be discontinued 72 hours before surgery and extended-release injectable naltrexone should be discontinued 30 days before an anticipated surgery.

Part 10: Special Populations: Adolescents

(1) Clinicians should consider treating adolescents who have opioid use disorder using the full range of treatment options, including pharmacotherapy.
(2) Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment of opioid use disorder in adolescents. Age is a consideration in treatment, and Federal laws and US FDA approvals need to be considered for patients under age 18.
(3) Psychosocial treatment is recommended in the treatment of adolescents with opioid use disorder.
(4) Concurrent practices to reduce infection (eg, sexual risk reduction interventions) are recommended as components of comprehensive treatment for the prevention of sexually transmitted infections and blood-borne viruses.
(5) Adolescents may benefit from treatment in specialized treatment facilities that provide multidimensional services.

Part 11: Special Populations: Individuals With Co-occurring Psychiatric Disorders

(1) A comprehensive assessment including determination of mental health status should evaluate whether the patient is stable. Patients with suicidal or homicidal ideation should be referred immediately for treatment and possibly hospitalization.
(2) Management of patients at risk for suicide should include: reducing immediate risk; managing underlying factors associated with suicidal intent; and monitoring and follow-up.
(3) All patients with psychiatric disorders should be asked about suicidal ideation and behavior. Patients with a history of suicidal ideation or attempts should have opioid use disorder, and psychiatric medication use, monitored.
(4) Assessment for psychiatric disorder should occur at the onset of agonist or antagonist treatment. Reassessment using a detailed mental status examination should occur after stabilization with methadone, buprenorphine, or naltrexone.
(5) Pharmacotherapy in conjunction with psychosocial treatment should be considered for patients with opioid use disorder and a co-occurring psychiatric disorder.
(6) Clinicians should be aware of potential interactions between medications used to treat co-occurring psychiatric conditions and opioid use disorder.

(7) Assertive community treatment should be considered for patients with co-occurring schizophrenia and opioid use disorder who have a recent history of, or are at risk of, repeated hospitalization or homelessness.

Part 12: Special Populations: Individuals in the Criminal Justice System

(1) Pharmacotherapy for the continued treatment of opioid use disorders, or the initiation of pharmacotherapy, has been shown to be effective and is recommended for prisoners and parolees regardless of the length of their sentenced term.
(2) Individuals with opioid use disorder who are within the criminal justice system should be treated with some type of pharmacotherapy in addition to psychosocial treatment.
(3) Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment. There is insufficient evidence to recommend any one treatment as superior to another for prisoners or parolees.
(4) Pharmacotherapy should be initiated a minimum of 30 days before release from prison.

Part 13: Naloxone for the Treatment of Opioid Overdose

(1) Naloxone should be given in case of opioid overdose.
(2) Naloxone can and should be administered to pregnant women in cases of overdose to save the mother's life.
(3) The Guideline Committee, based on consensus opinion, recommends that patients who are being treated for opioid use disorder and their family members/significant others be given prescriptions for naloxone. Patients and family members/significant others should be trained in the use of naloxone in overdose.
(4) The Guideline Committee, based on consensus opinion, recommends that first responders such as emergency medical services personnel, police officers, and firefighters be trained in and authorized to administer naloxone.

Abbreviations and Acronyms

AA Alcoholics Anonymous
ACT Assertive Community Treatment
AIDS Acquired Immunodeficiency Syndrome
ASAM American Society of Addiction Medicine
CBT Cognitive Behavioral Therapy
CDC Centers for Disease Control
COWS Clinical Opioid Withdrawal Scale
DATA 2000 Drug Addiction Treatment Act of 2000
DEA Drug Enforcement Agency
DSM-III Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition
DSM-IV Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DSM-5 Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
ECG Electrocardiogram
EMS Emergency Medical Services
FDA Food and Drug Administration
HBV Hepatitis B Virus
HCV Hepatitis C Virus
HIV Human Immunodeficiency Virus
IDU Injection Drug Use
IM Intramuscular
IV Intravenous
NA Narcotics Anonymous
NAS Neonatal Abstinence Syndrome
NSAIDs Nonsteroidal Anti-inflammatory Drugs
NSDUH National Survey on Drug Use and Health
OBOT Office-Based Opioid Treatment
OOWS Objective Opioid Withdrawal Scale
OTP Opioid Treatment Program
PMDP Prescription Drug Monitoring Program
RCT Randomized Clinical Trial
RAM RAND/UCLA Appropriateness Method
SAMHSA Substance Abuse and Mental Health Services Administration
SMART Self-Management and Recovery Therapy
SOWS Subjective Opioid Withdrawal Scale
TB Tuberculosis
UROD Ultrarapid Opioid Detoxification

National Practice Guideline Glossary

Abstinence: Intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors. These behaviors may involve, but are not necessarily limited to, gambling, video gaming, spending, compulsive eating, compulsive exercise, or compulsive sexual behaviors.[4]

Abuse: This term is not recommended for use in clinical or research contexts. Harmful use of a specific psychoactive substance. When used to mean ''substance abuse,'' this term also applies to one category of psychoactive substance-related disorders in previous editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). While recognizing that ''abuse'' is part of past diagnostic terminology, ASAM recommends that an alternative term be found for this purpose because of the pejorative connotations of the word ''abuse.''[4]

Addiction: Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[4]

Addiction specialist physician: Addiction specialist physicians include addiction medicine physicians and addiction psychiatrists who hold either a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology, a subspecialty board certification in addiction medicine from the American Osteopathic Association, or

certification in addiction medicine from the American Society of Addiction Medicine.[10]

Adherence (see also compliance): To ''adhere'' is ''to cling, cleave (to be steadfast, hold fast), to stick fast'' (Webster's Dictionary). Adherence is a term that health professionals have been using increasingly to replace the term ''compliance.'' Both terms have been used, sometimes interchangeably, to refer to how closely patients cooperate with, follow, and take personal responsibility for the implementation of their treatment plans. The terms are often used with the more narrow sense of how well patients accomplish the goal of persistently taking medications, and also refer more broadly to all components of treatment. Assessment of patients' efforts to accomplish the goals of a treatment plan is essential to treatment success. These efforts occur along a complex spectrum from independent proactive commitment, to mentored collaboration, to passive cooperation, to reluctant partial agreement, to active resistance, and to full refusal. Attempts to understand factors that promote or inhibit adherence/compliance must take into account behaviors, attitudes, willingness, and varying degrees of capacity and autonomy. The term ''adherence'' emphasizes the patient's collaboration and participation in treatment. It contributes to a greater focus on motivational enhancement approaches that engage and empower patients.[4]

Adolescence: The American Academy of Pediatrics categorizes adolescence as the totality of three developmental stages – puberty to adulthood – which occur generally between 11 and 21 years of age.[11]

Agonist medication: See Opioid Agonist Medication.

Antagonist medication: See Opioid Antagonist Medication.

ASAM Criteria dimensions: The ASAM Patient Placement Criteria use six dimensions to create a holistic biopsychosocial assessment of an individual to be used for service planning and treatment. Dimension one is acute intoxication or withdrawal potential. Dimension two is biomedical conditions and conditions. Dimension three is emotional, behavioral, or cognitive conditions or complications. Dimension four is readiness for change. Dimension five is continued use or continued problem potential. Dimension six is recovery/living environment.[4]

Assertive community treatment: An evidence-based, outreach-oriented, service delivery model for people with severe and persistent mental illnesses that uses a team-based model to provide comprehensive and flexible treatment.[12]

Clinician: A health professional, such as a physician, psychiatrist, psychologist, or nurse, involved in clinical practice, as distinguished from one specializing in research.[4]

Cognitive behavioral therapy: An evidence-based psychosocial intervention that seeks to modify harmful beliefs and maladaptive behaviors, and help patients recognize, avoid, and cope with the situations in which they are most likely to misuse drugs.[13]

Co-occurring disorders: Concurrent substance use and mental disorders. Other terms used to describe co-occurring disorders include ''dual diagnosis,'' ''dual disorders,'' ''mentally ill chemically addicted'' (MICA), ''chemically addicted mentally ill'' (CAMI), ''mentally ill substance abusers'' (MISA), ''mentally ill chemically dependent'' (MICD), ''concurrent disorders,'' ''coexisting disorders,'' ''comorbid disorders,'' and ''individuals with co-occurring psychiatric and substance symptomatology'' (ICOPSS). Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.[4]

Compliance: See also Adherence. ''To comply'' is ''to act in accordance with another's wishes, or with rules and regulations'' (Webster's Dictionary). The term ''compliance'' is falling into disuse because patient engagement and responsibility to change is a goal beyond passive compliance. Given the importance of shared decision-making to improve collaboration and outcomes, patients are encouraged to actively participate in treatment decisions and take responsibility for their treatment, rather than to passively comply.[4]

Concomitant conditions: Medical conditions (eg, HIV, cardiovascular disease) and/or psychiatric conditions (eg, depression, schizophrenia) that occur along with a substance use disorder.[14]

Contingency management: An evidence-based psychosocial intervention in which patients are given tangible rewards to reinforce positive behaviors such as abstinence. Also referred to as motivational incentives.[13]

Dependence: Used in three different ways: physical dependence is a state of adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist; psychological dependence is a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence; and one category of psychoactive substance use disorder in previous editions of the DSM, but not in DSM-5.[4]

Detoxification: Usually used to refer to a process of withdrawing a person from a specific psychoactive substance in a safe and effective manner. The term actually encompasses safe management of intoxication states (more literally, ''detoxification'') and of withdrawal states. In this document, this term has been replaced by the term Withdrawal Management.[4]

Failure (as in treatment failure): This term is not recommended for use in clinical or research contexts. Lack of progress and/or regression at any given level of care. Such a situation warrants a reassessment of the treatment plan, with modification of the treatment approach. Such situations may require changes in the treatment plan at the same level of care or transfer to a different (more or less intensive) level of care to achieve a better therapeutic response and outcome. Sometimes used to describe relapse after a single treatment episode – an inappropriate construct in describing a chronic disease or disorder. The use of ''treatment failure'' is therefore not a recommended concept or term to be used.[4]

Harm reduction: A treatment and prevention approach that encompasses individual and public health needs, aiming to decrease the health and socioeconomic costs and consequences of addiction-related problems, especially medical complications and transmission of infectious diseases,

without necessarily requiring abstinence. Abstinence-based treatment approaches are themselves a part of comprehensive harm reduction strategies. A range of recovery activities may be included in every harm reduction strategy.[4]

Induction (office and home): The phase of opioid treatment during which maintenance medication dosage levels are adjusted until a patient attains stabilization. Buprenorphine induction may take place in an office-based setting or home-based setting. Methadone induction must take place in an opioid treatment program (OTP).[15]

Illicit opioid (nonmedical drug use): Use of an illicit drug or the use of a prescribed medicine for reasons other than the reasons intended by the prescriber, for example, to produce positive reward or negative reward. Nonmedical use of prescription drugs often includes use of a drug in higher doses than authorized by the prescriber or through a different route of administration than intended by the prescriber, and for a purpose other than the indication intended by the prescriber (e.g. the use of methylphenidate prescribed for attention deficit hyperactivity disorder [ADHD] to produce euphoria rather than to reduce symptoms or dysfunction from ADHD).[16]

Maintenance treatment(s): Pharmacotherapy on a consistent schedule for persons with addiction, usually with an agonist or partial agonist, which mitigates against the pathological pursuit of reward and/or relief and allows remission of overt addiction-related problems.

Maintenance treatments of addiction are associated with the development of a pharmacological steady state in which receptors for addictive substances are occupied, resulting in relative or complete blockade of central nervous system receptors such that addictive substances are no longer sought for reward and/or relief. Maintenance treatments of addiction are also designed to mitigate against the risk of overdose. Depending on the circumstances of a given case, a care plan including maintenance treatments can be time-limited or can remain in place lifelong. Integration of pharmacotherapy via maintenance treatments with psychosocial treatment generally is associated with the best clinical results. Maintenance treatments can be part of an individual's treatment plan in abstinence-based recovery activities or can be a part of harm reduction strategies.[4]

Moderation management: Moderation management (MM) is a behavioral change program and national support group network for people concerned about their drinking and who desire to make positive lifestyle changes. MM empowers individuals to accept personal responsibility for choosing and maintaining their own path, whether moderation or abstinence. MM promotes early self-recognition of risky drinking behavior, when moderate drinking is a more easily achievable goal.[17]

Motivational interviewing:

(1) *Layperson's definition:* A collaborative conversation style for strengthening a person's own motivation and commitment to change.
(2) *Practitioner's definition:* A person-centered counseling style for addressing the common problem of ambivalence about change.
(3) *Technical definition:* A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.[4]

Naloxone challenge: Naloxone is a short-acting opioid antagonist. Naloxone challenge is a test in which naloxone is administered to patients to evaluate their level of opioid dependence before the commencement of opioid pharmacotherapy.[15,18]

Naltrexone-facilitated opioid withdrawal management: This is a method of withdrawal management. It involves the use of a single dose of buprenorphine combined with multiple small doses of naltrexone over a several day period to manage withdrawal and facilitate the initiation of treatment with naltrexone.[19]

Narcotic drugs: Legally defined by the Controlled Substances Act in the United States since its enactment in 1970. The term ''narcotic'' is broad and can include drugs produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. The main compounds defined as narcotics in the United States include: opium, opiates, derivatives of opium and opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, ethers (but not the isoquinoline alkaloids of opium), poppy straw and concentrate of poppy straw, coca leaves, cocaine, its salts, optical and geometric isomers, and salts of isomers and ecgonine, its derivatives, their salts, isomers, and salts of isomers. Any compound, mixture, or preparation which contains any quantity of any of the substances referred to above.[20]

Neuroadaption: See ''Tolerance'' for the definition.

Office-based opioid treatment (OBOT): Physicians in private practices or a number of types of public sector clinics can be authorized to prescribe outpatient supplies of the partial opioid agonist buprenorphine. There is no regulation *per se* of the clinic site itself, but of the individual physician who prescribes buprenorphine.[4]

Opiate: One of a group of alkaloids derived from the opium poppy *(Papaver somniferum)*, with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression. The term excludes synthetic opioids.[18]

Opioid: A current term for any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions.[16]

Opioid agonist medication: Opioid agonist medications pharmacologically occupy opioid receptors in the body. They thereby relieve withdrawal symptoms and reduce or extinguish cravings for opioids.[4]

Opioid antagonist medication: Opioid antagonist medications pharmacologically occupy opioid receptors in the body, but do not activate the receptors. This effectively blocks the receptor, preventing the brain from responding to opioids. The result is that further use of opioids does not produce euphoria or intoxication.[4]

Opioid intoxication: A condition that follows the administration of opioids, resulting in disturbances in the level

of consciousness, cognition, perception, judgment, affect, behavior, or other psychophysiological functions and responses. These disturbances are related to the acute pharmacological effects of, and learned responses to, opioids. With time, these disturbances resolve, resulting in complete recovery, except when tissue damage or other complications have arisen. Intoxication depends on the type and dose of opioid, and is influenced by factors such as an individual's level of tolerance. Individuals often take drugs in the quantity required to achieve a desired degree of intoxication. Behavior resulting from a given level of intoxication is strongly influenced by cultural and personal expectations about the effects of the drug. According to the International Classifications of Diseases-10 (ICD-10), acute intoxication is the term used for intoxication of clinical significance (F11.0). Complications may include trauma, inhalation of vomitus, delirium, coma, and convulsions, depending on the substance and method of administration.[18]

Opioid treatment program (OTP): A program certified by the United States, Substance Abuse and Mental Health Services Administration (SAMHSA), usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of individuals who are addicted to opioids. An OTP can exist in a number of settings including, but not limited to, intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.[15]

Opioid treatment services (OTS): An umbrella term that encompass es a variety of pharmacological and nonpharmacological treatment modalities. This term broadens understanding of opioid treatments to include all medications used to treat opioid use disorders and the psychosocial treatment that is offered concurrently with these pharmacotherapies. Pharmacological agents include opioid agonist medications such as methadone and buprenorphine, and opioid antagonist medications such as naltrexone.[4]

Opioid use disorder: A substance use disorder involving opioids. See ''Substance Use Disorder.''

Opioid withdrawal syndrome: Over time, morphine and its analogs induce tolerance and neuroadaptive changes that are responsible for rebound hyperexcitability when the drug is withdrawn. The withdrawal syndrome includes craving, anxiety, dysphoria, yawning, sweating, piloerection (gooseflesh), lacrimation (excessive tear formation), rhinorrhea (running nose), insomnia, nausea or vomiting, diarrhea, cramps, muscle aches, and fever. With short-acting drugs, such as morphine or heroin, withdrawal symptoms may appear within 8–12 hours of the last dose of the drug, reach a peak at 48–72 hours, and clear after 7–10 days. With longer-acting drugs, such as methadone, onset of withdrawal symptoms may not occur until 1–3 days after the last dose; symptoms peak between the third and eighth day and may persist for several weeks, but are generally milder than those that follow morphine or heroin withdrawal after equivalent doses.[18]

Overdose: The inadvertent or deliberate consumption of a dose much larger than that either habitually used by the individual or ordinarily used for treatment of an illness, and likely to result in a serious toxic reaction or death.[4]

Patient: As used in this document, an individual receiving alcohol, tobacco, and/or other drug or addictive disorder treatment. The terms ''client'' and ''patient'' sometimes are used interchangeably, although staff in nonmedical settings more commonly refer to ''clients.''[4]

Physical dependence: State of physical adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, and/or decreasing blood level of a substance and/or administration of an antagonist.[15]

Psychosocial treatment: Any nonpharmacological intervention carried out in a therapeutic context at an individual, family, or group level. Psychosocial interventions may include structured, professionally administered interventions (eg, cognitive behavior therapy or insight-oriented psychotherapy) or nonprofessional interventions (eg, self-help groups and nonpharmacological interventions from traditional healers).[12]

Precipitated withdrawal: A condition that occurs when an opioid agonist is displaced from the opioid receptors by an antagonist. It is also possible for a partial agonist to precipitate withdrawal.[18]

Recovery: A process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process. (Note: ASAM continues to explore, as an evolving process, improved ways to define Recovery.)[4]

Relapse: A process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors. When in relapse, there is often disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.[4]

Sedative, hypnotic, or anxiolytics: This class of substances includes all prescription sleeping medications and virtually all prescription antianxiety medications. Nonbenzodiazepine antianxiety medications, such as buspirone and gepirone, are not included in this class because they are not associated with significant misuse.[21]

Sobriety: A state of sustained abstinence with a clear commitment to and active seeking of balance in the biological, psychological, social, and spiritual aspects of an individual's health and wellness that were previously compromised by active addiction.[4]

Spontaneous withdrawal: A condition that occurs when an individual who is physically dependent on an opioid agonist suddenly discontinues or markedly decreases opioid use.[22]

Stabilization: Includes the medical and psychosocial processes of assisting the patient through acute intoxication and withdrawal to the attainment of a medically stable, fully supported, substance-free state. This often is done with the assistance of medications, though in some approaches to detoxification, no medication is used.[15]

Substance use disorder: Substance use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. Diagnostic criteria are given in the DSM-5. Substance use disorder is the new nomenclature for what was included as substance dependence and substance abuse in the DSM-IV.[16]

Tolerance: A decrease in response to a drug dose that occurs with continued use. If an individual is tolerant to a drug, increased doses are required to achieve the effects originally produced by lower doses. Both physiological and psychosocial factors may contribute to the development of tolerance. Physiological factors include metabolic and functional tolerance. In metabolic tolerance, the body can eliminate the substance more readily, because the substance is metabolized at an increased rate. In functional tolerance, the central nervous system is less sensitive to the substance. An example of a psychosocial factor contributing to tolerance is behavioral tolerance, when learning or altered environmental constraints change the effect of the drug. Acute tolerance refers to rapid, temporary accommodation to the effect of a substance after a single dose. Reverse tolerance, also known as sensitization, refers to a condition in which the response to a substance increased with repeated use. Tolerance is one of the criteria of the dependence syndrome.[18]

Withdrawal management: Withdrawal management describes services to assist a patient's withdrawal. The liver detoxifies, but clinicians manage withdrawal.[10]

INTRODUCTION

Purpose

The American Society of Addiction Medicine (ASAM) developed the *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (the ''*Practice Guideline*'') to provide information on evidence-based treatment of opioid use disorder. This guideline is intended to assist clinicians in the decision-making process for prescribing pharmacotherapies and psychosocial treatments to patients with opioid use disorder.

Specifically, the *Practice Guideline* helps in the following:

(1) Identifies current practices and outstanding questions regarding the safe and effective use of medications for the treatment of opioid use disorder.
(2) Uses a methodology that integrates evidence-based practices and expert clinical judgment to develop recommendations on best practices in opioid use disorder treatment.
(3) Presents best practices in a cohesive document for clinicians' use to improve the effectiveness of opioid use disorder treatment.

Background on Opioid Use Disorder

Opioid use disorder is a chronic, relapsing disease, which has significant economic, personal, and public health consequences. Many readers of this *Practice Guideline* may recognize the term ''opioid use disorder'' as it is used in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) developed by the American Psychiatric Association; others may be more familiar with the term ''opioid dependence,'' as used in previous editions of the DSM.

The ASAM defines addiction as ''a primary, chronic disease of brain reward, motivation, memory, and related circuitry,'' with a ''dysfunction in these circuits'' being reflected in ''an individual pathologically pursuing reward and/or relief of withdrawal symptoms by substance use and other behaviors.'' In this context, the preferred term by ASAM for this serious bio-psycho-social-spiritual illness would be ''addiction involving opioid use.'' ASAM views addiction as a fundamental neurological disorder of ''brain reward, motivation, memory, and related circuitry,'' and recognizes that there are unifying features in all cases of addiction, including substance-related addiction and nonsubstance-related addiction. It is clear that a variety of substances commonly associated with addiction work on specific receptors in the nervous system and on specific neurotransmitter systems. Specific pharmacological agents used in the treatment of addiction exert their effects via their actions on specific receptors. Hence, the medications used in the treatment of addiction have specific efficacy based on their own molecular structure and the particular neurotransmitters affected by that medication. Medications developed for the treatment of addiction involving opioid use may have benefits in the treatment of addiction involving an individual's use of other substances. For instance, naltrexone (US Food and Drug Administration [FDA]), for the treatment of opioid dependence using DSM, 4th Edition (DSM-IV) terminology, is also US FDA-approved for the treatment of alcohol dependence, as per the DSM-IV guidelines.

The ASAM recognizes that research is yet to be done to confirm the specificity of its conceptualization of addiction as a medical and a psychiatric illness (note: the International Classification of Diseases-10 [ICD-10], and the American Medical Association in various policy and position statements recognize addiction as both a medical and a psychiatric disorder). ASAM encourages clinicians, researchers, educators, and policy makers to use the term ''addiction'' regardless of whether the patient's condition at a given point in its natural history appears to more prominently involve opioid use or alcohol use, nicotine use, or engagement in addictive behaviors such as gambling. Given the widespread North American application of the DSM's categorization of disorders, this *Practice Guideline* will, for the sake of brevity and convention, use the term ''opioid use disorder.''

Epidemiology

According to the 2013 National Survey on Drug Use and Health (NSDUH),[5] 4.5 million individuals were current nonmedical users of prescription opioids (past month) and 1.9 million individuals met DSM-IV criteria for abuse or dependence of prescription opioids. In addition, the NSDUH reported that 289,000 people were current (past month) users of heroin

and 517,000 met DSM IV criteria for abuse or dependence in 2013. The rate of prescription opioid use for nonmedical purposes was 1.7% in persons 12 years and older. However, the rate of prescription opioid use among youth aged 12–17 declined from 3.2% in 2002 and 2003 to 1.7% in 2013. Importantly, nonmedical use of prescription opioids has been shown to be associated with the initiation of heroin use. In a study pooling data from the NSDUH from 2002 to 2012, the incidence of heroin use was 19 times greater among individuals who reported prior nonmedical use of prescription opioids compared to individuals who did not report prior nonmedical prescription opioid use.[23]

Mortality and Morbidity

Opioid use is associated with increased mortality. The leading causes of death in people using opioids for nonmedical purposes are overdose and trauma.[6] The number of unintentional overdose deaths from prescription opioids has more than quadrupled since 1999.[24]

Opioid use increases the risk of exposure to HIV, viral hepatitis, and other infectious agents through contact with infected blood or body fluids (eg, semen) that results from sharing syringes and injection paraphernalia, or through unprotected sexual contact. Similarly, it increases the risk of contracting infectious diseases such as HIV/AIDS and hepatitis because people under the influence of drugs may engage in risky behaviors that can expose them to these diseases.[6]

Importantly, injection drug use (IDU) is the highest-risk behavior for acquiring hepatitis C virus (HCV) infection and continues to drive this epidemic. Of the 17,000 new HCV infections in the United States in 2010, more than half (53%) involved IDU. In 2010, hepatitis B virus (HBV) infection rates were estimated to be 20% higher among people who engaged in IDU in the United States.[25]

Scope of Guideline

This *Practice Guideline* was developed to assist in the evaluation and treatment of opioid use disorder. Although there are existing guidelines for the treatment of opioid use disorder, none have included all of the medications used for its treatment at present. Moreover, few of the existing guidelines address the needs of special populations such as pregnant women, individuals with co-occurring psychiatric disorders, individuals with pain, adolescents, or individuals involved in the criminal justice system.

Overall, the *Practice Guideline* contains recommendations for the evaluation and treatment of opioid use disorder, opioid withdrawal management, psychosocial treatment, special populations, and opioid overdose.

(1) *Part 1:* Contains guidelines on the evaluation of opioid use disorder
(2) *Part 2:* Provides recommendations regarding treatment options
(3) *Part 3:* Describes the treatment of opioid withdrawal
(4) *Parts 4–6:* Provide guidelines on medications for treating opioid use disorder
(5) *Part 7:* Describes psychosocial treatment used in conjunc tion with medications
(6) *Parts 8–12:* Provide guidelines for treating special populations and circumstances
(7) *Part 13:* Describes the use of naloxone in treating opioid overdose

Included and Excluded Medications

The medications covered in this guideline include the following:

(1) Methadone (part 4)
(2) Buprenorphine (part 5)
(3) Naltrexone in oral and extended-release injectable formulations (part 6)
(4) Naloxone (part 13)

All of these medications act directly upon the opioid receptors, particularly the mu-subtype. Methadone is a mu-receptor agonist; buprenorphine is a partial mu-receptor agonist; and naltrexone is an antagonist. Naloxone is a fast-acting antagonist used to reverse opioid overdose, a condition that may be life-threatening. Because of the differing actions of these medications at the receptor level, they can have very different clinical effects during treatment.

Other medications show promise for the treatment of opioid use disorder; however, there is insufficient evidence at this writing to make a full analysis of their effectiveness. For example, whereas not US FDA-approved for opioid withdrawal syndrome in the United States, it is recognized that clonidine, an alpha-2 adrenergic agonist, has been in use in clinical settings for 25 years. Lofexidine (known as BritLofex, Britannia Pharmaceuticals) is approved for treating opioid withdrawal use in the United Kingdom. Because of their long history of off-label use in the United States, clonidine and buprenorphine are described for opioid withdrawal syndrome in this *Practice Guideline*. Again, there are other off-label medications for withdrawal management in the treatment of opioid use disorder (eg, tramadol) that have been excluded from this guideline because there is insufficient evidence to make a full analysis of their effectiveness or consensus recommendations for their use at this time.

The ASAM recognizes that withdrawal management and withdrawal management medications could be potential topics for future guideline development. ASAM will regularly review its published guidelines to determine when partial or full updates are needed. The emergence of newly approved medications and new research will be considered as part of this process. It is also recognized that ASAM may develop guidelines or consensus documents on topics addressed in this *Practice Guideline* (eg, urine drug testing). If that occurs before any update to this *Practice Guideline*, it is to be assumed that the recommendations in the latter documents will take precedence until this *Practice Guideline* is updated.

Intended Audience

This *Practice Guideline* is intended for all clinicians, at any level, involved in evaluating for, and/or providing, opioid use disorder treatment in the United States. The intended audience falls into the following broad groups:

(1) Physicians involved in the assessment, diagnosis, and treatment of opioid use disorder. General practice physicians (including family practitioners, pediatricians, obstetricians, and gynecologists) are often first-line providers of medical care related to opioid use disorder and are a key audience for the guideline.
(2) Clinicians involved with the completion of health assessments and delivery of health services to special populations.
(3) Clinicians involved in making an initial assessment and offering psychosocial treatments in conjunction with medications to treat opioid use disorder.
(4) Clinical case managers responsible for clinical care support, coordination of health-related and social services, and tracking of patient adherence to the treatment plan.

Qualifying Statement

The ASAM *Practice Guideline* is intended to aid clinicians in their clinical decision-making and patient management. It strives to identify and define clinical decision-making junctures that meet the needs of *most patients* in *most circumstances*. The ultimate judgment about care of a particular patient must be made together by the clinician and the patient in light of all the circumstances presented by the patient. As a result, situations may arise in which deviations from the *Practice Guideline* may be appropriate. Clinical decision-making should involve consideration of the quality and availability of expertise and services in the community wherein care is provided.

In circumstances in which the *Practice Guideline* is being used as the basis for regulatory or payer decisions, improvement in quality of care should be the goal. Finally, prescribed courses of treatment contained in recommendations in this *Practice Guideline* are effective only if the recommendations, as outlined, are followed. Because lack of patient understanding and adherence may adversely affect outcomes, clinicians should make every effort to engage the patient's understanding of, and adherence to, prescribed and recommended pharmacological and psychosocial treatments. Patients should be informed of the risks, benefits, and alternatives to a particular treatment and should be shared parties to decision-making whenever feasible. Recommendations in this *Practice Guideline* do not supersede any federal or state regulation.

METHODOLOGY

Overview of Approach

These guidelines were developed using the RAND/UCLA Appropriateness Method (RAM) – a process that combines scientific evidence and clinical knowledge to determine the appropriateness of a set of clinical procedures.[26] This process is particularly appropriate for these guidelines for two reasons. First, there are very few randomized clinical trials directly comparing the approved medications for the treatment of opioid use disorder. Second, evidence supporting the efficacy of the individual medications reflects varying years of research and varying levels of evidence (eg, nonrandomized studies, retrospective studies). The randomized clinical trial (RCT) is the gold standard for evidence-based medicine. When data are lacking from RCT, other methods must be used to help clinicians make the best choices. In addition, these guidelines are unique in that they include all three of the medications approved at present by the US FDA in multiple formulations, and they address the needs of special populations such as pregnant women, individuals with pain, adolescents, individuals with co-occurring psychiatric disorder, and individuals in criminal justice. Such special populations are often excluded from RCTs, making the use of RCT data even more difficult. The RAM process combines the best available scientific evidence combined with the collective judgment of experts to yield statements about the appropriateness of specific procedures that clinicians can apply to their everyday practice.

The ASAM's Quality Improvement Council (QIC) was the oversight committee for the guideline development. The QIC appointed a Guideline Committee to participate throughout the development process, rate treatment scenarios, and assist in writing. In selecting the committee members, the QIC made every effort to avoid actual, potential, or perceived conflicts of interest that may arise as a result of relationships with industry and other entities among members of the Guideline Committee. All QIC members, committee members, and external reviewers of the guideline were required to disclose all current related relationships, which are presented in Appendices III, IV, and V.

The Guideline Committee was comprised of 10 experts and researchers from multiple disciplines, medical specialties, and subspecialties, including academic research, internal medicine, family medicine, addiction medicine, addiction psychiatry, general psychiatry, obstetrics/gynecology, and clinical neurobiology. Physicians with both allopathic and osteopathic training were represented in the Guideline Committee. The Guideline Committee was assisted by a technical team of researchers from the Treatment Research Institute (TRI) affiliated with the University of Pennsylvania (see page 2), and worked under the guidance of Dr. Kyle Kampman who led the TRI team as Principal Investigator in implementing the RAM.

The RAM process is a deliberate approach encompassing review of existing guidelines, literature reviews, appropriateness ratings, necessity reviews, and document development. The steps are summarized in the flow chart in "Exhibit 1 Methodology."

Task 1: Review of Existing Guidelines

Review of Existing Clinical Guidelines

All existing clinical guidelines that addressed the use of medications and psychosocial treatments in the treatment of opioid use disorders including special populations (eg pregnant women, individuals with pain, and adolescents), and that were published during the period from January 2000 to April 2014, were identified and reviewed. In total, 49 guidelines were identified and 34 were ultimately included in the analysis. See "Appendix I" for a list of the guidelines that were reviewed. The included guidelines offered evidence-based recommendations for the treatment of opioid use disorder using methadone, buprenorphine, naltrexone, and/or naloxone.

The majority of existing clinical guidelines are based on systematic reviews of the literature including appropriateness

criteria used in the RAM. Therefore, the aim of this exercise was not to re-review all of the research literature, but to identify within the existing clinical guidelines how they addressed common questions or considerations that clinicians are likely to raise in the course of deciding whether and how to use medications as part of the treatment of individuals with opioid use disorder.

Analysis of Clinical Guidelines

On the basis of the previously reviewed existing clinical guidelines, an analytic table was created and populated to display the identified key components. This table served as the foundation for development of hypothetical statements. The hypothetical statements were sentences describing recommendations derived from the analysis of the clinical guidelines.

Preparation of Literature Review on Psychosocial Interventions

A review of the literature on the efficacy of psychosocial treatment delivered in conjunction with medications for the treatment of opioid use disorder was conducted. This review was partially supported by funding from the National Institute on Drug Abuse (NIDA). Articles were identified for inclusion in the review through searches conducted in two bibliographic databases (eg, PsycINFO and PubMed) using predefined search terms and established selection criteria. Titles and abstracts were reviewed for inclusion by two members of the research team.

To increase the overall relevance of the review, the search was limited to articles in the 6-year period from 2008 to the present. In the event that the article reflected a secondary analysis of data from a relevant study, the original study was included in the literature review. In addition, findings from three prominent systematic reviews (ie, 2007 review on psychosocial interventions in pharmacotherapy of opioid dependence prepared for the Technical Development Group for the World Health Organization, ''Guidelines for Psychosocially Assisted Pharmacotherapy of Opioid Dependence,'' and two 2011 Cochrane reviews examining psychosocial and pharmacological treatments for opioid withdrawal management and psychosocial interventions combined with agonist treatment) were summarized.[27–29]

The literature search yielded 938 articles. The titles and abstracts were reviewed to determine if the study met the inclusion/exclusion criteria, and those that did not ($n = 787$) were removed. The remaining 151 articles were then reviewed for inclusion, and 27 articles were ultimately retained for use in the literature review as the others did not meet the predetermined inclusion/exclusion criteria. These articles, along with the relevant systematic reviews of the literature, are described in the literature review in the next section.

Task 2: Identification of Hypothetical Statements and Appropriateness Rating

RAND/UCLA Appropriateness Method

The first step in the RAM is to develop a set of hypothetical statements, which were derived from the guideline analysis and literature review described in the previous section, for appropriateness rating.

The analysis and literature review generated a list of 245 hypothetical statements that reflected recommended medical or psychosocial treatment. Each member of the Guideline Committee reviewed the guideline analysis and literature review, and privately rated 245 hypothetical clinical statements on a nine-point scale of ''appropriateness.'' In the context of this *Practice Guideline*, the meaning of appropriateness was defined as:

> *''A statement, procedure or treatment is considered to be appropriate if the expected health benefit (eg, increased life expectancy, relief of pain, reduction in anxiety, improved functional capacity) exceeds the expected negative consequences (eg, mortality, morbidity, anxiety, pain) by a sufficiently wide margin that the procedure is worth doing, exclusive of cost.''*

An appropriateness score of 1 meant that the statement was ''highly inappropriate.'' An appropriateness rating of 9 meant that the statement was ''highly appropriate.'' These appropriateness statements were meant to identify a lack of consensus in existing guidelines and research literature.

Guideline Committee Meeting

Upon completion and collection of the individual Guideline Committee member ratings, 201 out of the 245 hypothetical statements were identified as meeting the criteria for consensus. The remaining 44 statements had divergent ratings. On September 15, 2014, the Guideline Committee met in Washington, District of Columbia, to discuss the hypothetical clinical statements. At this meeting, the committee came to consensus on the hypothetical statements. After the meeting, the information gathered was used to revise several of the statements; and the Guideline Committee was asked to re-rate the revised statements.

Literature Review

A supplementary literature review was also conducted to identify relevant studies that might resolve statements that had resulted in divergent ratings during the Guideline Committee meeting. Information relating to the vast majority of these divergent ratings was subsequently found within the existing guideline data set, and consequently included in the first draft of the *Practice Guideline*.

For the topics and questions for which answers were not found in the existing guideline data set, a full literature review was conducted. The topics and questions for which no further clarification was found in the literature were considered ''gaps'' that require additional research before inclusion in this guideline. These gaps in the literature were: urine drug testing; patients using marijuana; the safety of delivering injectable naltrexone doses to patients with high metabolism every 3 weeks; and the safety of adding full agonists to treatment with buprenorphine for pain management.

Creation and Revision of Guideline Outline

All the identified appropriate/uncertain hypothetical statements and supporting research were incorporated into an outline defining each specific section to be included in

the final *Practice Guideline*. The draft outline, review of existing guidelines, and literature review were all sent to the Guideline Committee members for review and discussion during two web teleconferences and through private communication. Two teleconferences were held to ensure full participation from members of the Guideline Committee.

Task 3: Comparative Analysis, Review, and Necessity Rating

Committee Review and Rating

The Guideline Committee then re-rated the 211 ''appropriate'' hypothetical statements for necessity. When rating for necessity, the Guideline Committee members were asked to adhere to the following guidance:

A statement was considered *necessary* when all the following criteria were met:

(1) It would be considered improper care not to provide this service.
(2) Reasonable chance exists that this procedure and/or service will benefit the patient. (A procedure could be *appropriate* if it had a low likelihood of benefit, but few risks; however, such procedures would not be *necessary*.)
(3) The benefit to the patient is of significance and certainty. (A procedure could be *appropriate* if it had a minor but almost certain benefit, but it would not be *necessary*.)

Necessity is a more stringent criterion than appropriateness. If a procedure is necessary, this means that the expected benefits outweigh the expected harms (ie, it is appropriate), and that they do so by such a margin that the physician must recommend the service. Of course, patients may decline to follow their physician's recommendations.[26]

Of the 211 rated statements, 184 hypothetical statements met the criteria for being both appropriate and necessary, and were incorporated in the guideline.

Final Draft Outline

The final draft outline highlighted hypothetical statements that had been determined to rise to the level of necessity.

Task 4: Drafting the National Practice Guideline

Draft and Review

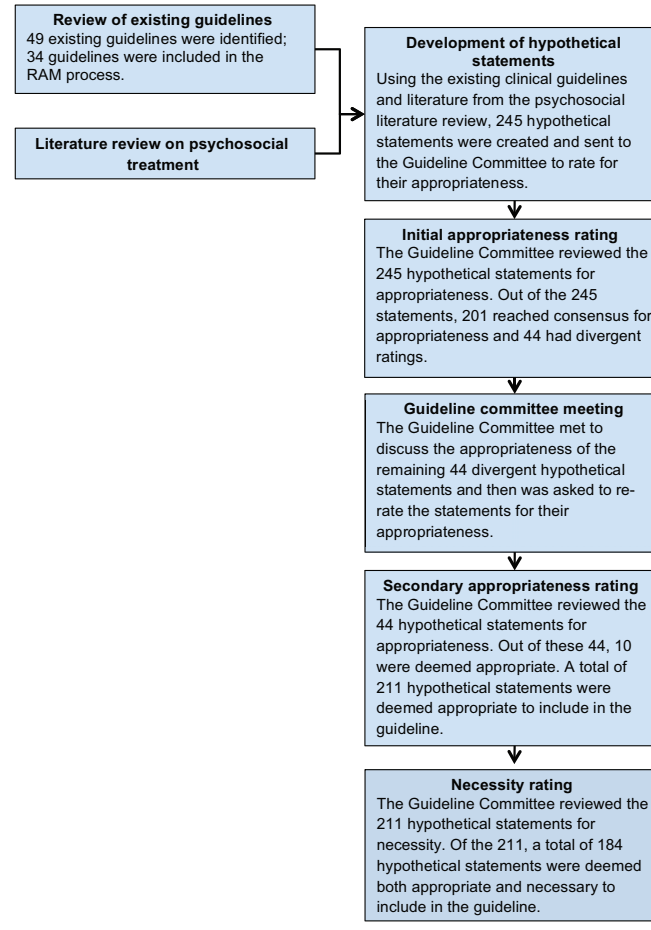
A first draft of the *Practice Guideline* was created using the Guideline Committee's recommendations resulting from supporting evidence and the appropriateness and necessity ratings discussed above. The first draft of the *Practice Guideline* was sent to the Guideline Committee for review and electronic comment. During a subsequent teleconference in January 2015, the Guideline Committee discussed the comments received via first review. Revisions were made to the draft, which went again through subsequent reviews by the Guideline Committee and the ASAM Quality Council throughout February and March 2015.

Task 5: External Review

External Review

The ASAM sought input from ASAM members – patient and caregiver groups, stakeholders including experts from the criminal justice system, government agencies, other professional societies, and hospitals and health systems. ASAM also made the document and a qualitative review guide available to ASAM members and the general public for a one week period of review and comment. The final draft *Practice Guideline* was submitted to the ASAM Board of Directors in April 2015.

Exhibit 1: Methodology



PART 1: ASSESSMENT AND DIAGNOSIS OF OPIOID USE DISORDER

Comprehensive Assessment

The ASAM *Standards of Care for the Addiction Specialist Physician* (the ''ASAM Standards'') describe the importance of comprehensive assessment. Though the assessment process is ongoing for the patient with substance use disorder, a comprehensive assessment is ''a critical aspect of

patient engagement and treatment planning'' and should be conducted during the initial phase of treatment.[10] The assessment is not necessarily the first visit; it is critical, however, to determine emergent or urgent medical problems. Patients with opioid use disorder often have other physiological or psychiatric conditions that may complicate their treatment. These concomitant medical and psychiatric conditions may need immediate attention and require transfer to a higher level of care (see ''Part 11: Special Populations: Individuals With Co-occurring Psychiatric Disorders'').

Medical History

The patient's medical history should include screening for concomitant medical conditions and routine identification of medications, allergies, pregnancy, family medical history, and so on. Particular attention should be paid to the following: history of infectious diseases such as hepatitis, HIV, and TB; acute trauma; psychiatric, substance use, addictive behavior, and addiction treatment history; and any previous history of pharmacotherapy. An intake of the patient's social history and assessment of readiness for change including identification of any facilitators and barriers are also components of the medical history.

Physical Examination

As part of the comprehensive assessment of patients with opioid use disorder, a physical examination should be completed by the prescriber him/herself (the clinician authorizing the use of a medication for the treatment of opioid use disorder), another member of the clinician's health system, or the prescribing physician. Further, the responsible clinician should assure that a current physical examination (in accordance with the ASAM Standards) is contained within the patient medical record before a patient is started on a new medication for the treatment of his/her opioid use disorder.

The examination should include identifying objective physical signs of opioid intoxication or withdrawal. See Table 1 for a list of common signs of intoxication or withdrawal. In addition, the examination should evaluate objective signs of substance use disorders. See Table 2 for a list of physical signs of substance use disorders (including opioid use disorder).

Special attention should be given to identifying IDU by the presence of new or older puncture marks. Common injection sites are inside the elbow (cubital fossa) and forearm, but other sites on the extremities may be injection sites.

TABLE 1. Common Signs of Opioid Intoxication and Withdrawal

Intoxication Signs	Withdrawal Signs
Drooping eyelids	Restlessness, irritability, anxiety
Constricted pupils	Insomnia
Reduced respiratory rate	Yawning
Scratching (due to histamine release)	Abdominal cramps, diarrhea, vomiting
Head nodding	Dilated pupils
	Sweating
	Piloerection

TABLE 2. Objective Physical Signs in Substance Use Disorders

System	Findings
Dermatologic	Abscesses, rashes, cellulitis, thrombosed veins, jaundice, scars, track marks, pock marks from skin popping
Ear, nose, throat, and eyes	Pupils pinpoint or dilated, yellow sclera, conjunctivitis, ruptured eardrums, otitis media, discharge from ears, rhinorrhea, rhinitis, excoriation or perforation of nasal septum, epistaxis, sinusitis, hoarseness, or laryngitis
Mouth	Poor dentition, gum disease, abscesses
Cardiovascular	Murmurs, arrhythmias
Respiratory	Asthma, dyspnea, rales, chronic cough, hematemesis
Musculoskeletal and extremities	Pitting edema, broken bones, traumatic amputations, burns on fingers
Gastrointestinal	Hepatomegaly, hernias

Assessment and History Considerations Specific to Females

Use of contraception and determination of pregnancy are factors in choosing treatment options for women with opioid use disorder. Contraception and reproductive health are topics of discussion within the assessment process of female patients who are considering opioid use disorder treatment. Clinicians and female patients should keep in mind that fertility increases as treatment becomes effective. Case management plans may need to include referral to gynecological services for female patients. An in-depth discussion of the treatment of opioid use disorder in pregnant women is described later in ''Part 8: Special Populations: Pregnant Women.''

Laboratory Tests

Initial lab testing should include hepatitis C and HIV testing. Hepatitis serology and vaccination are recommended. Hepatitis A and B testing and vaccination should be offered when appropriate. As above, women of childbearing potential and age should be tested for pregnancy. Tuberculosis testing and testing for sexually transmitted infections, including syphilis, may be considered.

A complete blood count and liver function study should be conducted to screen for liver dysfunction, infection, and other medical conditions. Abnormal results may require further investigation.

Assessment for Mental Health Status and Psychiatric Disorder

Patients being evaluated for opioid use disorder, and/or for possible medication use in the treatment of opioid use disorder, should undergo an evaluation of possible co-occurring psychiatric disorders. During the assessment process and physical examination, it is important for the clinician to assess for mental health status consistent with the ASAM Standards.

In the ASAM Standards, I.1 indicates that the physician ''assures that an initial comprehensive, multicomponent assessment is performed for each patient, either by performing it her/himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working.'' A thorough medical and psychiatric history and family history is indicated as a component of this same standard. Patients

who are determined as exhibiting urgent or emergent psychiatric conditions, or who are psychiatrically unstable and represent a danger to themselves or others, should be referred to the appropriate level of care for their safety and the safety of others. Further specialty evaluation may be warranted depending on severity of indicators for psychiatric instability. Indicators of psychiatric instability or disorder include acute suicidal or homicidal ideation, acute psychosis, and delirium.

Assessment for Alcohol and Substance Use and Treatment History

A careful evaluation of current and past use of alcohol and drugs, including nonmedical use of prescription medications, is required to diagnose opioid use disorder. Because opioid use disorder may co-occur with other use disorders, the evaluator should assess frequency and quantity of use.

Completing a history of opioid drug use with a patient who has been identified as using opioids should focus on the following:

(1) type and amount of opioid(s) used recently;
(2) route of administration;
(3) last use;
(4) treatment history; and
(5) problems resulting from drug use.

The amount of drug being consumed will impact the likelihood and severity of withdrawal symptoms when the drug is stopped, so it is useful to obtain an estimate of the amount used (each time and number of times per day).

Prescription Drug Monitoring Programs (PDMPs) offer information about prescription opioid use. They can serve as important resources for clinicians' use in completing full patient clinical assessments of opiate and other controlled substance use history, and it is recommended that they be utilized. It is recognized, as detailed in ''Exhibit 2 Prescription Drug Monitoring Programs,'' that there is variation across states in terms of the level of operation of these programs, the extent of their data sharing across states, and state requirements for their use before prescribing controlled substances.

In addition, a history of outpatient and inpatient treatment for alcohol and other substance use disorders should be collected. Clinicians should ask for information about the type and duration of treatment and outcomes.

Assessment for Co-occurring Alcohol and Substance Use

Opioid use disorder often co-occurs with alcohol and other substance use disorders. Therefore, evaluation of co-occurring alcohol and substance use is recommended.

Clinicians should assess signs and symptoms of alcohol or sedative, hypnotic, or anxiolytic intoxication or withdrawal. Alcohol or sedative, hypnotic, or anxiolytic withdrawal may result in seizures, hallucinosis, or delirium, and may represent a medical emergency. Likewise, concomitant use of alcohol and sedatives, hypnotics, or anxiolytics with opioids may contribute to respiratory depression. Patients with significant co-occurring substance use disorders, especially severe alcohol or sedative, hypnotic, or anxiolytic use, may require a higher level of care.

An evaluation of past and current substance use should be conducted, and a determination as to whether addiction involving other substances or other behaviors is present. For instance, the regular use of marijuana or cannabinoids, tobacco or electronic nicotine delivery devices, or other drugs should not be a reason to suspend medication use in the treatment of addiction involving opioid use. Concurrent use of other drugs or active engagement in other addictive behaviors should lead to consideration of other treatment plan components for the patient. The presence of co-occurring substance use disorders should provoke a re-evaluation of the level of care that is in place for psychosocial treatment, along with pharmacological therapy. In most cases, co-occurring drug use will not represent a medical emergency. In such cases, patients can be treated for both their opioid use disorder and co-occurring alcohol or substance use disorders. However, ongoing use of other drugs may lead to poorer treatment outcomes. Evidence does demonstrate that individuals who are actively using other substances during opioid use disorder treatment have a poorer prognosis.[30–32]

The Guideline Committee cautioned against excluding patients from treatment for their opioid use disorder because they are using marijuana or other psychoactive substances that do not interact with opioids, and that are not prescribed by their physician. Whereas there is a paucity of research examining this topic, evidence demonstrates that patients under treatment have better outcomes than those not retained under treatment.[33,34] Suspension of opioid use disorder treatment may increase the risk for death from overdose, accidents, or other health problems. However, continued use of marijuana or other psychoactive substances may impede treatment for opioid use disorder; thus, an approach emphasizing cessation of all unprescribed substances is likely to result in the best results. Further research is needed on the outcomes of patients in opioid use disorder treatment who are continuing the nonmedical use of psychoactive substances.

Assessment for Tobacco Use

Tobacco use should be queried, and the benefits of cessation should be promoted routinely with patients presenting for evaluation and treatment of opioid use disorder. Several studies have demonstrated that smoking cessation improves long-term outcomes among individuals receiving treatment for substance use disorders.[35–37]

Assessment of Social and Environmental Factors

Clinicians should conduct an assessment of social and environmental factors (as outlined in the ASAM Standards) to identify facilitators and barriers to addiction treatment and specifically to pharmacotherapy. Before a decision is made to initiate a course of pharmacotherapy for the patient with opioid use disorder, the patient should receive a multidimensional assessment in fidelity with *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occuring Conditions* (the ''ASAM Criteria''). The ASAM Patient Placement Criteria uses six dimensions to create a holistic biopsychosocial assessment of an individual to be used for service

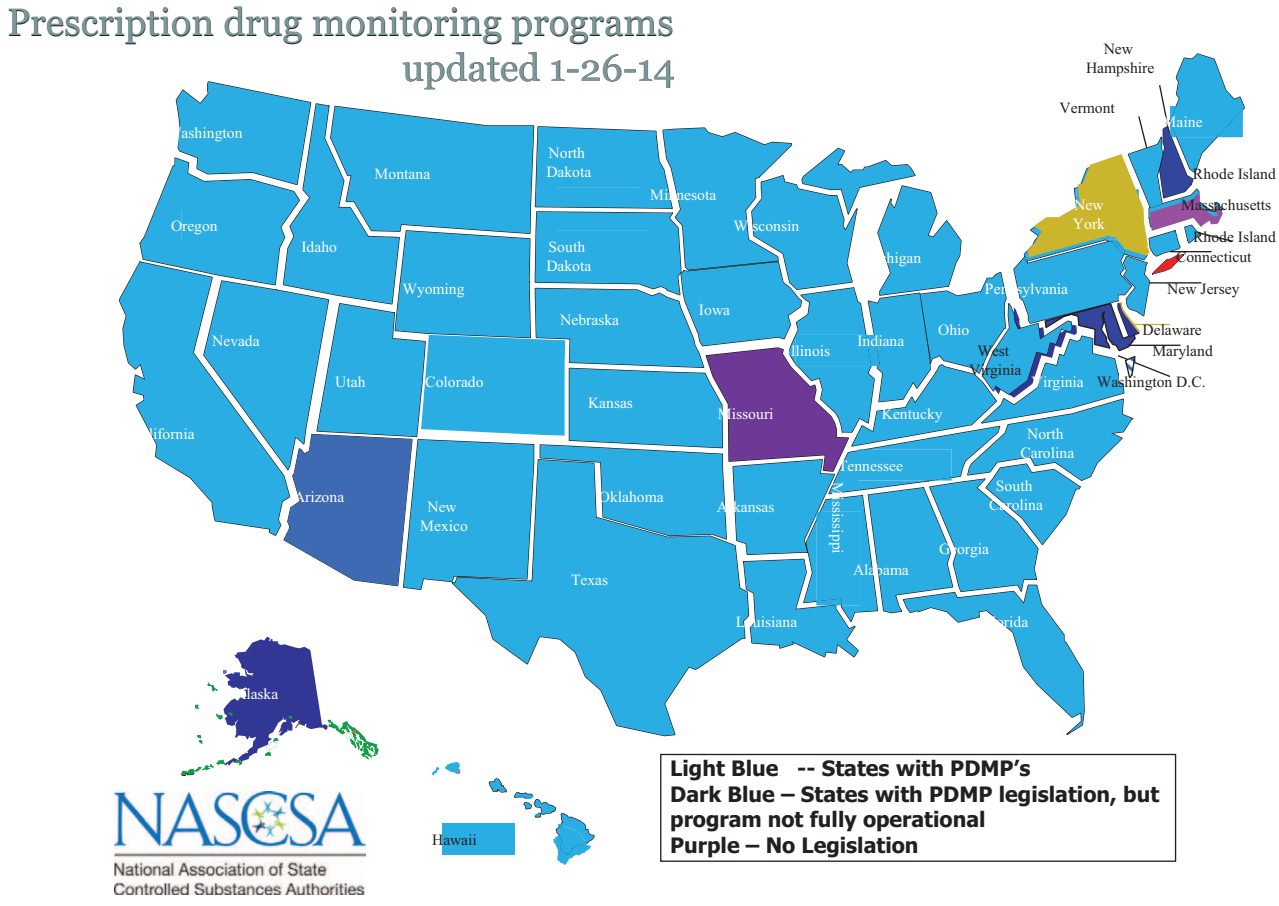


Exhibit 2: Prescription Drug Monitoring Programs

planning and treatment. Dimension one is acute intoxication or withdrawal potential. Dimension two is biomedical conditions and conditions. Dimension three is emotional, behavioral, or cognitive conditions or complications. Dimension four is readiness for change. Dimension five is continued use or continued problem potential. Dimension six is recovery/living environment.[4] The use of medications for the patient with addic-tion involving opioid use can be appropriate across all levels of care. Pharmacotherapy is not a "level of care" in addiction treatment, but one component of multidisciplinary treatment. Whereas medication as a standalone intervention has been utilized in North America and internationally, ASAM recommends that the use of medications in the treatment of addiction be part of a broad bio-psycho-social-spiritual intervention appropriate to the patient's needs and to the resources available in the patient's community. Addiction should be considered a bio-psycho-social-spiritual illness, for which the use of medication(s) is but only one component of overall treatment.

Diagnosing Opioid Use Disorder

Opioid use disorder is primarily diagnosed on the basis of the history provided by the patient and a comprehensive assessment that includes a physical examination. Corroborating information reported by significant others can be used to confirm the diagnosis, especially when there is lack of clarity or inconsistency in information. Other clinicians may make a diagnosis of opioid use disorder; however, provider confirmation of the diagnosis is required before medications are prescribed. This is discussed further in later parts that address specific medications.

DSM-5 Criteria for Diagnosis

The diagnosis of opioid use disorder is based on criteria outlined in the DSM-5. The criteria describe a problematic pattern of opioid use leading to clinically significant impairment or distress. There are a total of 11 symptoms and severity is specified as either mild (presence of 2-3 symptoms), moderate (presence of 4-5 symptoms) or severe (presence of 6 or more symptoms) within a 12 month period. Opioid use disorder requires that at least two of the following 11 criteria be met within a twelve-month period: (1) taking opioids in larger amounts or over a longer period of time than intended; (2) having a persistent desire or unsuccessful attempts to reduce or control opioid use; (3) spending excess time obtaining, using or recovering from opioids; (4) craving for opioids; (5) continuing opioid use causing inability to fulfill work, home, or school responsibilities; (6) continuing opioid use despite having persistent social or interpersonal problems; (7) lack of involvement in social, occupational or recreational activities; (8) using opioids in physically hazardous situations; (9) continuing opioid use in spite of awareness of persistent physical or psychological problems; (10) tolerance, including need for increased amounts of opioids or diminished effect with continued use at the same

amount – as long as the patient is not taking opioids under medical supervision; and (11) withdrawal manifested by characteristic opioid withdrawal syndrome or taking opioids to relieve or avoid withdrawal symptoms – as long as the patient is not taking opioids under medical supervision.

More detail about diagnosing opioid use disorder is available in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

Withdrawal Scales

There are a number of useful opioid withdrawal scales that can assist the clinician in evaluating patients with opioid use disorder by identifying and quantitating the severity of opioid withdrawal symptoms. The Objective Opioid Withdrawal Scale (OOWS), which relies on clinical observation, is useful in measuring and documenting the objectively measurable symptoms of opioid withdrawal. The Subjective Opioid Withdrawal Scale (SOWS) records the patient's rating of opioid withdrawal on a 16-item scale.[38] Finally, the Clinical Opioid Withdrawal Scale (COWS) includes 11 items, and contains signs and symptoms of opioid withdrawal, which are both objective and subjective in nature.[38]

Urine Drug Testing

Urine drug testing, or other reliable biological tests for the presence of drugs, during the initial evaluation and frequently throughout treatment, is highly recommended. There are a variety of toxicology tests available, some with greater and lesser reliability and validity. The person who is interpreting these labs should be very familiar with the methodology and the reliability. There is little research on the optimal frequency of testing. The recommendations given below are based on the consensus opinion of the Guideline Committee. The frequency of drug testing will be determined by a number of factors, including the stability of the patient, the type of treatment, the treatment setting, and the half-life of drugs in the matrix being tested. Patients will likely require more testing early in treatment or during periods of relapse. Patients participating in office-based treatment with buprenorphine may be tested at each office visit. Patients participating in treatment for opioid use disorder at Opioid Treatment Programs (OTPs) are mandated by the Federal law[39] to receive a minimum of eight drug tests per year, but may be tested more frequently based on clinical need. More detailed information on drug testing is contained in "*Drug Testing – A White Paper of the American Society of Addiction Medicine.*"[40]

Opioids are detectable in the urine for 1–3 days after use. A negative urine test combined with no history of withdrawal may indicate a lack of physical dependence. However, a negative urine test does not rule out opioid use, disorder, or physical dependence. Urine testing is also helpful to identify use of other psychoactive substances.

Summary of Recommendations

Assessment Recommendations

(1) First clinical priority should be given to identifying and making appropriate referral for any urgent or emergent medical or psychiatric problem(s), including drug-related impairment or overdose.
(2) Completion of the patient's medical history should include screening for concomitant medical conditions including infectious diseases (hepatitis, HIV, and TB), acute trauma, and pregnancy.
(3) A physical examination should be completed as a component of the comprehensive assessment process. The prescriber (the clinician authorizing the use of a medication for the treatment of opioid use disorder) may conduct this physical examination him/herself, or, in accordance with the ASAM Standards, ensure that a current physical examination is contained within the patient medical record before a patient is started on a new medication for the treatment of his/her addiction.
(4) Initial laboratory testing should include a complete blood count, liver function tests, and tests for hepatitis C and HIV. Testing for TB and sexually transmitted infections should also be considered. Hepatitis B vaccination should be offered, if appropriate.
(5) The assessment of women presents special considerations regarding their reproductive health. Women of childbearing age should be tested for pregnancy, and all women of childbearing potential and age should be queried regarding methods of contraception, given the increase in fertility that results from effective opioid use disorder treatment.
(6) Patients being evaluated for addiction involving opioid use, and/or for possible medication use in the treatment of opioid use disorder, should undergo (or have completed) an assessment of mental health status and possible psychiatric disorders (as outlined in the ASAM Standards).
(7) Opioid use is often co-occurring with other substance-related disorders. An evaluation of past and current substance use and a determination of the totality of substances that surround the addiction should be conducted.
(8) The use of marijuana, stimulants, or other addictive drugs should not be a reason to suspend opioid use disorder treatment. However, evidence demonstrates that patients who are actively using substances during opioid use disorder treatment have a poorer prognosis. The use of benzodiazepines and other sedative hypnotics may be a reason to suspend agonist treatment because of safety concerns related to respiratory depression.
(9) A tobacco use query and counseling on cessation of tobacco products and electronic nicotine delivery devices should be completed routinely for all patients, including those who present for evaluation and treatment of opioid use disorder.
(10) An assessment of social and environmental factors should be conducted (as outlined in the ASAM Standards to identify facilitators and barriers to addiction treatment, and specifically to pharmacotherapy). Before a decision is made to initiate a course of pharmacotherapy for the patient with opioid use disorder, the patient should receive a multidimensional assessment in fidelity with the ASAM Criteria. Addiction should be considered a bio-psycho-social-spiritual illness, for which the use of medication(s) is but only one component of overall treatment.

Diagnosis Recommendations

(1) Other clinicians may diagnose opioid use disorder, but confirmation of the diagnosis by the provider with prescribing authority and who recommends medication use must be obtained before pharmacotherapy for opioid use disorder commences.
(2) Opioid use disorder is primarily diagnosed on the basis of the history provided by the patient and a comprehensive assessment that includes a physical examination.
(3) Validated clinical scales that measure withdrawal symptoms, for example, the OOWS, SOWS, and the COWS, may be used to assist in the evaluation of patients with opioid use disorder.
(4) Urine drug testing during the comprehensive assessment process, and frequently during treatment, is recommended. The frequency of drug testing is determined by a number of factors, including the stability of the patient, the type of treatment, and the treatment setting.

Areas for Further Research

(1) More research is needed on best practices for drug testing during the initial evaluation and throughout the entire treatment process.
(2) Further research is needed on evidence-based approaches for treating opioid use disorder in patients who continue to use marijuana and/or other psychoactive substances.
(3) Whereas research indicates that offering tobacco cessation is a standard for all medical care, more research is needed before specific evidence-based recommendations can be made.

PART 2: TREATMENT OPTIONS

Introduction

Once the diagnosis of opioid use disorder has been established, and it has been determined that the patient is medically and psychiatrically stable, the next task is to decide on a course of treatment. Potential treatments include withdrawal management in conjunction with psychosocial treatment, or psychosocial treatment combined with one of three medications: methadone, buprenorphine, or naltrexone (oral or extended-release injectable formulations). Withdrawal management alone can be the first step, but is not a primary treatment for opioid use disorder and should ''only'' be considered as a part of a comprehensive and longitudinal plan of care that includes psychosocial treatment, with or without medication-assisted therapy.

The choice among available treatment options should be a shared decision between the clinician and the patient. There are a number of factors to consider in deciding what treatment to choose. Among the first considerations are the priorities of the patient, for instance: *Is the patient open to pharmacotherapy? What type of treatment setting does the patient prefer? Does the patient understand the physical dependence aspects of treatment medication?* A patient's past experiences with treatment for opioid use disorder should be considered as well. Of course, above all, evidence supporting the potential efficacy and safety of the various treatments is critically important.

For most patients with opioid use disorder, the use of medications (combined with psychosocial treatment) is superior to withdrawal management (combined with psychosocial treatment), followed finally by psychosocial treatment on its own. This is true for both agonist and partial agonist, and antagonist medications. Evidence suggests that methadone maintenance treatment is superior to withdrawal management alone and significantly reduces opioid drug use.[41] Further, mortality is lower in patients on methadone, as compared to those not undergoing treatment.[6] Methadone also lowers the risk of acquiring or spreading HIV infection.[42,43] In clinical studies, evidence favors buprenorphine, compared to no treatment, in decreasing heroin use and improving treatment retention.[33,44] Finally, evidence supports the efficacy of both oral naltrexone and extended-release injectable naltrexone versus placebo for the treatment of opioid use disorder.[45–47]

Pharmacotherapy Options

The medications covered in this guideline are mainly those that have been approved by the US FDA for the treatment of opioid dependence as defined in prior versions of the DSM-III and DSM-IV, and ''not necessarily'' the definition contained in the current version of the manual, the DSM-5. DSM-5 combined ''opioid abuse'' and ''opioid dependence'' criteria from prior versions of the DSM and included them in the new definition of ''opioid use disorder.'' As a result, pharmacologic treatment may not be appropriate for all patients along the entire opioid use disorder continuum. In a study comparing opioid dependence from DSM-IV and opioid use disorder from DSM-5, optimal concordance occurred when four or more DSM-5 criteria were endorsed (ie, the DSM-5 threshold for moderate opioid use disorder).[8]

The medications discussed in this *Practice Guideline* all have ample evidence supporting their safety and efficacy. It is recognized that other medications have been used off-label to treat opioid use disorder, but with some exceptions (clearly noted in the text) the Guideline Committee has not issued recommendations on the use of these medications. Cost-efficacy was not a consideration in the development of this *Practice Guideline*.

Each medication will be discussed in detail in subsequent sections:

(1) Methadone (mu-agonist) for opioid use disorder treatment and withdrawal management (part 4).
(2) Buprenorphine (partial mu-agonist) for opioid use disorder treatment and withdrawal management (part 5).
(3) Naltrexone (antagonist) for relapse prevention (part 6).
(4) Naloxone (antagonist) to treat overdose (part 13).

The only medication that is ''not'' US FDA-approved for the treatment of opioid use disorder that will be covered in this *Practice Guideline* is the use of the alpha-2 adrenergic agonist, clonidine, for the treatment of opioid withdrawal (see ''Part 3: Treating Opioid Withdrawal'').

Key outcomes in evaluating the efficacy of the various pharmacotherapies include: decreased mortality,

abstinence from opioids, and retention in treatment. In regards to these key outcomes, there is some evidence supporting the relative efficacy of one medication over another, but in many cases, there are no good-quality studies comparing the relative benefits of one medication over another. As noted above, there is strong evidence supporting the superiority of methadone over drug-free treatment for reducing mortality, reducing opioid use, and promoting treatment retention.[48]

Efficacy Considerations

Treatment Setting

In accordance with US Federal laws and regulations derived from the Harrison Act and Congressional exceptions to that 1914 law, the venue in which treatment for opioid use disorder is provided is as important a consideration as is the specific medication selected (methadone vs. buprenorphine vs. naltrexone).[49] Federal and state-licensed OTPs offer daily supervised dosing of methadone. OTPs are state and federally regulated to dispense opioid agonist treatment. An increasing number of such highly regulated programs also offer the option of daily supervised dosing of buprenorphine.

In accordance with Federal law 21 CFR §1306.07, office-based opioid treatment (OBOT), which provides authorization of medication via regular outpatient prescriptions filled in a retail pharmacy like any other prescription medication, is available for buprenorphine, but not for methadone. Physicians in private practices, or various other types of private and public sector clinics, can be authorized to prescribe outpatient supplies of the partial opioid agonist buprenorphine. This flexibility to provide OBOT is discussed more in ''Part 5: Buprenorphine.'' There are no regulations regarding facilities themselves, but rather of the individual physician who prescribes buprenorphine (see ''Part 5: Buprenorphine'' for physician qualifications associated with OBOT).

Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe any medication. It is not listed among federal or state-controlled substances schedules, and there are no regulations of facilities or prescribers for the use of naltrexone in the treatment of opioid use disorder (such that there are for OTP and OBOT).

It is recommended that the clinician consider a patient's psychosocial situation, co-occurring disorders, and opportunities for treatment retention versus risks of diversion when determining whether OTP or OBOT is most appropriate.

Pharmacology

Differences in efficacy may also arise from differences in pharmacology; whereas methadone is a full agonist at the mu-opioid receptor and produces higher levels of physiological dependence; buprenorphine is a partial agonist with less physiological dependence. There are few studies comparing the relative efficacy of methadone versus buprenorphine in reducing opioid use. Likewise, evidence supports the efficacy of naltrexone for relapse prevention compared to a placebo control.[45,50] There is an absence of studies that compare treatment using either oral naltrexone or extended-release injectable naltrexone versus agonist treatment with either methadone or buprenorphine.

Contraindications and Precautions

The following section describes the major indications, contraindications, and precautions for methadone, buprenorphine, and naltrexone. This section is a summary and is not an exhaustive description of medication information. (Refer to Table 3 below for a summary of contraindications and precautions.)

Methadone

Methadone is frequently used to manage withdrawal symptoms from opioids and is recommended for pharmacological treatment of opioid use disorder (see ''Part 4: Methadone'').

Methadone is ''contraindicated'' for the following conditions:

(1) Patients with known hypersensitivity to methadone hydrochloride.
(2) Patients experiencing respiratory depression (in the absence of resuscitative equipment or in unmonitored settings).
(3) Patients with acute bronchial asthma or hypercapnia (also known as hypercarbia).
(4) Patients with known or suspected paralytic ileus.

Methadone should be used with ''caution'' for the following conditions:

(1) Patients with decompensated liver disease (eg, jaundice, ascites) due to increased risk of hepatic encephalopathy.
(2) Patients with respiratory insufficiency.
(3) Patients with concomitant substance use disorders, particularly patients with sedative, hypnotic, or anxiolytic use disorders. Interactions between methadone and hypnotics, sedatives, or anxiolytics may be life-threatening.
(4) Patients with concomitant psychiatric diagnoses that impair their ability to maintain daily attendance at an OTP.
(5) Patients with low levels of physical dependence to opioids should be started with low doses of methadone.

Significant ''medication interactions'' to consider before starting methadone are as follows:

(1) Methadone may prolong the QT interval and should be used in caution with other agents that may also prolong the QT interval. These include class I or class III antiarrhythmic drugs, calcium channel blockers, some antipsychotics, and some antidepressants.
(2) Methadone is metabolized through the cytochrome P450 enzyme pathway. Many agents interact with this pathway including alcohol, anticonvulsants, antiretrovirals, and macrolide antibiotics.

Buprenorphine

Buprenorphine is a partial opioid agonist and mixed opioid agonist–antagonist. It is usually provided in a formulation that includes naloxone. Buprenorphine is recommended

TABLE 3. Contraindications and Precautions for Pharmacotherapy Options

Medication	Contraindications	Warnings and Precautions
Methadone	Hypersensitivity Respiratory depression Severe bronchial asthma or hypercapnia Paralytic ileus	Cardiac conduction effects Diversion and misuse are possible Physical dependence Respiratory depression when used in association with CNS depressants including alcohol, other opioids, and illicit drugs Head injury and increased intracranial pressure Liver disease Respiratory insufficiency Concomitant substance use disorders Co-occurring psychiatric disorders Drug interactions with medications metabolized by cytochrome p450 enzymes principally CYP34A, CYP2B6, CYP2C19, and to a lesser extent by CYP2C9and CYP2D6 Drugs coadministered with methadone should be evaluated for interaction potential
Buprenorphine (all formulations)	Hypersensitivity	Diversion and misuse are possible Physical dependence Respiratory depression when used in association with CNS depressants including alcohol, other opioids, and illicit drugs Precipitated withdrawal if used in patients physically dependent on full agonists opioids before the agonist effects have worn off Neonatal withdrawal has been reported after use of buprenorphine during pregnancy Not recommended for patients with severe hepatic impairment May cause sedation
Naltrexone (oral and injectable formulations)	Hypersensitivity reactions to naltrexone, or for injectable previous hypersensitivity reactions to polylactide-co-glycolide, carboxymethylcellulose, or any other constituent of the diluent Patients currently physically dependent on opioids, including partial agonists Patients receiving opioid analgesics Patients in acute opioid withdrawal	Vulnerability to overdose Injection site reactions associated with injectable naltrexone Precipitated opioid withdrawal Risk of hepatotoxicity Patient should be monitored for the development of depression and suicidality Emergency reversal of opiate blockade may require special monitoring in a critical care setting Eosinophil pneumonia has been reported in association with injectable naltrexone Administer IM injections with caution to patients with thrombocytopenia or a coagulation disorder

IM, intramuscular.

for pharmacological treatment of opioid use disorder (see ''Part 5: Buprenorphine'').

Buprenorphine is also an effective treatment for opioid withdrawal with efficacy similar to methadone, and much superior to clonidine in opioid withdrawal management.[51–53] Although one trial did find that longer courses of buprenorphine with gradual tapering were superior to rapid tapering for withdrawal,[54] there is insufficient evidence on outcomes to make recommendations on buprenorphine taper duration.

Buprenorphine is ''contraindicated'' for the following conditions:

(1) Patients with hypersensitivity to buprenorphine or any component of the formulation.
(2) Patients with severe liver impairment are not good candidates for office-based treatment with buprenorphine. (Patients with hepatitis C infection who do not have severe liver impairment may, however, be considered for buprenorphine.)

Buprenorphine should be used with ''caution'' for the following conditions:

(1) Patients in whom hepatitis has been reported, particularly in patients with previous hepatic dysfunction. A direct comparison of the effects of buprenorphine and methadone, however, showed no evidence of liver damage during the initial 6 months in either treatment groups.[55] Monitoring liver function in patients at increased risk for hepatotoxicity may be considered.
(2) Patients who, at present, have an alcohol use or sedative, hypnotic, or anxiolytic use disorder.
(3) Patients with hypovolemia, severe cardiovascular disease, or taking drugs that may exaggerate hypotensive effects. Buprenorphine may cause hypotension, including orthostatic hypotension and syncope.

Significant ''medication interactions'' to consider before starting buprenorphine include the following:

(1) Alcohol and sedatives, hypnotics, or anxiolytics may enhance the central nervous system depressive effect of buprenorphine.
(2) Buprenorphine is metabolized to nor-buprenorphine primarily by cytochrome CYP3A4; therefore, potential interactions may occur when buprenorphine is given concurrently with agents that affect CYP3A4 activity. The concomitant use of buprenorphine with CYP3A4 inhibitors (eg, azole antifungals such as ketoconazole, macrolide antibiotics such as erythromycin, and HIV protease inhibitors) should be monitored and may require dose reduction of one or both agents.[56–58]

Naltrexone

Naltrexone is recommended for pharmacological treatment of opioid use disorder (see ''Part 6: Naltrexone''). Naltrexone is an opioid antagonist that blocks the effects of opioids. It is a pharmacotherapy option used to treat opioid use disorder and prevent relapse after detoxification. Naltrexone causes immediate withdrawal symptoms (precipitated withdrawal) in a person with active physical dependence on opioids. There are oral and extended-release injectable formulas of naltrexone. Oral naltrexone, if taken daily, is most effective in patients who are highly motivated or legally mandated to receive treatment, and/or when taking the medication is closely supervised. Conversely, the efficacy of oral naltrexone for the treatment of opioid use disorder is often adversely affected by poor medication adherence.[59] Clinicians may want to reserve using oral naltrexone for patients who are able to comply with special techniques to enhance their adherence, for example, observed dosing. An extended-release injectable naltrexone formulation is available, which may overcome the adherence limitations of the oral formulation. This formulation requires a once-monthly injection.

Naltrexone is ''contraindicated'' under the following conditions:

(1) Patients with hypersensitivity reactions to naltrexone.
(2) Patients who have previously exhibited hypersensitivity to naltrexone, polylactide-co-glycolide, carboxymethylcellulose, or any other components of the diluent (for extended-release injectable naltrexone).
(3) Patients with current physical dependence on opioids, including partial agonists.
(4) Patients with current physiologic opioid dependence.
(5) Patients in acute opioid withdrawal.
(6) Any individual who has failed the naloxone challenge test (see ''Glossary'') or has a positive urine screen for opioids.

Naltrexone should be used with ''caution'' under the following conditions:

(1) All patients should be warned of the risk of hepatic injury and advised to seek medical attention if they experience symptoms of acute hepatitis. Hepatic injury is a concern if very high doses are used, for example, 200–300 mg per day. Use of naltrexone should be discontinued in the event of symptoms and/or signs of acute hepatitis. Cases of hepatitis and clinically significant liver dysfunction were observed in association with naltrexone exposure during the clinical development program and in the postmarketing period. Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period.
(2) Patients with liver impairment should complete liver enzyme tests before and during treatment with naltrexone to check for additional liver impairment.
(3) Patients who experience injection site reactions should be monitored for pain, redness, or swelling. Incorrect administration may increase the risk of injection site reactions. Reactions have occurred with extended-release injectable naltrexone.
(4) Patients with co-occurring psychiatric disorders should be monitored for adverse events. Suicidal thoughts, attempted suicide, and depression have been reported.

Significant ''medication interactions'' with naltrexone are as follows:

(1) Naltrexone should not be used with methylnaltrexone or naloxegol.
(2) Naltrexone blocks the effects of opioid analgesics because it is an opioid antagonist.
(3) Glyburide may increase serum concentration of naltrexone. Monitor for increased toxicity effects of naltrexone.

Summary of Recommendations

(1) The choice of available treatment options for addiction involving opioid use should be a shared decision between the clinician and the patient.
(2) Clinicians should consider the patient's preferences, past treatment history, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone in the treatment of addiction involving opioid use. The treatment setting described as level 1 treatment in the ASAM Criteria may be a general outpatient location such as a clinician's practice site. The setting as described as level 2 in the ASAM Criteria may be an intensive outpatient treatment or partial hospitalization program housed in a specialty addiction treatment facility, a community mental health center, or another setting. The ASAM Criteria describes level 3 or level 4 treatment, respectively, as a residential addiction treatment facility or hospital.
(3) The venue in which treatment is provided is as important as the specific medication selected. OTPs offer daily supervised dosing of methadone, and increasingly of buprenorphine. In accordance with Federal law (21 CFR §1306.07), OBOT, which provides medication on a prescribed weekly or monthly basis, is limited to buprenorphine.[9] Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe any medication. Clinicians should consider a patient's psychosocial situation, co-occurring disorders, and risk of diversion when determining whether OTP or OBOT is most appropriate.
(4) OBOT may not be suitable for patients with active alcohol use disorder or sedative, hypnotic, or anxiolytic

use disorder (or who are in the treatment of addiction involving the use of alcohol or other sedative drugs, including benzodiazepines or benzodiazepine receptor agonists). It may also be unsuitable for persons who are regularly using alcohol or other sedatives, but do not have addiction or a specific substance use disorder related to that class of drugs. The prescribing of benzodiazepines or other sedative-hypnotics should be used with extreme caution in patients who are prescribed methadone or buprenorphine for the treatment of an opioid use disorder.

(5) Methadone is recommended for patients who may benefit from daily dosing and supervision in an OTP, or for patients for whom buprenorphine for the treatment of opioid use disorder has been used unsuccessfully in an OTP or OBOT setting.

(6) Oral naltrexone for the treatment of opioid use disorder is often adversely affected by poor medication adherence. Clinicians should reserve its use for patients who would be able to comply with special techniques to enhance their adherence, for example, observed dosing. Extended-release injectable naltrexone reduces, but does not eliminate, issues with medication adherence.

Areas for Further Research

More research is needed to compare the advantages of agonists and antagonists in the treatment of opioid use disorder. Whereas methadone, buprenorphine, and naltrexone are all superior to no treatment in opioid use disorder, less is known about their relative advantages.

PART 3: TREATING OPIOID WITHDRAWAL

Background

Opioid withdrawal syndrome refers to the wide range of symptoms that occur after stopping or dramatically reducing the dose of opioid drugs after heavy and prolonged use. For short-acting opioids such as heroin and oxycodone, symptoms usually emerge within 12 hours of the last opioid use, peak within 24–48 hours, and diminish over 3–5 days. For long-acting opioids such as methadone, withdrawal symptoms generally emerge within 30 hours of the last methadone exposure and may last up to 10 days. Although distressing, opioid withdrawal syndrome is rarely life-threatening. However, abrupt discontinuation of opioids is not recommended because it may precipitate withdrawal, lead to strong cravings, and result in relapse to drug use.

Symptoms of opioid withdrawal may include any of the following:

(1) Muscle aches
(2) Increased tearing
(3) Runny nose
(4) Dilated pupils
(5) Piloerection
(6) Agitation
(7) Anxiety
(8) Insomnia
(9) Sweating
(10) Yawning
(11) Abdominal cramping
(12) Nausea
(13) Vomiting
(14) Diarrhea.

Opioid withdrawal generally results from the cessation or a dramatic reduction in the dose of opioids, which is referred to as spontaneous withdrawal. Opioid withdrawal can also be precipitated when a patient who is physically dependent on opioids is administered an opioid antagonist such as naloxone or naltrexone, or an opioid partial agonist such as buprenorphine. Signs and symptoms of precipitated withdrawal are similar to those of spontaneous withdrawal, but the time course is different and symptoms may be much more severe. Review of postmarketing cases of precipitated opioid withdrawal in association with treatment with naltrexone has identified cases with symptoms of withdrawal severe enough to require hospital admission, and in some cases, management in the intensive care unit.[60,61]

The timing of maximal precipitated withdrawal usually occurs in the following scenarios:

(1) Within 1 minute for intravenously administered naloxone.
(2) Several minutes after IM naloxone.
(3) Up to 90 minutes after sublingual buprenorphine.
(4) Up to several hours after extended-release injectable naltrexone.[62]

The duration of the withdrawal depends on the half-life and dose of the partial agonist or antagonist. Naloxone-precipitated withdrawal typically lasts for 30–60 minutes, whereas buprenorphine or naltrexone-precipitated withdrawal may last for several days. The ability to accurately assess patients for opioid withdrawal is important to avoid precipitated withdrawal when introducing antagonists and partial agonists for relapse prevention.

Withdrawal management can make withdrawal from opioids more comfortable. Given the high rate of relapse, opioid withdrawal management is not considered an effective treatment of opioid use disorder on its own.[63] If withdrawal management alone, or withdrawal management followed by psychosocial treatment alone is proposed, the patient should be informed of the estimated risks of subsequent relapse, including the increased risk for death, as compared to treatment with opioid agonists. Withdrawal management is not necessary or recommended for patients being referred for treatment with methadone or buprenorphine.

Assessment of Patient for Opioid Withdrawal

Assessment of a patient undergoing opioid withdrawal should include a thorough medical history and physical examination focusing on signs and symptoms associated with opioid withdrawal. There are various scales available to assess opioid withdrawal. Objective signs, when present, are more reliable, but subjective withdrawal features can also be sensitive measures of opioid withdrawal. These scales may be

used to measure opioid withdrawal symptoms during the initial assessment to make the diagnosis of opioid withdrawal. In addition, clinicians can assess the effectiveness of withdrawal management by repeating these scales intermittently as they treat withdrawal symptoms.

Objective Opioid Withdrawal Scale (OOWS) is an objective measure in which the clinician checks for 13 signs of opioid withdrawal (eg, yawning, perspiration).[38]

Clinical Opioid Withdrawal Scale (COWS) is a clinical assessment for 11 medical signs and symptoms of opioid withdrawal (eg, gastrointestinal distress).[64]

Subjective Opioid Withdrawal Scale (SOWS) is a measure of 16 subjective symptoms of withdrawal, in which the patient rates their experience on a 5-point scale (eg, ''I feel restless'').[38]

Opioid withdrawal management may occur in either inpatient or outpatient settings. There is a lack of evidence to determine the relative safety of inpatient versus outpatient withdrawal management. Inpatient withdrawal management has higher rates of completion compared to outpatient withdrawal management; however, there is no demonstrable difference in relapse among inpatient versus outpatient withdrawal management.[65]

Medications in Opioid Withdrawal

For the management of opioid withdrawal, two main strategies have evolved. The first involves the provision of gradually tapering doses of opioid agonists, typically methadone or buprenorphine. The other strategy is the use of alpha-2 adrenergic agonists (clonidine) along with other non-narcotic medications to reduce withdrawal symptoms. Both strategies have advantages and disadvantages. Using tapering doses of opioid agonists has been shown to be superior to clonidine in terms of retention and opioid abstinence. However, the use of nonopioid medications may be the only option available to clinicians in some healthcare settings and may also facilitate the transition of patients to opioid antagonist medications and help prevent subsequent relapse. Recently, researchers have begun to investigate the use of combinations of buprenorphine and low doses of oral naltrexone to rapidly detoxify patients and facilitate the accelerated introduction of extended-release injectable naltrexone.[19] Although these techniques seem promising, more research will be needed before these can be accepted as standard practice.

Withdrawal Management with Opioid Agonists

Methadone and buprenorphine are both recommended in the management of opioid withdrawal and have comparable results in terms of retention and opioid abstinence. Withdrawal management with methadone must be done in an OTP or inpatient setting. Methadone tapers generally start with doses in the range of 20–30 mg per day, and are completed in 6–10 days.

Buprenorphine withdrawal management can be done either in an outpatient or an inpatient setting. None of the available forms of buprenorphine, including the buprenorphine monoproducts (Suboxone, Zubsolv, and Bunavail), are specifically US FDA-approved for withdrawal management, but may be used for this purpose. None of the products have shown superiority over another for this purpose. In the remainder of this section, the term buprenorphine refers to the monotherapy and combination formulations.

Buprenorphine is a partial mu-opioid receptor antagonist with a higher affinity for the mu-receptor than most full agonists such as heroin and oxycodone. Therefore, it is important that buprenorphine should not be started until a patient is exhibiting opioid withdrawal to avoid precipitated withdrawal. Usually buprenorphine is not started until 12–18 hours after the last dose of a short-acting agonist such as heroin or oxycodone, and 24–48 hours after the last dose of a long-acting agonist such as methadone. A dose sufficient to suppress withdrawal symptoms is achieved (4–16 mg per day) and then the dose is tapered. The duration of the taper can be as brief as 3–5 days or as long as 30 days or more.

Studies examining the relative efficacy of long versus short-duration tapers are not conclusive, and the Guideline Committee was unable to reach a consensus on this issue. Physicians should be guided by patient response in determining the optimum duration of the taper.

Withdrawal Management with Alpha-2 Adrenergic Agonists

Because opioid withdrawal results largely from overactivity of the brain's noradrenergic system, alpha-2 adrenergic agonists (clonidine, lofexidine) have a long history of off-label use for the treatment of opioid withdrawal in the United States. Lofexidine is approved for the treatment of opioid withdrawal in the United Kingdom. Clonidine is generally used at doses of 0.1–0.3 mg every 6–8 hours, with a maximum dose of 1.2 mg daily. Its hypotensive effects often limit the amount that can be used. Clonidine is often combined with other non-narcotic medications targeting specific opioid withdrawal symptoms such as benzodiazepines for anxiety, loperamide or bismuth-salycilate for diarrhea, acetaminophen or nonsteroidal anti-inflammatory medications (NSAIDs) for pain, various medications for insomnia, and ondansetron for nausea. Other agents in the same pharmacological family as clonidine, such as guanfacine (available in the United States) and lofexidine (available in many other countries) can be used off-label as safe and effective agents in the management of opioid withdrawal.

Anesthesia-Assisted Withdrawal Management

Anesthesia-assisted opioid detoxification or ultra-rapid opioid detoxification (UROD) uses large doses of naloxone to precipitate acute opioid withdrawal in the patient who is under general anesthesia. Patients are anesthetized, then intubated and mechanically ventilated. A diuretic is used to enhance excretion of the opioid. Patients experience mild withdrawal symptoms for about 6 days after awakening from anesthesia, compared with similar withdrawal symptoms on a 20-day methadone taper.[66,67]

The ASAM recommends against the use of UROD in the treatment of opioid withdrawal and stated these same recommendations in a policy statement.[68] ASAM's position is in accordance with other guidelines. Serious complications including cardiac arrest and death have been reported with anesthesia-assisted withdrawal management.[69] The Centers for

Disease Control issued a warning in 2013 about severe adverse events including death from anesthesia-assisted withdrawal management.[70] Furthermore, a systematic review of five randomized trials concluded that the lack of benefit, potential serious harms, and costs of heavy sedation or anesthesia do not support its use.[71]

Summary of Recommendations

(1) Using medications for opioid withdrawal management is recommended over abrupt cessation of opioids. Abrupt cessation of opioids may lead to strong cravings, which can lead to continued use.
(2) Patients should be advised about risk of relapse and other safety concerns from using opioid withdrawal management as standalone treatment for opioid use disorder. Opioid withdrawal management on its own is not a treatment method.
(3) Assessment of a patient undergoing opioid withdrawal management should include a thorough medical history and physical examination focusing on signs and symptoms associated with opioid withdrawal.
(4) Opioid withdrawal management in cases in which methadone is used to manage withdrawal symptoms must be done in an inpatient setting or in an OTP. For short-acting opioids, tapering schedules that decrease in daily doses of prescribed methadone should begin with doses between 20 and 30 mg per day, and should be completed in 6–10 days.
(5) Opioid withdrawal management in cases in which buprenorphine is used to manage withdrawal symptoms should not be initiated until 12–18 hours after the last dose of a short-acting agonist such as heroin or oxycodone, and 24–48 hours after the last dose of a long-acting agonist such as methadone. A dose of buprenorphine sufficient to suppress withdrawal symptoms is given (this can be 4–16 mg per day) and then the dose is tapered. The duration of the tapering schedule can be as brief as 3–5 days or as long as 30 days or more.
(6) The use of combinations of buprenorphine and low doses of oral naltrexone to manage withdrawal and facilitate the accelerated introduction of extended-release injectable naltrexone has shown promise. More research will be needed before this can be accepted as standard practice.
(7) The Guideline Committee recommends, based on consensus opinion, the inclusion of clonidine as a recommended practice to support opioid withdrawal. Clonidine is not US FDA-approved for the treatment of opioid withdrawal, but it has been extensively used off-label for this purpose. Clonidine may be used orally or transdermally at doses of 0.1–0.3 mg every 6–8 hours, with a maximum dose of 1.2 mg daily to assist in the management of opioid withdrawal symptoms. Its hypotensive effects often limit the amount that can be used. Clonidine can be combined with other non-narcotic medications targeting specific opioid withdrawal symptoms such as benzodiazepines for anxiety, loperamide for diarrhea, acetaminophen or NSAIDs for pain, and ondansetron or other agents for nausea.
(8) Opioid withdrawal management using anesthesia UROD is not recommended due to high risk for adverse events or death. Naltrexone-facilitated opioid withdrawal management can be a safe and effective approach, but should be used only by clinicians experienced with this clinical method and in cases in which anesthesia or conscious sedation are not being employed.

Areas for Further Research

(1) Further research is needed to evaluate the efficacy and safety of alpha-2 adrenergic and other nonopioid medications that are being used off-label for withdrawal management. These nonopioid medications may have use in transitioning patients onto antagonists for relapse prevention.
(2) Further study is needed on other methods to accelerate the withdrawal process and facilitate the introduction of antagonists.
(3) More research is needed to make recommendations on the optimal duration of a buprenorphine taper.
(4) More research is needed to evaluate the safety of inpatient as compared to outpatient withdrawal management.
(5) More research is needed to compare the effectiveness of short versus long tapers with buprenorphine withdrawal management.

PART 4: METHADONE

Background

Methadone (Dolophine or Methadose) is a slow-acting opioid agonist. Methadone is an effective treatment for opioid withdrawal management and the treatment of opioid use disorder. Methadone is taken orally so that it reaches the brain slowly, dampening the euphoria that occurs with other routes of administration while preventing withdrawal symptoms. Methadone has been used since the 1960s to treat heroin addiction and remains an effective treatment option. Many studies have demonstrated its superiority to using abstinence-based approaches.[41] Methadone is only available through approved OTPs, where it is dispensed to patients on a daily or almost daily basis in the initial stages of treatment. Federal and State laws allow take-home doses for patients who have demonstrated treatment progress and are judged to be at low risk for diversion.

Patient Selection and Treatment Goals

Treatment with methadone at an OTP is recommended for patients who have opioid use disorder, are able to give informed consent, and have no specific contraindications for agonist treatment. Treatment with methadone has the following four goals:

(1) To suppress opioid withdrawal.
(2) To block the effects of illicit opioids.
(3) To reduce opioid craving and stop or reduce the use of illicit opioids.
(4) To promote and facilitate patient engagement in recovery-oriented activities including psychosocial intervention.

Precautions

Arrhythmias

Patients should be informed of the potential risk of arrhythmia when they are dispensed methadone. It is

recommended to get a history of structural heart disease, arrhythmia, or syncope. In addition, the clinician should assess the patient for other risk factors for QT-interval prolongation. An electrocardiogram (ECG) should be considered when high doses of methadone (over 120 mg per day) are being employed, there is a history of prolonged QT interval, or the patient is taking medications known to prolong the QT. However, there is no research on the use of ECG data for improving patient outcomes.

Course of Treatment

Induction

Initial dosing depends on the level of physical dependence. Consequently, induction varies widely. In a recent publication prepared by ASAM's Methadone Action Group, the recommended initial dose ranges from 10 to 30 mg, with reassessment in 2–4 hours when peak levels have been reached.[72]

Given the risk of overdose in the first 2 weeks, tolerance is an important safety consideration. Federal law mandates that the initial dose cannot exceed 30 mg and not exceed 40 mg in 1 day.[39]

Dosing

Methadone has a long half-life and care must be taken to avoid too rapid dose increases during the first 1–3 weeks of treatment so as to avoid increasing the dose before the full effect of the last dose has been realized. Dosing should be based on patients achieving goals of treatment, can vary widely between patients, and doses do not correlate well with blood levels. Trough and peak plasma levels of methadone (or methadone blood levels) may be used in addition to clinical evaluation to assess the safety and adequacy of a patient's dose, particularly in patients who seem to be rapid metabolizers and may need a split dose.[15,73–76] A relatively low dose of methadone (eg, <30 mg per day) can lessen acute opioid withdrawal, but is often not effective in suppressing craving and blocking the effects of other opioids. Most patients fare better on methadone doses between 60 and 120 mg per day, which typically creates sufficient tolerance to minimize a euphoric response if patients self-administer additional opioids.

A relatively low dose of methadone (eg, <30 mg per day) can lessen acute withdrawal, but is often not effective in suppressing craving and blocking the effects of other opioids. Though a few patients respond to a maintenance dose of 30–60 mg per day, most patients fare better if their initial 30–40 mg per day dose is gradually raised to a maintenance level of 60–120 mg per day, which typically creates sufficient tolerance to minimize a euphoric response if patients self-administer additional opioids. Multiple randomized trials have found that patients have better outcomes, including retention in treatment, with higher doses (80–100 mg per day) than lower doses.[77,78] Though not well studied, doses above 120 mg per day are being used with some patients as blockade of opioid effects is becoming increasingly more difficult due to the increased purity of heroin and strength of prescription opioids.[72]

Adverse Effects

Higher methadone doses may be associated with increased risk of adverse effects, including prolongation of the QT interval and other arrhythmias (torsades des pointes), which in some cases have been fatal.[79] The US FDA issued a safety alert for methadone regarding these cardiac events.[80] Clinicians, in consultation with patients, may need to consider the relative risk of adverse events due to QT prolongation with methadone as compared to the risk of morbidity and mortality of an untreated opioid use disorder.[81] Changing to buprenorphine or naltrexone maintenance should be considered when risks of QT prolongation are high as they do not seem to significantly prolong the QT.

Psychosocial Treatment

Because opioid use disorder is a chronic relapsing disease, strategies specifically directed at relapse prevention are an important part of comprehensive outpatient treatment and should include drug counseling and/or other psychosocial treatments. However, there may be instances when pharmacotherapy alone results in an excellent outcome.

Family involvement in treatment provides strong support for patient recovery; and family members also benefit. The concept of "family" should be expanded to include members of the patient's social network (as defined by the patient), including significant others, clergy, employers, and case managers.

Monitoring Treatment

Federal and state-approved OTPs dispense methadone and supervise administration. Treatment should include relapse monitoring with frequent testing for alcohol and other relevant psychoactive substances. Testing for methadone and buprenorphine is recommended to ensure adherence and detect possible diversion.

Length of Treatment

The optimal duration of treatment with methadone has not been established; however, it is known that relapse rates are high for most patients who drop out; thus long-term treatment is often needed. Treatment duration depends on the response of the individual patient and is best determined by collaborative decisions between the clinician and the patient. Treatment should be reinstituted immediately for most patients who were previously taking methadone and have relapsed or are at risk for relapse.

Switching Treatment Medications

Switching from methadone to other opioid treatment medications may be appropriate in the following cases:

(1) Patient experiences intolerable methadone side effects.
(2) Patient has not experienced a successful course of treatment on methadone.
(3) Patient wants to change and is a candidate for the alternative treatment.

Transfer of medications should be planned, considered, and monitored. Particular care should be taken in reducing

methadone dosing before transfer to avoid precipitating a relapse. If the patient becomes unstable and appears at risk for relapse during the transfer of medications, reinstating methadone may be the best option.

Switching to Buprenorphine

Patients on low doses of methadone (30–40 mg per day or less) generally tolerate the transition to buprenorphine with minimal discomfort; whereas patients on higher doses of methadone may find that switching causes significant discomfort. Patients should be closely monitored during such a switch because there is a risk that stable methadone patients may become unstable when changing to buprenorphine.

To minimize the risk of precipitated withdrawal, it is recommended that physicians use careful initial dosing followed by rapid titration up to an appropriate maintenance dose. Because of concern that sublingually-absorbed naloxone could increase the risk of precipitated withdrawal, treatment initiation with buprenorphine monoproduct is recommended for patients transitioning from methadone and any other long-acting opioid. Patients should be experiencing mild to moderate opioid withdrawal before the switch. This would typically occur at least 24 hours after the last dose of methadone, and indicates that sufficient time has elapsed for there to be minimal risk that the first dose of buprenorphine will precipitate significant withdrawal. Moderate withdrawal would equate to a score greater than 12 on the COWS.[64]

An initial dose of 2–4 mg of buprenorphine should be given and the patient should be observed for 1 hour. If withdrawal symptoms improve, the patient can be dispensed two additional 2–4-mg doses to be taken as needed. The prescribing doctor should contact the patient later in the day to assess the response to dosing. The likelihood of precipitating withdrawal on commencing buprenorphine is reduced as the time interval between the last methadone dose and the first buprenorphine dose increases.

Switching to Naltrexone

Patients switching from methadone to oral naltrexone or extended-release injectable naltrexone need to be completely withdrawn from methadone and other opioids before they can receive naltrexone. This may take up to 14 days, but can typically be achieved in 7 days.[82] A naloxone challenge (administration of 0.4–0.8 mg naloxone and observation for precipitated withdrawal) may be useful before initiating treatment with naltrexone to document the absence of physiological dependence and to minimize the risk for precipitated withdrawal (see ''Glossary'' for more on naloxone challenge).

Summary of Recommendations

(1) Methadone is a treatment option recommended for patients who are physiologically dependent on opioids, able to give informed consent, and who have no specific contraindications for agonist treatment when it is prescribed in the context of an appropriate plan that includes psychosocial intervention.
(2) The recommended initial dose ranges for methadone are from 10 to 30 mg, with reassessment in 3–4 hours and a second dose not to exceed 10 mg on the first day if withdrawal symptoms are persisting.
(3) The usual daily dosage of methadone ranges from 60 to 120 mg. Some patients may respond to lower doses and some may need higher doses. Dosage increases in 5–10-mg increments applied no more frequently than every 7 days (depending on clinical response) are necessary to avoid oversedation, toxicity, or even iatrogenic overdose deaths.
(4) The administration of methadone should be monitored because unsupervised administration can lead to misuse and diversion. OTP regulations require monitored medication administration until the patient's clinical response and behavior demonstrate that the prescribing of nonmonitored doses is appropriate.
(5) Psychosocial treatment, though sometimes minimally needed, should be implemented in conjunction with the use of methadone in the treatment of opioid use disorder.
(6) Methadone should be reinstituted immediately if relapse occurs, or when an assessment determines that the risk of relapse is high for patients who previously received methadone in the treatment of opioid use disorder, but who are no longer prescribed such treatment.
(7) Strategies directed at relapse prevention are an important part of comprehensive addiction treatment and should be included in any plan of care for a patient receiving active opioid treatment or ongoing monitoring of the status of their addictive disease.
(8) Switching from methadone to another medication for the treatment of opioid use disorder may be appropriate if the patient experiences intolerable side effects or is not successful in attaining or maintaining treatment goals through the use of methadone.
(9) Patients switching from methadone to buprenorphine in the treatment of opioid use disorder should be on low doses of methadone before switching medications. Patients on low doses of methadone (30–40 mg per day or less) generally tolerate transition to buprenorphine with minimal discomfort, whereas patients on higher doses of methadone may experience significant discomfort in switching medications.
(10) Patients switching from methadone to oral naltrexone or extended-release injectable naltrexone must be completely withdrawn from methadone and other opioids, before they can receive naltrexone. The only exception would apply when an experienced clinician receives consent from the patient to embark on a plan of naltrexone-facilitated opioid withdrawal management.
(11) Patients who discontinue agonist therapy with methadone or buprenorphine and then resume opioid use should be made aware of the risks associated with opioid overdose, and especially the increased risk of death.

Areas for Further Research

(1) Further research is needed to assess the effectiveness of added psychosocial treatment to treatment with methadone in OTP or inpatient settings. Treatment with methadone generally includes some psychosocial components.

However, it is unclear whether added psychosocial treatment improves patient outcomes.
(2) Research is needed to evaluate the use of ECG in treatment with methadone in preventing adverse events.

PART 5: BUPRENORPHINE

Background

Buprenorphine is recommended for the treatment of opioid use disorder. Buprenorphine relieves drug cravings without producing the euphoria or dangerous side effects of other opioids. In addition to its pharmacological properties, an important feature of buprenorphine is its ability to be prescribed in office-based treatment settings. The US FDA approved buprenorphine in 2002, making it the first medication eligible to be prescribed by certified physicians through the Drug Addiction Treatment Act of 2000 (DATA 2000). Through DATA 2000, physicians may apply for waivers to prescribe certain narcotic schedule III, IV, or V medications, including buprenorphine, from their office settings. This provision of the act expands accessibility of community-based treatment options and mitigates the need to receive treatment through more specialized, and often less available, OTPs. However, buprenorphine may also be administered in an OTP setting with structure and administration requirements identical to those for methadone.

Formulations of Buprenorphine

For this *Practice Guideline*, recommendations using the term ''buprenorphine'' will refer generally to both the buprenorphine only and the combination buprenorphine/naloxone formulations. When recommendations differ by product, the type of product will be described. The monoproduct (generic name buprenorphine) will be referred to as ''buprenorphine monoproduct.'' The combination product will be referred to as ''combination buprenorphine/naloxone.''

This *Practice Guideline* recommends using combination buprenorphine/naloxone for withdrawal management and treatment of opioid use disorder, with the exception of treatment for pregnant women. (Buprenorphine monoproduct is recommended for pregnant women, because naloxone in the combination product is not recommended for use by pregnant women.) (See ''Part 8: Special Populations: Pregnant Women.'')

Combination buprenorphine contains naloxone (an opioid antagonist), which is included to discourage intravenous misuse of buprenorphine. If a patient who is physically dependent on a full agonist opioid injects buprenorphine/naloxone, the naloxone will induce withdrawal symptoms. These withdrawal symptoms are averted when buprenorphine/naloxone is taken sublingually as prescribed.

A combination product of buprenorphine and naloxone (Suboxone, Zubsolv, Bunavail) is taken sublingually or in a buccal film. The US FDA-approved generic forms of buprenorphine/naloxone sublingual tablets and buprenorphine monoproduct provide a broader array of treatment options.

The ratio of buprenorphine to naloxone in Suboxone is 4 : 1, and a variety of dose sizes are available (eg, 2/0.5, 4/1, 8/2). Other formulations of buprenorphine/naloxone (Zubsolv, Bunavail) have different bioavailability and have different buprenorphine/naloxone dose strengths. The approved doses of Zubsolv and Bunavail are bioequivalent to the doses of Suboxone discussed in this guideline. Bioequivalence information and charts are contained in Appendix II.

All information provided in this section is based on dosages for the generic equivalents of buprenorphine/naloxone sublingual tablets and buprenorphine sublingual tablets. Because of the possibility of slight differences in bioavailability between the different formulations of buprenorphine, patients switching from one form of buprenorphine to another should be monitored for adverse effects.

Patient Selection and Treatment Goals

Buprenorphine is an effective treatment recommended for patients who have opioid use disorder, are able to give informed consent, and have no specific contraindications for agonist treatment. Treatment with buprenorphine has the following four goals:

(1) To suppress opioid withdrawal.
(2) To block the effects of illicit opioids.
(3) To reduce opioid craving and stop or reduce the use of illicit opioid.
(4) To promote and facilitate patient engagement in recovery-oriented activities including psychosocial intervention.

There is ample evidence for the efficacy of buprenorphine for the treatment of opioid use disorder.[83] The risk of lethal overdose in an opioid-tolerant individual on buprenorphine is substantially less than that associated with the use of other opioid medications such as methadone. This is due to the ceiling effects of buprenorphine across a wide range of doses. Consequently, buprenorphine has been approved for OBOT.

Precautions

Alcohol or Sedative, Hypnotic, or Anxiolytic Use

Some studies have shown potential adverse interactions between buprenorphine and sedatives. Therefore, patients with opioid use disorder and concurrent alcohol, sedative, hypnotic, or anxiolytic use disorders should receive more intensive monitoring during office-based treatment with buprenorphine to minimize the risk of adverse events. Alternatively, patients with these co-occurring disorders may be better treated in a setting with greater supervision such as an OTP.

Course of Treatment

The DATA 2000[9] allows physicians who are trained or experienced in opioid addiction treatment to obtain waivers to prescribe certain schedule III, IV, or V narcotic drugs in the Controlled Substances Act, for the treatment of opioid dependence in their office practices or in a clinic setting. Both buprenorphine monoproduct and combination buprenorphine/naloxone are approved by the US FDA for the treatment of opioid dependence and can be used in settings outside of an OTP. Physicians who wish to prescribe buprenorphine monoproduct or combination buprenorphine/naloxone for the treatment of opioid use disorder or withdrawal management must qualify for a waiver under DATA 2000. Physicians with

approved DATA 2000 waivers are not confined to the office-based setting. Physicians with DATA 2000 waivers may treat opioid addiction with approved buprenorphine products in any outpatient practice settings in which they are otherwise credentialed to practice and in which such treatment would be medically appropriate. This flexibility for place of services is referred to as OBOT. Physicians who qualify for DATA 2000[9] waivers are initially limited in the number of patients they can treat, but after 1 year may apply for a waiver to treat more (see ''Exhibit 4: Physician Qualifications for OBOT'').

Exhibit 4: Physician Qualifications for OBOT

To qualify for a DATA 2000 waiver, a physician must hold a current, valid state medical license and a drug enforcement agency (DEA) registration number.

In addition, the physician must meet at least one of the following criteria outlined by the US Department of Health and Human Services, Substance Abuse, and Mental Health Services Administration:

(1) The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.
(2) The physician holds an addiction certification from the ASAM. (ASAM certification was taken over by the American Board of Addiction Medicine (ABAM) in 2007.)
(3) The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association.
(4) The physician has, with respect to the treatment and management of opioid-addicted patients, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the ASAM, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.
(5) The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.
(6) The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opioid-addicted patients.
(7) The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opioid-addicted patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

More detailed information can be found at the web site: http://buprenorphine.samhsa.gov/waiver_qualifications.html

Induction

The buprenorphine monoproduct and Suboxone film are the only medications approved by the US FDA for induction. However, other forms of the combination product have been used by clinicians in patients addicted to short-acting opioids without other complications. Because of concern that sublingually-absorbed naloxone could increase the risk of precipitated withdrawal, treatment initiation with buprenorphine monoproduct is recommended for patients transitioning from methadone and any other long-acting opioid, and patients with hepatic impairment.

Buprenorphine has a higher affinity for the mu-opioid receptor compared to most full opioid agonists. Because buprenorphine is a partial mu-agonist, the risk of overdose during buprenorphine induction is low. However, buprenorphine will displace full agonists from the receptor with resultant reduction in opioid effects. Thus, some patients may experience precipitated withdrawal if insufficient time has elapsed since their last dose of opioids.

Patients should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6–12 hours after the last use of heroin or other short-acting opioids, or 24–72 hours after their last use of long-acting opioids such as methadone. The use of the COWS can be helpful in determining if patients are experiencing mild to moderate withdrawal.[64] A COWS score of 11–12 or more (mild to moderate withdrawal) is indicative of sufficient withdrawal to allow a safe and comfortable induction onto buprenorphine.

Induction within the clinician's office is recommended to reduce the risk of precipitated opioid withdrawal. Office-based induction is also recommended if the patient or physician is unfamiliar with buprenorphine. However, buprenorphine induction may be done by patients within their own homes.[84] Home-based induction is recommended only if the patient or prescribing physician is experienced with the use of buprenorphine. The recommendation supporting home induction is based on the consensus opinion of the Guideline Committee.

Dosing

At Induction

The risk of precipitated withdrawal can be reduced by using a lower initial dose of buprenorphine. It is recommended that induction start with a dose of 2–4 mg, and that the patient is observed for signs of precipitated withdrawal. If 60–90 minutes have passed without the onset of withdrawal symptoms, then additional dosing can be done in increments of 2–4 mg. Repeat of the COWS during induction can be useful in assessing the effect of buprenorphine doses. Once it has been established that

the initial dose is well tolerated, the buprenorphine dose can be increased fairly rapidly to a dose that provides stable effects for 24 hours and is clinically effective.

After Induction

On average, buprenorphine doses after induction and titration are usually at least 8 mg per day. However, if patients are continuing to use opioids, consideration should be given to increasing the dose by 4–8 mg (daily dose of 12–16 mg or higher). The US FDA approves dosing to a limit of 24 mg per day, and there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion.

Adverse Effects

Buprenorphine and combinations of buprenorphine and naloxone are generally well tolerated. Side effects reported with these medications include headache, anxiety, constipation, perspiration, fluid retention in lower extremities, urinary hesitancy, and sleep disturbance. Unlike treatment with methadone, QT-interval prolongation does not seem to be an adverse effect associated with treatment with buprenorphine.

Psychosocial Treatment

Psychosocial treatment is recommended for all patients. The types and duration of psychosocial treatment will vary, and the topic is discussed further in ''Part 7: Psychosocial Treatment in Conjunction With Medications for the Treatment of Opioid Use Disorder.''

Monitoring Treatment

Patients should be seen frequently at the beginning of their treatment. Weekly visits (at least) are recommended until patients are determined to be stable. The stability of a patient is determined by an individual clinician based on a number of indicators which may include abstinence from illicit drugs, participation in psychosocial treatment and other recovery-based activities, and good occupational and social functioning. Stable patients can be seen less frequently but should be seen at least monthly.

Accessing PDMP data is advisable to check for other medications that the patient may be receiving. Due to the variation in state PDMP laws, clinicians are encouraged to be familiar with the legal requirements associated with PDMPs and prescribing of controlled substances in their state (see ''Exhibit 2'' in ''Part 1: Assessment and Diagnosis of Opioid Use Disorder''). In addition, objective measurement of body fluids for the presence of buprenorphine and illicit drugs of misuse is recommended.

Urine drug testing is a reasonably practical and reliable method to test for buprenorphine and illicit drugs. However, other reliable biological tests for the presence of drugs may be used. It is recommended that patients be tested often and that testing should be done for buprenorphine, substances such as heroin and marijuana, and prescription medications including benzodiazepines, prescription opioids, and amphetamines. How often and exactly what drugs should be tested for to optimize treatment has not been definitively established and is a topic that should be researched further (please see ''Drug Testing a White Paper of the American Society of Addiction Medicine for detail on types of drug testing'').[40]

Clinicians should take steps to reduce the chance of diversion. Diversion has been reported with buprenorphine monotherapy and combination buprenorphine/naloxone.[85] Strategies to reduce the potential of diversion include: frequent office visits, urine drug testing including testing for buprenorphine and metabolites, observed dosing, and recall visits for pill counts. Patients receiving treatment with buprenorphine should be counseled to have adequate means to secure their medications to prevent theft. Unused medication should be disposed of safely.[86]

Length of Treatment

There is no recommended time limit for treatment with buprenorphine. Buprenorphine taper and discontinuation is a slow process and close monitoring is recommended. Buprenorphine tapering is generally accomplished over several months. Patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly. Factors associated with successful termination of treatment with buprenorphine are not well described, but may include the following:

(1) Employment, engagement in mutual help programs, or involvement in other meaningful activities.
(2) Sustained abstinence from opioid and other drugs during treatment.
(3) Positive changes in the psychosocial environment.
(4) Evidence of additional psychosocial supports.
(5) Persistent engagement in treatment for ongoing monitoring past the point of medication discontinuation.

Patients who relapse after treatment has been terminated should be returned to treatment with buprenorphine.

Switching Treatment Medications

Buprenorphine is generally tolerated well by patients. Switching from buprenorphine to other opioid treatment medications may be appropriate in the following cases:

(1) Patient experiences intolerable side effects.
(2) Patient has not experienced a successful course of treatment in attaining or maintaining goal through the initially chosen pharmacotherapy option.
(3) Patient requires a greater level of supervision or services than office-based buprenorphine offers.
(4) Patient wants to change and is a candidate for treatment.

Switching to Naltrexone

Buprenorphine has a long half-life; 7–14 days should elapse between the last dose of buprenorphine and the start of naltrexone to ensure that the patient is not physically dependent on opioids before starting naltrexone. It may be useful to conduct a naloxone challenge (see ''Glossary'') before starting naltrexone to demonstrate an absence of physical dependence. Recently, investigators have begun to evaluate newer methods of rapidly transitioning patients from buprenorphine to naltrexone using repeated dosing over several days with very low doses of naltrexone along with ancillary medications.[87]

Although the results are promising, it is too early to recommend these techniques for general practice, and the doses of naltrexone used may not be readily available to most clinicians.

Switching to Methadone

Transitioning from buprenorphine to methadone is less problematic because the addition of a full mu-opioid agonist to a partial agonist does not typically result in any type of adverse reaction. There is no time delay required in transitioning a patient from buprenorphine to treatment with methadone.

Summary of Recommendations

(1) Opioid-dependent patients should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6–12 hours after the last use of heroin or other short-acting opioids, or 24–72 hours after their last use of long-acting opioids such as methadone.
(2) Induction of buprenorphine should start with a dose of 2–4 mg. Dosages may be increased in increments of 2–4 mg.
(3) Clinicians should observe patients in their offices during induction. Emerging research, however, suggests that many patients need ''not'' be observed and that home buprenorphine induction may be considered. Home-based induction is recommended only if the patient or prescribing physician is experienced with the use of buprenorphine. This is based on the consensus opinion of the Guideline Committee.
(4) Buprenorphine doses after induction and titration should be, on average, at least 8 mg per day. However, if patients are continuing to use opioids, consideration should be given to increasing the dose by 4–8 mg (daily doses of 12–16 mg or higher). The US FDA approves dosing to a limit of 24 mg per day, and there is limited evidence regarding the relative efficacy of higher doses. In addition, the use of higher doses may increase the risk of diversion.
(5) Psychosocial treatment should be implemented in conjunction with the use of buprenorphine in the treatment of opioid use disorder.
(6) Clinicians should take steps to reduce the chance of buprenorphine diversion. Recommended strategies include frequent office visits (weekly in early treatment), urine drug testing including testing for buprenorphine and metabolites, and recall visits for pill counts.
(7) Patients should be tested frequently for buprenorphine, other substances, and prescription medications. Accessing PDMP data may be useful for monitoring.
(8) Patients should be seen frequently at the beginning of their treatment. Weekly visits (at least) are recommended until patients are determined to be stable. There is no recommended time limit for treatment.
(9) Buprenorphine taper and discontinuation is a slow process and close monitoring is recommended. Buprenorphine tapering is generally accomplished over several months. Patients should be encouraged to remain in treatment for ongoing monitoring past the point of discontinuation.
(10) When considering a switch from buprenorphine to naltrexone, 7–14 days should elapse between the last dose of buprenorphine and the start of naltrexone to ensure that the patient is not physically dependent on opioids before starting naltrexone.
(11) When considering a switch from buprenorphine to methadone, there is no required time delay because the addition of a full mu-opioid agonist to a partial agonist does not typically result in any type of adverse reaction.
(12) Patients who discontinue agonist therapy and resume opioid use should be made aware of the risks associated with an opioid overdose, and especially the increased risk of death.

Areas for Further Research

Further research is needed to evaluate the safety and efficacy of buprenorphine induction conducted in the patient's own home, although current research supports this practice in select cases.

PART 6: NALTREXONE

Background

Naltrexone is a long-acting opioid antagonist that may be used to prevent relapse to opioid use. Naltrexone blocks the effects of opioids if they are used. Naltrexone is available in oral (ReVia, Depade) and extended-release injectable (Vivitrol) formulations.

Formulations of Naltrexone: Oral Versus Extended-Release Injectable

Most studies that found oral naltrexone effective were conducted in situations in which patients were highly motivated, were legally mandated to receive treatment, and/or taking the medication under the supervision of their family or significant others. A meta-analysis of 1158 participants in 13 randomized trials compared treatment with oral naltrexone to either placebo or no medication for opioid use disorder.[88] The evidence generated from these trials was limited by poor adherence and high dropout rates. Oral naltrexone was more efficacious than placebo in sustaining abstinence in three trials in which patients had external mandates (eg, legal requirements) and were monitored in adhering to daily doses of the medication.[88,89]

An extended-release injectable naltrexone formulation is available for patients with difficulty adhering to daily medication. This formulation requires an injection once per month. Extended-release injectable naltrexone has been found to be more efficacious than placebo for opioid dependence in randomized trials, although the trials were limited by high dropout rates of about 45% observed at 6 months.[50] One trial found naltrexone to be efficacious in patients with more than one substance use disorder and using more than one drug (heroin and amphetamines), which is a drug combination common in patients with opioid use disorder.[90]

Patient Selection and Treatment Goals

Oral naltrexone and extended-release injectable naltrexone are efficacious treatments recommended for patients who have an opioid use disorder, are able to give informed consent, and have no specific contraindications for agonist treatment. The 1-month protection from relapse after a single dose may make it particularly useful in preventing overdoses and facilitating entry into longer-term treatment if given to prisoners shortly before re-entry or to patients who are discharged from general hospitals after being detoxified in the course of treatment for medical or surgical problems.

Treatment with naltrexone generally has the following four goals:

(1) To prevent relapse to opioids in patients who have already been detoxified and are no longer physically dependent on opioids.
(2) To block the effects of illicit opioids.
(3) To reduce opioid craving.
(4) To promote and facilitate patient engagement in recovery-oriented activities including psychosocial intervention.

Oral Naltrexone

Because oral naltrexone has high rates of nonadherence and the potential for overdose upon relapse, this treatment is best for candidates who can be closely supervised and who are highly motivated. There is a risk of opioid overdose if the patient ceases naltrexone and then uses opioids. Groups that may benefit from oral naltrexone include employed patients, those who have been using drugs for only a short time (eg, younger patients), and those under threat of legal sanctions.

Extended-Release Injectable Naltrexone

Extended-release injectable naltrexone is also an efficacious treatment for opioid use disorder. It may be especially useful for patients who have contraindications to, or who failed pharmacotherapy with buprenorphine and methadone; patients confined to drug-free environments such as prison or inpatient rehabilitation; patients living in areas where agonist treatment is not available; individuals who are highly motivated and are willing to taper off their current agonist therapy; or patients who simply do not want to be treated with an agonist. Because it is US FDA-approved for the treatment of alcohol use disorder, it may be well suited for patients with co-occurring opioid and alcohol use disorders.

Precautions

Risk of Relapse and Subsequent Opioid Overdose

Patients maintained on naltrexone will have diminished tolerance to opioids and may be unaware of the consequent increased sensitivity to opioids if they stop taking naltrexone. Patients who discontinue antagonist therapy should be made aware of this phenomenon. If the patient stops naltrexone and resumes use of opioids in doses similar to those that were being used before the start of treatment with naltrexone, there is risk of an opioid overdose. This is due to the loss of tolerance to opioids and a resulting misjudgment of dose at the time of relapse.[91] A similar dynamic occurs in patients who detoxify with no meaningful follow-up treatment, or those who drop out of methadone or buprenorphine maintenance.

Course of Treatment

Induction

Before administering naltrexone, it is important that the patient has been adequately detoxified from opioids and is no longer physically dependent. Naltrexone can precipitate severe withdrawal symptoms in patients who have not been adequately withdrawn from opioids. As a general rule, patients should be free from short-acting opioids for about 6 days before starting naltrexone, and free from long-acting opioids such as methadone and buprenorphine for 7–10 days. A naloxone challenge can be used if it is uncertain whether the patient is no longer physically dependent on opioids. In the naloxone challenge, naloxone hydrochloride (a shorter-acting injectable opioid antagonist) is administered and the patient is monitored for signs and symptoms of withdrawal. A low-dose oral naltrexone challenge has been used as an alternative.

Dosing

''Oral naltrexone'' can be dosed at: 50 mg daily or three times weekly dosing with two 100-mg doses followed by one 150-mg dose. Oral naltrexone seems to be most useful when there is a support person to administer and supervise the medication. A support person may be a family member, close friend, or an employer.

''Extended-release injectable naltrexone'' can be given every 4 weeks by deep intramuscular (IM) injection in the gluteal muscle at a set dosage of 380 mg per injection. Whereas the injection interval is generally every 4 weeks, some clinicians have administered the medication more frequently (eg, every 3 weeks). There is no objective evidence supporting the safety or efficacy of this practice, however, and the Guideline Committee did not endorse it. More research is needed on safe dosing intervals for long-acting injectable naltrexone.

Special consideration should be made in naltrexone dosing for incarcerated groups. Re-entry into the community after imprisonment is a high-risk period for relapse to opioid misuse and overdose. Therefore, extended-release injectable naltrexone dosing before re-entry may serve to prevent relapse and overdose. A similar situation may apply to individuals leaving detoxification with no meaningful follow-up treatment, or to persons who have been detoxified in the course of medical or surgical treatment and who leave the hospital with no immediate relapse prevention follow-up therapy.

Adverse Effects

Naltrexone, both oral and extended-release injectable, is generally well tolerated. Apart from opioids, it does not typically interact with other medications. Most common side effects in random order can include insomnia, lack of energy/sedation, anxiety, nausea, vomiting, abdominal pain/cramps, headache, cold symptoms, joint and muscle pain, and specific to extended-release injectable naltrexone injection site reactions. To reduce injection site reactions in obese patients, a longer needle size may be used.[32]

Psychosocial Treatment

Psychosocial treatment is recommended and its efficacy is established when used in combination with naltrexone. Extended-released injectable naltrexone has not been studied as a standalone therapy without psychosocial treatment (for more recommendations regarding psychosocial treatment, see ''Part 7: Psychosocial Treatment in Conjunction with Medications for the Treatment of Opioid Use Disorder'').

Monitoring Treatment

Patients should be seen frequently at the beginning of their treatment. Weekly or more frequent visits are recommended until patients are determined to be stable. The stability of a patient is determined by an individual clinician based on a number of indicators which may include abstinence from illicit drugs, participation in psychosocial treatment and other recovery-based activities, and good occupational and social functioning. Stable patients can be seen less frequently, but should be seen at least monthly.

Accessing PDMP data is advisable to check for use of other prescription medications. In addition, objective measurement of body fluids for the presence of drugs of misuse is recommended.

Urine drug testing is a reasonably practical and reliable method to test for illicit drugs. However, other reliable biological tests for the presence of drugs may be used. It is recommended that patients be tested often and that testing should be done for substances such as heroin and marijuana, and prescription medications including benzodiazepines, prescription opioids, and amphetamines. How often and exactly what drugs should be tested for to optimize treatment has not been definitively established and is a topic that should be researched further.[16]

Length of Treatment

Data are not available at present on the recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. Duration of treatment depends on the response of the individual patient, the patient's individual circumstances, and clinical judgment.

Switching Treatment Medications

Switching from naltrexone to other opioid treatment medications may be appropriate in the following cases:

(1) Patient experiences intolerable side effects.
(2) Patient has not experienced a successful course of treatment in attaining or maintaining goal through the initially chosen pharmacotherapy option.
(3) Patient wants to change medications and is a candidate for alternative treatment.

Transfer of medications should be planned, considered, and monitored. Switching from an antagonist such as naltrexone to a full agonist (methadone) or a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist because there is no physical dependence associated with antagonist treatment. Patients being switched from naltrexone to buprenorphine or methadone will not have physical dependence on opioids and thus the initial doses of methadone or buprenorphine used may be less. Patients should not be switched until a significant amount of the naltrexone is no longer in their system – about 1 day for oral naltrexone or 30 days for extended-release injectable naltrexone.

Summary of Recommendations

(1) Naltrexone is a recommended treatment in preventing relapse in opioid use disorder. Oral formula naltrexone may be considered for patients in whom adherence can be supervised or enforced. Extended-release injectable naltrexone may be more suitable for patients who have issues with adherence.
(2) Oral naltrexone should be taken daily in 50-mg doses, or three times weekly in two 100-mg doses followed by one 150-mg dose.
(3) Extended-release injectable naltrexone should be administered every 4 weeks by deep IM injection in the gluteal muscle at a set dosage of 380 mg per injection.
(4) Psychosocial treatment is recommended in conjunction with treatment with naltrexone. The efficacy of naltrexone use in conjunction with psychosocial treatment has been established, whereas the efficacy of extended-release injectable naltrexone without psychosocial intervention ''has not'' been established.
(5) There is no recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. Duration depends on clinical judgment and the patient's individual circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms.
(6) Switching from naltrexone to methadone or buprenorphine should be planned, considered, and monitored. Switching from an antagonist such as naltrexone to a full agonist (methadone) or a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist because there is no physical dependence associated with antagonist treatment and thus no possibility of precipitated withdrawal. Patients being switched from naltrexone to buprenorphine or methadone will not have physical dependence on opioids and thus the initial doses of methadone or buprenorphine used should be low. Patients should not be switched until a significant amount of the naltrexone is no longer in their system – about 1 day for oral naltrexone or 30 days for extended-release injectable naltrexone.
(7) Patients who discontinue antagonist therapy and resume opioid use should be made aware of the increased risks associated with an opioid overdose, and especially the increased risk of death.

Areas for Further Research

(1) Further research is needed to test the relative efficacy of extended-release injectable naltrexone as compared to agonist treatment.
(2) Further research is needed on optimal withdrawal management to initiate treatment with naltrexone and minimize the risk of precipitated withdrawal.

(3) Further research is needed about the safety and efficacy of administering extended-release injectable naltrexone every 3 weeks for individuals who metabolize naltrexone at higher rates.

PART 7: PSYCHOSOCIAL TREATMENT IN CONJUNCTION WITH MEDICATIONS FOR THE TREATMENT OF OPIOID USE DISORDER

Background

Psychosocial treatment can help patients manage cravings, reduce the likelihood of relapse, and assist them in coping with the emotional and social challenges that often accompany substance use disorders. Psychosocial treatment is available in a variety of outpatient and inpatient settings, but the majority of studies have focused on outpatient treatment. Psychosocial treatment is provided using a variety of approaches in various milieus, including social skills training; individual, group, and couples counseling; cognitive behavioral therapy; motivational interviewing; and family therapy. Determining level of need and best approach to psychosocial treatment is individualized to each patient. In accordance with ASAM policy, mutual help compliments professional treatment, but is not a substitute for professional treatment.[92]

Goals of Psychosocial Treatment for Opioid Use Disorder

Although psychosocial treatment options vary, common therapeutic goals are to:

(1) modify the underlying processes that maintain or reinforce use behavior;
(2) encourage engagement with pharmacotherapy (eg, medication compliance); and
(3) treat any concomitant psychiatric disorders that either complicate a substance use disorder or act as a trigger for relapse.

Components of Psychosocial Treatment for Opioid Use Disorder

Psychosocial treatment is recommended in conjunction with any/all pharmacological treatment for opioid use disorder. At a minimum, the psychosocial treatment component of the overall treatment program should include the following:

(1) assessment of psychosocial needs;
(2) supportive individual and/or group counseling;
(3) linkages to existing family support systems; and
(4) referrals to community-based services.

More structured psychosocial treatment may be offered, and may potentially include more intensive individual counseling and psychotherapy, more specific social needs assistance (eg, employment, housing, and legal services), and case management.

Efficacy of Psychosocial Treatments in Opioid Use Disorder

There is evidence of the superiority of some psychosocial treatments over others, particularly contingency management (CM) and cognitive behavioral therapy (CBT). A 2008 meta-analysis compared the 2340 participants who received one of the following interventions: CM, relapse prevention, CBT, and CBT combined with CM. Participants receiving any psychosocial treatment had better outcomes than participants who did not. Contingency management and the combined CM and CBT intervention produced better outcomes than the other interventions.[93]

Other potentially useful psychosocial treatments include, but are not limited to the following:

(1) behavioral couples counseling;
(2) cognitive behavioral coping skills training;
(3) community reinforcement approach;
(4) contingency management/motivational incentives; and
(5) motivational enhancement.

Most recommendations for psychosocial treatments are not correlated with any specific pharmacological approach. Many patients have been shown to experience improved outcomes after receiving psychosocial treatment, in both individual and group formats, from a variety of approaches. Ancillary drug addiction counseling and mutual-help programs are generally considered beneficial.

Mutual Help Programs

Although not considered by ASAM to be a psychosocial treatment on its own, mutual help is an ancillary service that may be effective. Mutual-help programs may include 12-step programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Methadone Anonymous (MA). Other mutual-help groups include Self-Management and Recovery Therapy (SMART), and Moderation Management. Many providers recommend mutual-help programs, but there is anecdotal information to suggest that some of these programs may be less acceptable to patients receiving medications for opioid use disorder.

Adherence to Psychosocial Treatment Within Overall Treatment

Clinicians should determine the optimal type of psychosocial treatment to which to refer patients based on shared decision-making with the patient and in consideration of the availability and accessibility of area resources. Collaboration with qualified behavioral health providers is one way for clinicians to determine the type of psychosocial treatment that would best fit within a patient's individualized treatment plan. The ASAM Standards describe in standards III.1 and III.2 the role of the clinician in coordinating care and providing therapeutic alternatives. Key concepts within these standards speak to the importance of patient education about alternatives, shared decision-making in selection of therapeutic services, and the incumbent responsibility of the clinician to assure through the treatment planning and treatment

management processes to assure that psychosocial treatment is being received and that the patient is progressing towards mutually agreed upon goals. Renegotiated treatment plans should be established when patients do not follow through with psychosocial treatment referrals and/or that it is determined that the treatment plan goals are not being advanced.

Psychosocial Treatment and Treatment with Methadone

Psychosocial treatment is generally recommended for patients in treatment with methadone (see ''Part 4: Methadone,'' subsection ''Patient Selection and Treatment Goals''). Studies have found that psychosocial treatment in conjunction with methadone pharmacotherapy improves treatment effectiveness. The addition of psychosocial treatment has been associated with improved retention and reduced opioid use. A meta-analysis in 2011 found that psychosocial treatment improved withdrawal management outcomes.[28]

Some research, however, suggests the lack of efficacy in adding psychosocial treatment to treatment with methadone alone. Analyses of specific psychosocial treatments, including contingency management, did not show significant benefit over agonist medication alone.[93] This analysis, however, did not examine the effect of existing psychosocial treatments given during the course of treatment with methadone. Instead, the meta-analysis measured the effect of added psychosocial treatments.

Psychosocial Treatment and Treatment with Buprenorphine

Clinicians who are prescribing buprenorphine should consider providing or recommending office-based or community-based psychosocial treatment. There is some research evidence that the addition of psychosocial treatment improves adherence and retention in treatment with buprenorphine[63,94,95]; however, these findings are mixed.[29,96–99] It is recommended that clinicians offer patients psychosocial treatment early in their treatment with buprenorphine.

Effective therapies may include the following:

(1) cognitive behavioral therapies;
(2) contingency management;
(3) relapse prevention; and
(4) motivational interviewing.

Psychosocial Treatment and Treatment with Naltrexone

Psychosocial treatment is a recommended component of the treatment plan that utilizes the pharmacological therapy of naltrexone. In fact, extended-release injectable naltrexone's efficacy was established only when used in combination with psychosocial treatment. Conversely, extended-release injectable naltrexone's efficacy has not been tested as a standalone treatment without a psychosocial component. There are, however, limited data available on long-term outcomes.

Summary of Recommendations

(1) Psychosocial treatment is recommended in conjunction with any pharmacological treatment of opioid use disorder. At a minimum, psychosocial treatment should include the following: psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services.
(2) Treatment planning should include collaboration with qualified behavioral healthcare providers to determine the optimal type and intensity of psychosocial treatment and for renegotiation of the treatment plan for circumstances in which patients do not adhere to recommended plans for, or referrals to, psychosocial treatment.
(3) Psychosocial treatment is generally recommended for patients who are receiving opioid agonist treatment (methadone or buprenorphine).
(4) Psychosocial treatment should be offered with oral and extended-release injectable naltrexone. The efficacy of extended-release injectable naltrexone to treat opioid use disorder has not been confirmed when it has been used as pharmacotherapy without accompanying psychosocial treatment.

Areas for Further Research

(1) Further research is needed to identify the comparative advantages of specific psychosocial treatments.
(2) Further study is needed to evaluate the effectiveness of psychosocial treatment in combination with specific pharmacotherapies.
(3) More research is needed on which concurrent psychosocial treatments are most effective for different patient populations and treatment settings including primary care.
(4) Further research is needed on which psychosocial treatments are suitable for addition to buprenorphine or treatment with naltrexone, which can be delivered in primary care settings.

PART 8: SPECIAL POPULATIONS: PREGNANT WOMEN

Background

Many of the medical risks associated with opioid use disorder are similar for both pregnant and nonpregnant women; however, opioid use disorder carries obstetrical risks for pregnant women. Several obstetrical complications have been associated with opioid use in pregnancy, including preeclampsia, miscarriage, premature delivery, fetal growth restriction, and fetal death.[100] It is difficult to establish the extent to which these problems are due to opioid use, withdrawal, or co-occurring use of other drugs. Other factors that may contribute to obstetrical complications include concomitant maternal medical, nutritional, and psychosocial issues.

Pregnant women with opioid use disorder are candidates for opioid agonist treatment if a return to opioid use is likely during pregnancy. Methadone is the accepted standard of care for use during pregnancy. Buprenorphine monoproduct is a reasonable and recommended alternative to methadone for pregnant women. There is insufficient evidence to recommend the combination buprenorphine/naloxone formulation, though there is evidence of safety.

Assessment of Opioid Use Disorder in Pregnant Women

As is the case for any patient presenting for assessment of opioid use disorder, the first clinical priority should be to identify any emergent or urgent medical conditions that require immediate attention. Diagnosing emergent conditions can be challenging because women may present with symptoms that may be related to overdose and/or a complication in pregnancy.

A comprehensive assessment including medical examination and psychosocial assessment is recommended in evaluating opioid use disorder in pregnant women. The clinician should ask questions in a direct and nonjudgmental manner to elicit a detailed and accurate history.

Medical Examination

Physical Examination

A physical examination should be conducted for pregnant women who are presenting with potential opioid use disorder. The examination should include identifying objective physical signs of opioid intoxication or withdrawal. The objective physical signs for patients, including pregnant women, are described in ''Part 1: Assessment and Diagnosis of Opioid Use Disorder.''

Obstetricians and gynecologists should be alert to signs and symptoms of opioid use disorder. Pregnant women with opioid use disorder are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, or exhibit signs of withdrawal or intoxication. Positive results of serologic tests for HIV, hepatitis B, or hepatitis C may also indicate opioid use disorder.

On physical examination, some signs of drug use may be present, such as puncture marks from intravenous injection, abscesses, or cellulitis.

Laboratory Tests

Routine prenatal laboratory tests should be performed. Women who use opioids intravenously are at high risk for infections related to sharing injection syringes and sexually transmitted infections. Therefore, counseling and testing for HIV should be provided, according to state laws. Tests for hepatitis B and C and liver function are also suggested. Hepatitis A and B vaccination is recommended for those whose hepatitis serology is negative.

Urine drug testing may be used to detect or confirm suspected opioid and other drug use, but should be performed only with the patient's consent and in compliance with state laws. State laws differ in terms of clinicians' reporting requirements of identified drug use to child welfare services and/or health authorities. Laws that penalize pregnant women for substance use disorders serve to prevent women from obtaining prenatal care and treatment for opioid use disorder, which may worsen outcomes for mother and child. According to the American Congress of Obstetricians and Gynecologists (ACOG) 2014 Toolkit on State Legislation, mandatory urine drug testing is considered an unfavorable policy that does not support healthy pregnancy outcomes.[16] Routine urine drug testing is not highly sensitive for many drugs and results in false-positive and negative results that are misleading and potentially devastating for the patient. ACOG suggests that even with patient consent, urine testing should not be relied upon as the sole or valid indication of drug use. They suggest that positive urine screens should be followed with a definitive drug assay. Similarly, in a study conducted on pregnant women in Florida, where there is mandatory reporting to health authorities, study authors identified that compliant clinician reporting of drug misuse was biased by racial ethnicity and socioeconomic status of the pregnant woman. It was their conclusion that any state that regulates for mandatory urine testing and reporting do so based on medical criteria and medical necessity of such testing.[101]

Imaging

Confirmation of a viable intrauterine pregnancy by sonography is often required before acceptance into an OTP that is tailored specifically to pregnant women. Imaging is also useful for confirmation of gestational age.

Psychosocial Assessment

Research has found that the majority of women entering treatment for opioid use disorder have a history of sexual assault, domestic violence, and/or come from homes where their parents used drugs. Therefore, it is important to obtain a psychosocial history when evaluating pregnant women for opioid use disorder.

Opioid Agonist Treatment in Pregnancy

Decisions to use opioid agonist medications in pregnant women with opioid use disorder revolve around balancing the risks and benefits to maternal and infant health. Opioid agonist treatment is thought to have minimal long-term developmental impacts on children relative to harms resulting from maternal use of heroin and prescription opioids. Therefore, women with opioid use disorder who are not in treatment should be encouraged to start opioid agonist treatment with methadone or buprenorphine monotherapy (without naloxone) as early in the pregnancy as possible. Furthermore, pregnant women who are on agonist treatment should be encouraged not to discontinue treatment while they are pregnant.

Treatment Management Team

Pregnancy in women with opioid use disorder should be co-managed by an obstetrician and an addiction specialist physician. Release of information forms need to be completed to ensure communication among healthcare providers.

Opioid Agonists Versus Withdrawal Management

Pregnant women who are physically dependent on opioids should receive treatment using agonist medications rather than withdrawal management or abstinence as these approaches may pose a risk to the fetus. Furthermore, withdrawal management has been found to be inferior in effectiveness over pharmacotherapy with opioid agonists and increases the risk of relapse without fetal or maternal benefit.

Methadone Versus Buprenorphine

The discussion and decision for medication should be reviewed with the patient and documented in her chart. For

women who are pregnant or breastfeeding, opioid agonist treatment with methadone or buprenorphine is seen as the most appropriate treatment, taking into consideration effects on the fetus, neonatal abstinence syndrome, and impacts on perinatal care and parenting of young children.

Methadone is the accepted standard of care for use during pregnancy; however, buprenorphine monoproduct is a reasonable alternative and also has some advantages over methadone. Infants born to mothers treated with buprenorphine had shorter hospital stays (10 vs. 17.5 days), had shorter treatment durations for neonatal abstinence syndrome (NAS) (4.1 vs. 9.9 days), and required a lower cumulative dose of morphine (1.1 vs. 10.4 mg) compared to infants born to mothers on treatment with methadone.[102] However, in this trial, mothers treated with buprenorphine were more likely to drop out of treatment compared to mothers treated with methadone.

Combination Buprenorphine/Naloxone

There is some evidence suggesting that buprenorphine/naloxone is equivalent in safety and efficacy to the monoproduct for pregnant women.[103,104] At present, however, this evidence is insufficient to recommend the combination buprenorphine/naloxone formulation in this population. The buprenorphine monoproduct should be used instead.

Naltrexone in Pregnancy

If a woman becomes pregnant while she is receiving naltrexone, it is appropriate to discontinue the medication if the patient and doctor agree that the risk of relapse is low. If the patient is highly concerned about relapse and wishes to remain on naltrexone, it is important to inform the patient about the risks of staying on naltrexone and obtain consent for ongoing treatment. If the patient discontinues treatment with naltrexone and subsequently relapses, it may be appropriate to consider methadone or treatment with buprenorphine.

Naloxone in Pregnancy

The use of an antagonist such as naloxone to diagnose opioid use disorder in pregnant women is contraindicated because induced withdrawal may precipitate preterm labor or fetal distress. Naloxone should be used only in the case of maternal overdose to save the woman's life.

Methadone Induction

Conception While in Treatment with Methadone

Conceiving while on methadone has been associated with better drug treatment outcomes compared to women who initiate methadone during pregnancy. Pregnant women in treatment with methadone before conception who are not in physical withdrawal can be continued on methadone as outpatients.

Timing of Treatment in Pregnancy

Treatment with methadone should be initiated as early as possible during pregnancy to produce the most optimal outcomes. Longer duration of treatment with methadone is associated with longer gestation and higher birth weight.[105] There is insufficient evidence of teratogenic effects in pregnancy. NAS occurs while under treatment with methadone, but is easily treated if all parties are aware that it is likely to occur. The NAS risk to the fetus is significantly less than the risk of untreated opioid dependence. Data collected on exposure in human pregnancies are complicated by confounding variables including drug, alcohol, and cigarette use; poor maternal nutrition; and an increased prevalence of maternal infection.

The optimum setting for initiation of therapy has not been evaluated in this population. Hospitalization during initiation of treatment with methadone may be advisable due to the potential for adverse events (eg, overdose and adverse drug interactions), especially in the third trimester. This is also an ideal time for the woman to be assessed by a social worker and case manager, and initiate prenatal care if it has not been initiated earlier.

In an inpatient setting, methadone is initiated at a dose range from 10 to 30 mg. Incremental doses of 5–10 mg are given every 3–6 hours as needed to treat withdrawal symptoms, to a maximum first day dose of 30–40 mg. After induction, clinicians should increase the methadone dose in 5–10-mg increments per week, if indicated, to maintain the lowest dose that controls withdrawal symptoms and minimizes the desire to use additional opioids.

Buprenorphine Induction

Initiation or induction of buprenorphine may lead to withdrawal symptoms in patients with physical dependence on opioids. To minimize this risk, induction should be initiated when a woman begins to show objective, observable signs of moderate withdrawal, but before severe withdrawal symptoms are evidenced. This usually occurs 6 hours or more after the last dose of a short-acting opioid, and typically 24–48 hours after the use of long-acting opioids. Hospitalization during initiation of treatment with buprenorphine may be advisable due to the potential for adverse events, especially in the third trimester.

Drug dosing is similar to that in women who are not pregnant (see ''Part 5: Buprenorphine'' for more information).

Dosing of Opioid Agonists During Pregnancy

Methadone Dosing

In the second and third trimester, methadone doses may need to be increased due to increased metabolism and circulating blood volume. With advancing gestational age, plasma levels of methadone progressively decrease and clearance increases.[106–109] The half-life of methadone falls from an average of 22–24 hours in nonpregnant women to 8.1 hours in pregnant women.[110] As a result, ''increased'' or split methadone doses may be needed as pregnancy progresses to maintain therapeutic effects. Splitting the methadone dose into two 12-hour doses may produce more adequate opioid replacement in this period. There is frequent misconception that doses of methadone should decrease as pregnancy progresses; however, data refute this misconception. The risk and severity of NAS are not correlated with methadone doses taken by the mother at the time of delivery and tapering of

dose is not indicated.[111,112] After birth, the dose of methadone may need to be adjusted.

Buprenorphine Dosing

The need to adjust dosing of buprenorphine during pregnancy is less than that of methadone. Clinicians may consider split dosing in patients who complain of discomfort and craving in the afternoon and evening.

Breastfeeding

Mothers receiving methadone and buprenorphine monoproduct for the treatment of opioid use disorders should be encouraged to breastfeed. Naltrexone is not recommended for use during breastfeeding.[82]

Specialty advice should be sought for women with concomitant medical or substance use disorders. Contraindications or precautions in breastfeeding include the following:

(1) HIV-positive mothers.
(2) Mothers using alcohol, cocaine, or amphetamine-type drugs.

Guidelines from the Academy of Breastfeeding Medicine encourage breastfeeding for women treated with methadone who are enrolled in methadone programs.[113] Some of the benefits include improved maternal–infant bonding and favorable effects on NAS.[114,115] It is not clear whether the favorable effects of breastfeeding on NAS are related to the breast milk itself or the act of breastfeeding.[115,116] In a study of buprenorphine and breastfeeding, it was shown that the amount of buprenorphine metabolites secreted in breast milk are so low that they pose little risk to breastfeeding infants.[117]

Summary of Recommendations

(1) The first priority in evaluating pregnant women for opioid use disorder should be to identify emergent or urgent medical conditions that require immediate referral for clinical evaluation.
(2) A medical examination and psychosocial assessment is recommended when evaluating pregnant women for opioid use disorder.
(3) Obstetricians and gynecologists should be alert to signs and symptoms of opioid use disorder. Pregnant women with opioid use disorder are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, or exhibit signs of withdrawal or intoxication.
(4) Psychosocial treatment is recommended in the treatment of pregnant women with opioid use disorder.
(5) Counseling and testing for HIV should be provided in accordance with state law. Tests for hepatitis B and C and liver function are also suggested. Hepatitis A and B vaccination is recommended for those whose hepatitis serology is negative.
(6) Urine drug testing may be used to detect or confirm suspected opioid and other drug use with informed consent from the mother, realizing that there may be adverse legal and social consequences of her use. State laws differ on reporting substance use during pregnancy. Laws that penalize women for use and for obtaining treatment serve to prevent women from obtaining prenatal care and worsen outcomes.
(7) Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine monoproduct rather than withdrawal management or abstinence.
(8) Care for pregnant women with opioid use disorder should be comanaged by an obstetrician and an addiction specialist physician. Release of information forms need to be completed to ensure communication among healthcare providers.
(9) Treatment with methadone should be initiated as early as possible during pregnancy.
(10) Hospitalization during initiation of methadone and treatment with buprenorphine may be advisable due to the potential for adverse events, especially in the third trimester.
(11) In an inpatient setting, methadone should be initiated at a dose range of 20–30 mg. Incremental doses of 5–10 mg are given every 3–6 hours, as needed, to treat withdrawal symptoms.
(12) After induction, clinicians should increase the methadone dose in 5–10-mg increments per week. The goal is to maintain the lowest dose that controls withdrawal symptoms and minimizes the desire to use additional opioids.
(13) Twice-daily dosing is more effective and has fewer side effects than single dosing, but may not be practical because methadone is typically dispensed in an outpatient clinic.
(14) Clinicians should be aware that the pharmacokinetics of methadone are affected by pregnancy. With advancing gestational age, plasma levels of methadone progressively decrease and clearance increases. Increased or split doses may be needed as pregnancy progresses. After child birth, doses may need to be adjusted.
(15) Buprenorphine monoproduct is a reasonable and recommended alternative to methadone for pregnant women. Whereas there is evidence of safety, there is insufficient evidence to recommend the combination buprenorphine/naloxone formulation.
(16) If a woman becomes pregnant while she is receiving naltrexone, it is appropriate to discontinue the medication if the patient and doctor agree that the risk of relapse is low. If the patient is highly concerned about relapse and wishes to continue naltrexone, she should be informed about the risks of staying on naltrexone and provide her consent for ongoing treatment. If the patient wishes to discontinue naltrexone, but then reports relapse to opioid use, it may be appropriate to consider treatment with methadone or treatment with buprenorphine.
(17) Naloxone is not recommended for use in pregnant women with opioid use disorder except in situations of life-threatening overdose.
(18) Mothers receiving methadone and buprenorphine monoproduct for the treatment of opioid use disorders should be encouraged to breastfeed.

Areas for Further Research

Further research is needed to establish the safety of buprenorphine or the combination of the buprenorphine/naloxone for use in pregnancy.

PART 9: SPECIAL POPULATIONS: INDIVIDUALS WITH PAIN

Background

The occurrence of acute and chronic pain among patients with an opioid use disorder is not uncommon. Because of the current epidemic of nonmedical prescription drug use, it is critical to know how to manage pain safely and effectively. There are three general situations (listed below), each of which will be addressed separately, in which patients with opioid use disorder could be treated for pain:

(1) Pain in patients with an untreated and active opioid use disorder
(2) Pain in patients under opioid use disorder treatment with opioid agonists
(3) Pain in patients under opioid use disorder treatment with naltrexone

General Considerations for All Patients With Pain

For all patients with pain, it is important that the correct diagnosis of pain etiology be made and that a suitable treatment be identified. Nonpharmacological treatments have been shown to be effective for pain (eg, physical therapy) and may be considered.

If pharmacological treatment is considered, then non-narcotic medications such as acetaminophen and NSAIDs should be tried first. Adjunctive medications including anticonvulsants may be useful. Tricyclic antidepressants or combined norepinephrine-serotonin reuptake inhibitors may also be used.

Pain Management in Patients Using Opioids

Opioid agonists (methadone or buprenorphine) may be considered for patients with an active opioid use disorder who are not undergoing treatment. Both methadone and buprenorphine have analgesic effects. Transition to opioid agonist treatments can help co-manage pain and opioid use disorder.

Methadone and Pain Management

Patients prescribed methadone for opioid use disorder treatment should receive pain management in the same way as other patients in consultation with a pain specialist.

Acute and Chronic Pain Control

Because of the tolerance associated with daily methadone dosing, the usual dose of methadone may be inadequate for pain control. Patients in treatment with methadone will require doses of opioids in addition to their regular daily dose of methadone to manage acute pain.[118] However, in some cases, the tolerance associated with daily methadone dosing may result in the need for higher doses of narcotic analgesics.[119,120] Methadone patients who have chronic pain should optimally be treated in consultation with a pain specialist.

Buprenorphine and Pain Management

Acute Pain Control

Although it is a mu-opioid partial agonist, buprenorphine does have analgesic properties. Temporarily increasing buprenorphine dosing or dividing the dose may be effective for acute pain management.

Patients' pain may not be adequately addressed with buprenorphine and may require a full agonist. In situations when a full opioid agonist is needed for pain control, patients may be taken off buprenorphine and switched to a full opioid agonist until analgesia is no longer necessary. This may occur when patients undergo elective surgery. However, there are data to suggest that the discontinuation of buprenorphine is unnecessary and that adequate analgesia may be possible by simply adding non-narcotic and narcotic analgesics to the patient's baseline buprenorphine dose.[121]

For severe acute pain, discontinuing buprenorphine is advisable, and then commencing a high-potency opioid (such as fentanyl) in an attempt to over-ride the partial mu-receptor blockade of the buprenorphine is recommended. Patients should be monitored closely because high doses of a full agonist may be required. As the buprenorphine's partial blockade dissipates, the full agonist effect may lead to oversedation and respiratory depression. Additional interventions such as regional anesthesia should also be considered.

Chronic Pain Control

Buprenorphine may be adequate for chronic pain control in many patients with opioid use disorder and other types of chronic pain. Chronic opioid therapy, especially at high doses, may heighten pain sensitivity.[122] There is some evidence suggesting that patients experiencing significant pain on high doses of full agonist opioid pain relievers experience improved pain control when transitioned to buprenorphine.[123] Split dosing of buprenorphine should be considered for patients with pain.

Considerations for Buprenorphine in Surgery

Discontinuation of buprenorphine is not recommended before elective cesarean section as it creates the potential for fetal withdrawal. For other elective surgeries in which buprenorphine is discontinued, the last dose of buprenorphine is usually delivered 24–36 hours before the anticipated need for analgesia. The buprenorphine is then restarted after a period of time after the discontinuation of full opioid agonists. Short-acting opioids should be given during or after surgery and titrated to maintain proper analgesia. In cases in which the buprenorphine cannot be stopped abruptly, pain control may be achieved with full opioid agonists added to the buprenorphine, but the doses may need to be increased to overcome the receptor blockade produced by buprenorphine.[124–126] The decision to discontinue buprenorphine before an elective

surgery should optimally be made in consultation with the attending surgeon and anesthesiologist.

Naltrexone and Pain Management

Patients on naltrexone will not respond to opioid analgesics in the usual manner. Mild pain may be treated with NSAIDs. Ketorolac may be prescribed for moderate to severe pain, but its use should be time-limited due to higher risk of gastritis.

Emergency pain control options in patients taking naltrexone include the following:

(1) regional anesthesia;
(2) conscious sedation with benzodiazepines or ketamine; and
(3) nonopioid options in general anesthesia.

Considerations for Naltrexone in Surgery

Oral naltrexone should be discontinued at least 72 hours before elective surgery if pain management using opioids is anticipated. Extended-release naltrexone should be stopped at least 30 days before surgery, and oral naltrexone may be used temporarily. The surgical team should be aware of the use of naltrexone. Patients should be off opioids for 3–7 days before resuming naltrexone (oral or extended-release formulations). A naloxone challenge may be used to confirm that opioids are no longer being used.

Summary of Recommendations

(1) For all patients with pain, it is important that the correct diagnosis be made and that a target suitable for treatment is identified.
(2) If pharmacological treatment is considered, non-narcotic medications such as acetaminophen and NSAIDs should be tried first.
(3) Opioid agonists (methadone or buprenorphine) should be considered for patients with active opioid use disorder who are not under treatment.
(4) Pharmacotherapy in conjunction with psychosocial treatment should be considered for patients with pain who have opioid use disorder.
(5) Patients on methadone for the treatment of opioid use disorder will require doses of opioids in addition to their regular daily dose of methadone to manage acute pain.
(6) Patients on methadone for the treatment of opioid use disorder and who are admitted for surgery may require additional short-acting opioid pain relievers. The dose of pain relievers prescribed may be higher due to tolerance.
(7) Temporarily increasing buprenorphine dosing may be effective for mild acute pain.
(8) For severe acute pain, discontinuing buprenorphine and commencing on a high-potency opioid (such as fentanyl) is advisable. Patients should be monitored closely and additional interventions such as regional anesthesia should also be considered.
(9) The decision to discontinue buprenorphine before an elective surgery should be made in consultation with the attending surgeon and anesthesiologist. If it is decided that buprenorphine should be discontinued before surgery, this should occur 24–36 hours in advance of surgery and restarted postoperatively when the need for full opioid agonist analgesia has passed.
(10) Patients on naltrexone will not respond to opioid analgesics in the usual manner. Therefore, it is recommended that mild pain be treated with NSAIDs and moderate to severe pain be treated with ketorolac on a short-term basis.
(11) Oral naltrexone should be discontinued 72 hours before surgery and extended-release injectable naltrexone should be discontinued 30 days before an anticipated surgery.

Areas for Further Research

Further research is needed to examine whether the discontinuation of buprenorphine before elective surgery is necessary. Studies on whether it is possible to provide adequate analgesia by adding full agonist opioid analgesics to the patient's baseline buprenorphine dose are needed.

PART 10: SPECIAL POPULATIONS: ADOLESCENTS

Background

The American Academy of Pediatrics categorizes adolescence as the totality of three developmental stages – puberty to adulthood – which occur generally between 11 and 21 years of age.[11] Young people within this age group – adolescents – present for treatment with a broad spectrum of opioid use disorder severity and with co-occurring medical and psychiatric illness. Consequently, physicians will need to respond with a full range of treatment options, including pharmacotherapy. However, limited evidence exists regarding the efficacy of opioid withdrawal management in adolescents.[127] Pharmacological therapies have primarily been developed through research with adult populations.[128]

The treatment of adolescents with opioid use disorder presents many unique medical, legal, and ethical dilemmas that may complicate treatment. Given these unique issues, adolescents with opioid use disorder often benefit from services designed specifically for them. Furthermore, the family should be involved in treatment whenever possible.

Confidentiality in Treatment

One issue that may be of particular importance to consider in the treatment of adolescents is confidentiality. Adolescents have reported that they are less likely to seek substance use disorder treatment if services are not confidential.[129] Confidential care, particularly with respect to sensitive issues such as reproductive health and substance use, has become a well established practice.[130,131] This is a subject of complexity as it is an area governed by both Federal and state laws. Moreover, defined age ranges of ''adolescence'' vary. A myriad of clinical and legal responsibilities may be evoked if confronted by a young person's request for confidentiality. More than half of the states in the United States, by law, permit adolescents less than 18 years of age to consent to substance use disorder treatment without parental consent. State law should also be consulted. An additional reference

source in decision-making regarding the implications on coordination of care, effectiveness of treatment without parental communication, and more are fully discussed in a publication of the Substance Abuse and Mental Health Services Administrations (SAMHSA), Center for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) #33.[132]

Pharmacotherapy Options for Adolescents

Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment of opioid use disorder in adolescents. However, efficacy studies for these medications have largely been conducted in adults. This recommendation is based on the consensus opinion of the Guideline Committee. There are virtually no data comparing the relative effectiveness of these treatments in adolescents.

Opioid Agonists: Methadone and Buprenorphine

Agonist medications are indicated for the treatment of patients who are aged 18 years and older. The Federal code on opioid treatment – 42 CFR § 8.12 – offers an exception for patients aged 16 and 17, who have a documented history of at least two prior unsuccessful withdrawal management attempts, and have parental consent.[133]

Efficacy Research on Agonists and Partial Agonists in Adolescents

There are no controlled trials evaluating methadone for the treatment of opioid use disorder in adolescents under the age of 18. Descriptive trials support the usefulness of treatment with methadone in supporting treatment retention in adolescent heroin users.[134] The usefulness of treatment with buprenorphine has been demonstrated in two RCTs. Studies have, however, not included adolescents under the age of 16.[135,136] Buprenorphine is not US FDA-approved for use in patients less than 16 years old. Buprenorphine is more likely to be available in programs targeting older adolescents and young adults. No direct comparison of the efficacy of buprenorphine versus methadone has been conducted in adolescent populations.

Opioid Antagonist: Naltrexone

Naltrexone may be considered for young adults aged 18 years and older who have opioid use disorder. Naltrexone does not induce physical dependence and is easier to discontinue. Oral naltrexone may be particularly useful for adolescents who report a shorter duration of opioid use. Extended-release injectable naltrexone is administered monthly and can be delivered on an outpatient basis. There is only one small case series that demonstrated the efficacy of extended-release injectable naltrexone in adolescents.[137] The safety, efficacy, and pharmacokinetics of extended-release injectable naltrexone have not been established in the adolescent population.

Psychosocial Treatment for Adolescents

Psychosocial treatment is recommended in the treatment of adolescents with opioid use disorder. Recommended treatments based on the consensus opinion of the Guideline Committee include family intervention approaches, vocational support, and behavioral interventions to incrementally reduce use. Holistic risk-reduction interventions, which promote practices to reduce infection, are particularly important in the prevention of sexually transmitted infections and blood-borne viruses. Treatment of concomitant psychiatric conditions is also especially important in this population. Adolescents often benefit from specialized treatment facilities that provide multiple services.

Summary of Recommendations

(1) Clinicians should consider treating adolescents who have opioid use disorder using the full range of treatment options, including pharmacotherapy.
(2) Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment of opioid use disorder in adolescents. Age is a consideration in treatment, and Federal laws and US FDA approvals need to be considered for patients under age 18.
(3) Psychosocial treatment is recommended in the treatment of adolescents with opioid use disorder.
(4) Concurrent practices to reduce infection (eg, sexual risk-reduction interventions) are recommended as components of comprehensive treatment for the prevention of sexually transmitted infections and blood-borne viruses.
(5) Adolescents may benefit from treatment in specialized treatment facilities that provide multidimensional services.

Areas for Further Research

(1) More studies are needed to examine the efficacy of pharmacotherapy for adolescents with opioid use disorder. Due to the few clinical trials in adolescents, most of the current recommendations are based on research with adults.
(2) More research is needed to identify which psychosocial treatments, alone and in combination with pharmacotherapy, are best suited for use with adolescents.

PART 11: SPECIAL POPULATIONS: INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC DISORDERS

Background

Co-occurring psychiatric disorders are common among individuals who have opioid use disorder. Epidemiological studies have demonstrated a higher prevalence of substance use among people with psychiatric disorders relative to the general population.[138]

Reasons for the association between psychiatric and substance use disorders are not known. One hypothesis is that the dual diagnoses result from risk factors that are common to both disorders. A shared genetic vulnerability has been proposed to explain dysregulation in dopamine and glutamate systems in schizophrenia and substance use disorders.[139,140] Another hypothesis is that people with psychiatric disorders are more likely to use drugs as a method of self-medication.[141–143]

Co-occurring psychiatric disorders should not bar patients from opioid use disorder treatment. The presence of the following common psychiatric disorders should be evaluated in patients presenting with possible opioid use disorder:

(1) Depression
(2) Anxiety

(3) Personality disorders
(4) Post-traumatic stress disorder.

Assessment of Psychiatric Co-occurrence

The assessment of psychiatric disorders is critical when attempting to place patients in the appropriate treatment. Hospitalization may be appropriate for patients with severe or unstable psychiatric symptoms that may compromise the safety of self and others. An initial patient assessment should determine whether the patient is stable. Patients with suicidal or homicidal ideation should be referred immediately for treatment and possibly hospitalization. Patients should also be assessed for signs or symptoms of acute psychosis and chronic psychiatric disorders.

An assessment including medical history, physical examination, and an assessment of mental health status and/or psychiatric disorder should occur at the beginning of agonist or antagonist treatment (see ''Part 1: Assessment and Diagnosis of Opioid Use Disorder''). Reassessment using a detailed mental status examination should occur after stabilization with methadone, buprenorphine, or naltrexone.

Co-occurring Psychiatric Disorders and Suicide Risk

Psychiatric disorders are strongly associated with suicide. More than 90% of patients who attempt suicide have a major psychiatric disorder.[144] In cases where suicide attempts resulted in death, 95% of patients had a psychiatric diagnosis.[145]

Management of a suicidal patient should include the following:

(1) Reduce immediate risk
(2) Manage underlying factors associated with suicidal intent
(3) Monitor and follow-up

Considerations with Specific Psychiatric Disorders

Depression or Bipolar Disorder

Antidepressant therapy may be initiated with pharmacotherapy for opioid use disorder for patients with symptoms of depression. Patients presenting with mania should be evaluated to determine whether symptoms arise from the bipolar disorder or substance use. Patients with bipolar disorder may require additional psychiatric care, hospitalization, and/or treatment with prescription mood stabilizers.

All patients with depression, including bipolar disorder, should be asked about suicidal ideation and behavior. Patients with a history of suicidal ideation or attempts should have their medication use monitored regularly. This includes medications for the treatment of opioid use disorder and psychiatric medications.

Schizophrenia

Antipsychotic therapy may be initiated with pharmacotherapy for opioid use disorder for patients with schizophrenia or other psychotic disorder. Coadministration of antipsychotic medications with agonist pharmacotherapy or use of long-acting depot formulations of antipsychotic medications is an option to consider in patients with histories of medication nonadherence.

All patients with schizophrenia should be asked about suicidal ideation and behavior. Patients with a history of suicidal ideation or attempts should have their medication use monitored regularly. This includes medications for the treatment of opioid use disorder and psychiatric medications.

For patients with schizophrenia and concomitant opioid use disorder who have a recent history of, or are at risk of repeated hospitalization or homelessness, assertive community treatment (ACT) should be considered. ACT is designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with severe psychiatric disorders, and whose needs have not been well met by more traditional psychiatric or psychosocial services. The efficacy of ACT has had mixed results on substance use disorder outcomes, but has shown benefit in preventing homelessness.[146–148] When ACT or another intensive case management program is unavailable, traditional case management can be helpful to patients who are unable to manage necessary, basic tasks.

Co-occurring Psychiatric Disorders and Agonist Treatment

Pharmacological and conjunctive psychosocial treatments should be considered for patients with both an opioid use disorder and a psychiatric disorder. Actively suicidal patients are not good candidates for any opioid treatment.

Methadone

Methadone for the treatment of opioid use disorder has been found to reduce psychiatric distress in a few weeks. Psychotherapy has been found useful in patients who have moderate to severe psychiatric disorders.

Buprenorphine

Psychiatrically stable patients are good candidates for buprenorphine. Patients with depression who are receiving treatment with buprenorphine require a higher level of monitoring.

Co-occurring Psychiatric Disorders and Antagonist Treatment

Psychiatrically stable patients are good candidates for treatment with oral naltrexone or extended-release injectable naltrexone. There are little data, however, regarding the relative efficacy of these medications in opioid-dependent patients with co-occurring psychiatric disorders. The once-monthly injections of extended-release injectable naltrexone may be especially useful in patients with a co-occurring psychiatric disorder, who may not be able to adhere well to daily dosing. Patients should be closely observed for adverse events as some patients have reported suicidal ideation, suicide attempts, and depression.

Summary of Recommendations

(1) A comprehensive assessment including determination of mental health status should evaluate whether the patient is

stable. Patients with suicidal or homicidal ideation should be referred immediately for treatment and possibly hospitalization.
(2) Management of patients at risk for suicide should include the following: reducing immediate risk; managing underlying factors associated with suicidal intent; and monitoring and follow-up.
(3) All patients with psychiatric disorders should be asked about suicidal ideation and behavior. Patients with a history of suicidal ideation or attempts should have opioid use disorder, and psychiatric medication use, monitored.
(4) Assessment for psychiatric disorder should occur at the onset of agonist or antagonist treatment. Reassessment using a detailed mental status examination should occur after stabilization with methadone, buprenorphine, or naltrexone.
(5) Pharmacotherapy in conjunction with psychosocial treatment should be considered for patients with opioid use disorder and a co-occurring psychiatric disorder.
(6) Clinicians should be aware of potential interactions between medications used to treat co-occurring psychiatric disorders and opioid use disorder.
(7) Assertive community treatment should be considered for patients with co-occurring schizophrenia and opioid use disorder, who have a recent history of, or are at risk of, repeated hospitalization or homelessness.

PART 12: SPECIAL POPULATIONS: INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

Background

A substantial proportion of persons in prisons, jails, drug courts, probation, parole, and who are criminally involved have opioid use disorder and related problems. A lifetime history of incarceration is common among intravenous drug users; 56–90% of intravenous drug users have been incarcerated previously.[149] The United States leads the world in the number of people incarcerated in Federal and state correctional facilities. There are, at present, more than 2 million people in American prisons. Approximately one-quarter of those people held in US prisons have been convicted of a drug offense.[150] Continued drug use is common among prisoners, and many individuals initiate intravenous drug use while in prison.[151,152]

Prison drug use is particularly risky because of the environment. The high concentration of at-risk individuals and general overcrowding can increase the risk of adverse consequences associated with drug use, including violence, drug-related deaths, suicide, and self-harm.[153] Drugs and sterile injection equipment is rare and sharing needles is common, leading to a high risk of spreading HIV and hepatitis C. Discharge from prison is often associated with opioid overdose and death. Consequently, it is important to identify and implement effective treatments for prisoners and probationers/parolees.

For the purposes of this *Practice Guideline*, a prison is to be differentiated from a jail. At the most basic level, the fundamental difference between jail and prison is the length of stay for inmates. Jails are usually run by local law enforcement and/or local government agencies, and are designed to hold inmates awaiting trial or serving a short sentence. Prison terms are of longer duration. Anyone incarcerated, regardless of sentence term, should be continued on opioid treatment.

Effectiveness of Pharmacotherapy

Pharmacotherapy for the treatment of opioid use disorder among prisoners has been shown to be effective. Most evidence for the effectiveness of pharmacotherapy for the treatment of opioid use disorder among prisoners has been derived from treatment with methadone. However, there is some evidence supporting the use of buprenorphine and naltrexone in this population.[154]

Methadone

Treatment with methadone has been shown to have a number of beneficial effects in inmates with opioid use disorders. Prisoners with opioid use disorder treated with methadone inject a lesser amount of drugs.[151,155–157] Prisoners treated with methadone used less drugs after release and were more likely to participate in community-based addiction treatment.[158] Treatment with methadone lowered the rate of reincarceration during the 3-year period following first incarceration.[158,159]

Buprenorphine

Although less extensively studied, in some early trials, buprenorphine has also been associated with beneficial effects in prisoners with opioid use disorder. A RCT comparing buprenorphine and methadone among male heroin users who were newly admitted to prison showed that treatment completion rates were similar, but that buprenorphine patients were significantly more likely to enter community-based treatment after release.[160] In a more recent trial, buprenorphine initiated in prison was also associated with a greater likelihood of entering community treatment.[161] However, buprenorphine was diverted in some cases. Although promising, more research needs to be done to establish the effectiveness of inprison treatment with buprenorphine.

Naltrexone

Extended-release injectable naltrexone is the newest, and consequently least studied, medication for the treatment of prisoners and parolees. It has been shown to be effective for the treatment of opioid dependence in some early trials; however, there are no published studies evaluating the effectiveness of extended-release injectable naltrexone for the treatment of opioid use disorder in prisoners. In one small pilot trial involving parolees with prior opioid use disorder, 6 months of treatment with extended-release injectable naltrexone was associated with fewer opioid-positive urine drug screens and a reduced likelihood of reincarceration.[162] There are no studies establishing effectiveness of extended-release injectable naltrexone for persons in prison, or comparing it to either methadone or buprenorphine. Further research is needed in this area.

Treatment Options

All adjudicated individuals, regardless of type of offense and disposition, should be screened for opioid use

disorder and considered for initiation or continuation of medication for the treatment of opioid use disorder. For incarcerated individuals, it should be initiated a minimum of 30 days before release, and aftercare should be arranged in advance.[163]

Methadone and Buprenorphine

Methadone or treatment with buprenorphine that is initiated during incarceration and to be continued after release is recommended for inmates with opioid use disorder without contraindications to these two medications. There is limited research comparing methadone and buprenorphine. In one trial, outcomes after release were similar; however, there was a problem with diversion of buprenorphine.[160]

Naltrexone

Extended-release injectable naltrexone may be considered for prisoners with opioid use disorder. However, there are little data about efficacy in prison populations. Extended-release injectable naltrexone should be considered for patients with opioid use disorder, with no contraindications, before their release from prison. Whether or not extended-release injectable naltrexone is superior to buprenorphine or methadone for the treatment of prisoners with opioid use disorder is unknown.

Summary of Recommendations

(1) Pharmacotherapy for the continued treatment of opioid use disorders, or the initiation of pharmacotherapy, has been shown to be effective and is recommended for prisoners and parolees regardless of the length of their sentenced term.
(2) Individuals with opioid use disorder who are within the criminal justice system should be treated with some type of pharmacotherapy in addition to psychosocial treatment.
(3) Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment. There is insufficient evidence to recommend any one treatment as superior to another for prisoners or parolees.
(4) Pharmacotherapy should be initiated a minimum of 30 days before release from prison.

Areas for Further Research

Further research is needed on the effectiveness of pharmacotherapy in prisoner populations.

PART 13: NALOXONE FOR THE TREATMENT OF OPIOID OVERDOSE

Introduction

Death from opioid overdose is a growing epidemic in the United States. Poisoning deaths involving opioid analgesics have more than tripled in the United States since 1999.[164] Unintentional poisoning (primarily due to drug overdose) is now the leading cause of injury-related death among Americans aged 25–64, having surpassed motor vehicle accidents in 2009.[165] Patients who overdose on opioids are in a life-threatening situation that requires immediate medical intervention. Naloxone is a mu-opioid antagonist with well established safety and efficacy that can reverse opioid overdose and prevent fatalities. As well, naloxone can and should be administered to pregnant women in cases of overdose to save the mother's life.

As of December 15, 2104, a total of 27 states (NM, NY, IL, WA, CA, RI, CT, MA, NC, OR, CO, VA, KY, MD, VT, NJ, OK, UT, TN, ME, GA, WI, MN, OH, DE, PA, and MI) and the District of Columbia amended their state laws to make it easier for medical professionals to prescribe and dispense naloxone, and for lay administrators to use it without fear of legal repercussions.[166] State laws generally dictate various levels of prescriptive authority and generally speaking discourage the prescription of drugs to an individual other than the intended recipient, third-party prescription, or to a person the physician has not examined to be used in specific scenarios to assist others (prescription via standing order).

Patients and Significant Others/Family Members

Patients who are being treated for opioid use disorder, and their family members or significant others, should be given prescriptions for naloxone. Patients and family members/significant others should be trained in the use of naloxone in overdose. The practice of coprescribing naloxone for home use in the event of an overdose situation experienced by the patient or by any others in the household is endorsed by ASAM in a public policy statement and by SAMHSA in its toolkit on opioid overdose.[167,168]

Individuals Trained and Authorized to Use Naloxone

Until recently, administration of naloxone for the treatment of opioid overdose was only recommended for hospital personnel and paramedics. However, efforts are underway to expand the use of naloxone for the treatment of overdose to other first responders, including emergency medical technicians, police officers, firefighters, correctional officers, and others who might witness opioid overdose such as addicted individuals and their families. The primary issues to be considered in this *Practice Guideline* include the safety and efficacy of naloxone for the treatment of opioid overdose by first responders and bystanders, and the best form of naloxone to use for this purpose.

Safety and Efficacy of Bystander Administered Naloxone

Although there is ample evidence supporting the safety and efficacy of naloxone for the treatment of opioid overdose,[164,169,170] less is known about the effectiveness of naloxone used by other first responders and bystanders. Naloxone has been shown to be effective when used by paramedics.[171,172] There are no trials specifically evaluating the effectiveness of naloxone when administered by nonmedical first responders such as police officers and firefighters.

There have been a number of nonrandomized studies evaluating the effectiveness of community-based overdose prevention programs that include the distribution of naloxone

to nonmedical personnel. In a comprehensive review of these trials, Clark et al.[164] concluded that bystanders (mostly opioid users) can and will use naloxone to reverse opioid overdose when properly trained, and that this training can be done successfully through these programs. The authors acknowledge that the lack of randomized controlled trials of community-based overdose prevention programs limits conclusions about their overall effectiveness. SAMHSA supports the use of naloxone for the treatment of opioid overdose by bystanders in their Opioid Overdose Prevention Toolkit.[168]

Routes of Administration

Naloxone is marketed in vials for injection and in an autoinjector for either IM or subcutaneous (SC) use. The US FDA-approved autoinjectors were designed to be used by a patient or family member for the treatment of opioid overdose. There is not yet an US FDA-approved intranasal formulation – there are only kits made available to deliver the injectable formulation intranasally. Despite the intranasal formulation's current lack of US FDA approval, it is being used off-label by first responders.

Although there are some data from head-to-head trials suggesting that IM naloxone may be superior to intranasal naloxone, there are few studies comparing the superiority of naloxone by route of administration, including intranasal, IM, or intravenous. The present available intranasal naloxone formulation is not dispensed in a preloaded syringe and this may affect its usefulness.[173] More research is needed to definitively assess the relative effectiveness of injectable vs. intranasal naloxone. In addition, the development of a more convenient administration device for intranasal naloxone could improve the effectiveness of this form of naloxone.

Summary of Recommendations

(1) Naloxone should be given in case of opioid overdose.
(2) Naloxone can and should be administered to pregnant women in cases of overdose to save the mother's life.
(3) The Guideline Committee, based on consensus opinion, recommends that patients who are being treated for opioid use disorder and their family members/significant others be given prescriptions for naloxone. Patients and family members/significant others should be trained in the use of naloxone in overdose.
(4) The Guideline Committee, based on consensus opinion, recommends that first responders, for example, emergency medical services personnel, police officers, and firefighters be trained in and authorized to administer naloxone.

PART 14: AREAS FOR FURTHER RESEARCH

Although this *Practice Guideline* is intended to guide the assessment, treatment, and use of medications in opioid use disorder, there are areas where there was insufficient evidence to make a recommendation. Further research is needed to compare the advantages of different medications for different patient groups, especially with the emergence of new treatments. The recommended areas of future research are outlined below and presented in the order they were introduced in the guideline.

Assessment and Diagnosis of Opioid Use Disorder (Part 1)

(1) More research is needed on best practices for drug testing during the initial evaluation and throughout the entire treatment process.
(2) Further research is needed on evidence-based approaches for treating opioid use disorder in patients who continue to use marijuana and/or other psychoactive substances.
(3) Whereas research indicates that offering tobacco cessation is a standard for all medical care, more research is needed before specific evidence-based recommendations can be made.

Treatment Options (Part 2)

(1) More research is needed to compare the advantages of agonists and antagonists in the treatment of opioid use disorder. Whereas methadone, buprenorphine, and naltrexone are all superior to no treatment in opioid use disorder, less is known about their relative advantages.

Opioid Withdrawal Management (Part 3)

(1) Further research is needed to evaluate the efficacy and safety of alpha-2 adrenergic and other nonopioid medications that are being used off-label for withdrawal management. These nonopioid medications may have use in transitioning patients onto antagonists for relapse prevention.
(2) Further study is needed on other methods to accelerate the withdrawal process and facilitate the introduction of antagonists.
(3) More research is needed to make recommendations on the optimal duration of a buprenorphine taper.
(4) More research is needed to evaluate the safety of inpatient as compared to outpatient withdrawal management.
(5) More research is needed to compare the effectiveness of short versus long tapers with buprenorphine withdrawal management.

Methadone (Part 4)

(1) Further research is needed to assess the effectiveness of added psychosocial treatment to treatment with methadone in OTP or inpatient settings. Treatment with methadone generally includes some psychosocial components. However, it is unclear whether added psychosocial treatment improves patient outcomes.

Research is needed to evaluate the use of ECG in treatment with methadone in preventing adverse events.

Buprenorphine (Part 5)

(1) Further research is needed to evaluate the safety and efficacy of buprenorphine induction conducted in the patient's own home, although present research supports this practice in select cases.

Naltrexone (Part 6)

(1) Further research is needed to test the relative efficacy of extended-release injectable naltrexone as compared to agonist treatment.

(2) Further research is needed on optimal withdrawal management to initiate treatment with naltrexone and minimize the risk of precipitated withdrawal.
(3) Further research is needed about the safety and efficacy of administering extended-release injectable naltrexone every 3 weeks for individuals who metabolize naltrexone at higher rates.

Psychosocial Treatment in Conjunction With Medications for the Treatment of Opioid Use Disorder (Part 7)

(1) Further research is needed to identify the comparative advantages of specific psychosocial treatments.
(2) Further study is needed to evaluate the effectiveness of psychosocial treatment in combination with specific pharmacotherapies.
(3) More research is needed on which concurrent psychosocial treatments are most effective for different patient populations and treatment settings including primary care.
(4) Further research is needed on which psychosocial treatments are suitable for addition to buprenorphine or treatment with naltrexone, which can be delivered in primary care settings.

Special Populations: Pregnant Women (Part 8)

(1) Further research is needed to establish the safety of buprenorphine or the combination of the buprenorphine/naloxone for use in pregnancy.

Special Population: Individuals With Pain (Part 9)

(1) Further research is needed to examine whether the discontinuation of buprenorphine before elective surgery is necessary. Studies on whether it is possible to provide adequate analgesia by adding full agonist opioid analgesics to the patient's baseline buprenorphine dose are needed.

Special Populations: Adolescents (Part 10)

(1) More studies are needed to examine the efficacy of pharmacotherapy for adolescents with opioid use disorder. Due to the few clinical trials in adolescents, most of the present recommendations are based on research with adults.
(2) More research is needed to identify which psychosocial treatments, alone and in combination with pharmacotherapy, are best suited for use with adolescents.

Special Populations: Individuals in the Criminal Justice System (Part 12)

(1) Further research is needed on the effectiveness of pharmacotherapy in prisoner populations.

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APPENDICES

Appendix I: Clinical References Reviewed

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Appendix II: Bioequivalence Information and Charts

Bioequivalence of Suboxone® (buprenorphine and naloxone) Sublingual Tablets and Suboxone Sublingual Film

Patients being switched between Suboxone® (buprenorphine and naloxone) sublingual tablets and Suboxone® sublingual film should be started on the same dosage as the previously administered product. However, dosage adjustments may be necessary when switching between products. Not all strengths and combinations of the Suboxone® sublingual films are bioequivalent to Suboxone® (buprenorphine and naloxone) sublingual tablets as observed in pharmacokinetic studies. Therefore, systemic exposures of buprenorphine and naloxone may be different when patients are switched from tablets to film, or vice-versa. Patients should be monitored for symptoms related to over-dosing or under-dosing.

In pharmacokinetic studies, the 2 mg/0.5 mg and 4 mg/1 mg doses administered as Suboxone® sublingual films showed comparable relative bioavailability to the same total dose of Suboxone® (buprenorphine and naloxone) sublingual tablets, whereas the 8 mg/2 mg and 12 mg/3 mg doses administered as Suboxone® sublingual films showed higher relative bioavailability for both buprenorphine and naloxone compared to the same total dose of Suboxone® (buprenorphine and naloxone) sublingual tablets. A combination of one 8 mg/2 mg and two 2 mg/0.5 mg Suboxone® sublingual films (total dose of 12 mg/ 3 mg) showed comparable relative bioavailability to the same total dose of Suboxone® (buprenorphine and naloxone) sublingual tablets.

Switching between Suboxone® (buprenorphine and naloxone) Sublingual Film and Suboxone® Sublingual Tablets

Because of the potentially greater relative bioavailability of Suboxone® sublingual film compared to Suboxone® (buprenorphine and naloxone) sublingual tablets, patients switching from Suboxone® (buprenorphine and naloxone) sublingual tablets to Suboxone® sublingual film should be monitored for over-medication. Those switching from Suboxone® sublingual film to Suboxone® (buprenorphine and naloxone) sublingual tablets should be monitored for withdrawal or other indications of under-dosing. In clinical studies, pharmacokinetics of Suboxone® sublingual film were similar to the respective dosage strengths of Suboxone® (buprenorphine and naloxone) sublingual tablets, although not all doses and dose combinations met bioequivalence criteria.

Switching between Suboxone® Sublingual Tablets or Films and Bunavail® Buccal Film

The difference in bioavailability of Bunavail® compared to Suboxone® sublingual tablet requires a different dosage strength to be administered to the patient. A Bunavail® 4.2/0.7 mg buccal film provides equivalent buprenorphine exposure to a Suboxone® 8/2 mg sublingual tablet. Patients being switched between Suboxone® dosage strengths and Bunavail® dosage strengths should be started on the corresponding dosage as defined below:

Suboxone® Sublingual Tablet Dosage Strength	Corresponding Bunavail® Buccal Film Strength
4/1 mg buprenorphine/naloxone	2.1/0.3 mg buprenorphine/naloxone
8/2 mg buprenorphine/naloxone	4.2/0.7 mg buprenorphine/naloxone
12/3 mg buprenorphine/naloxone	6.3/1 mg buprenorphine/naloxone

Dosage and Administration of Zubsolv®

The difference in bioavailability of Zubsolv® compared to Suboxone® tablet requires a different tablet strength to be given to the patient. One Zubsolv® 5.7/1.4 mg sublingual tablet provides equivalent buprenorphine exposure to one Suboxone® 8/2 mg sublingual tablet. The corresponding doses ranging from induction to maintenance treatment are:

Induction phase: Final sublingual buprenorphine dose	Maintenance phase: Corresponding sublingual Zubsolv® dose
8 mg buprenorphine, taken as:	5.7 mg/1.4 mg Zubsolv®, taken as:
• One 8 mg buprenorphine tablet	• One 5.7 mg/1.4 mg Zubsolv® tablet
12 mg buprenorphine, taken as:	8.6 mg/2.1 mg Zubsolv®, taken as:
• One 8 mg buprenorphine tablet AND	• One 8.6 mg/2.1 mg Zubsolv® tablet
• Two 2 mg buprenorphine tablets	
16 mg buprenorphine, taken as:	11.4 mg/2.9 mg Zubsolv®, taken as:
• Two 8 mg buprenorphine tablets	• One 11.4/2.9 mg Zubsolv® tablet

Switching between Zubsolv® Sublingual Tablets and other buprenorphine/naloxone combination products

For patients being switched between Zubsolv® sublingual tablets and other buprenorphine/naloxone products dosage adjustments may be necessary. Patients should be monitored for over-medication as well as withdrawal or other signs of under-dosing.

The differences in bioavailability of Zubsolv® compared to Suboxone® tablet requires that different tablet strengths be given to the patient.

One Zubsolv® 5.7/1.4 mg sublingual tablet provides equivalent buprenorphine exposure to one Suboxone® 8/2 mg sublingual tablet.

When switching between Suboxone® dosage strengths and Zubsolv® dosage strengths the corresponding dosage strengths are:

Suboxone® sublingual tablets (including generic equivalents)	Corresponding dosage strength of Zubsolv® sublingual tablets
One 2 mg/0.5 mg buprenorphine/naloxone sublingual tablet	One 1.4 mg/0.36 mg Zubsolv® sublingual tablet
One 8 mg/2 mg buprenorphine/naloxone sublingual tablet	One 5.7 mg/1.4 mg Zubsolv® sublingual tablet
12 mg/3 mg buprenorphine/naloxone, taken as:	One 8.6 mg/2.1 mg Zubsolv® sublingual tablet
• One 8 mg/2 mg sublingual buprenorphine/naloxone tablet AND	
• Two 2 mg/0.5 mg sublingual buprenorphine/naloxone tablets	
16 mg/4 mg buprenorphine/naloxone, taken as:	One 11.4 mg/2.9 mg Zubsolv® sublingual tablet
• Two 8 mg/2 mg sublingual buprenorphine/naloxone tablets	

Appendix III: Guideline Committee Member Relationships with Industry and Other Entities

Guideline Committee Member	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, Organizational or other financial benefit	Salary	Expert Witness	Other
Sandra D. Comer, PhD	Columbia University and NYSPI	• J&J	None	None	• Reckitt Benckiser**	None	None	None	None
	New York, NY	• AstraZeneca			• Omeras**				
	Professor of Neurobiology	Salix			• Medicinova**				
		• Cauarus							
		• Pfizer							
		• Mallincrodt							
Chinazo Cunningham, MD, MS	Albert Einstein College of Medicine, Yeshiva University	None	None	None	None	None	None	None	Quest Diagnostics**
	Bronx, NY								
Marc Fishman, MD, FASAM	Maryland Treatment Centers	• CRC Health Group, Advisory Board	None	Maryland Treatment Centers**	• Alkermes	None	Maryland Treatment Centers**	Board of Physician case reviews	None
	Baltimore, MD	• NY State JBS/SAMHSA Youth Opioid Addiction Project			• US World Meds**				
	Medical Director	• University of Maryland			• NIDA**				
Adam Gordon,	University of Pittsburgh and VA Pittsburgh Healthcare System	None	None	None	None	None	None	None	None
MD, MPH, FASAM									
Kyle Kampman, MD, TRI (Chair and Principal Investigator)	University of Pennsylvania	None	None	None	Braeburn Pharma	None	None	None	None
	VAMC								
	Philadelphia, PA								
	Professor of Psychiatry/Staff Physician								
Daniel Langleben, MD	University of Pennsylvania	None	None	None	Alkermes	None	None	None	None
	Philadelphia, PA								
	Associate Professor								
Benjamin Nordstrom, MD, PhD	Dartmouth College	None	None	None	None	None	None	None	None
	Hanover, NH								
	Associate Professor of Psychiatry								
	Director of Addiction Services								
	Director, Addiction Psychiatry Fellowship								

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Guideline Committee Member	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, Organizational or other financial benefit	Salary	Expert Witness	Other
David Oslin, MD	University of Pennsylvania Medical Center	None	None	None	Department of Veteran Affairs, State of Pennsylvania	None	None	None	None
	Philadelphia, PA								
	Associate Professor of Psychiatry								
	Associate Chief of Staff, Behavioral Health								
George Woody, MD	Perelman School of Medicine	RADARS Scientific Advisory Board**	None	None	• Alkermes**	None	NIDA **	• U.S. Attorney's Office and DEA, Philadelphia**	None
	University of Pennsylvania				• Reckitt Benckiser**			• Pennsylvania Bureau of Professional and Occupational Affairs**	
	Philadelphia, PA				• Fidelity Capital**				
	Professor, Department of Psychiatry								
Tricia E. Wright, MD, MS	University of Hawaii	None	None	None	None	None	None	None	None
	John A. Burns School of Medicine								
	Honolulu, HI								
	Assistant Professor								
Stephen A. Wyatt, D.O.	Carolinas Healthcare System	None	None	None	None	None	None	None	None
	Medical Director, Addiction Medicine								
	Charlotte, NC								

The above table presents the relationships of Guideline Committee Members during the past 12 months with industry and other entities that were determined to be relevant to this document. These relationships are current as of the completion of this document and may not necessarily reflect relationships at the time of this document's publication. A person is deemed to have a *significant* interest in a business if the interest represents ownership of 5% or more of the voting stock or share of the business entity, or ownership of $10,000 or more of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of the person's gross income for the previous year. A relationship is considered to be *modest* if it is less than *significant* under the preceding definition. *No financial relationship* pertains to relationships for which there is no monetary reimbursement.**Indicates significant relationship.

Appendix IV: ASAM Quality Improvement Council (Oversight Committee) Relationships with Industry and Other Entities

Oversight Committee Member	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, organization, or Other Financial Benefit	Salary	Expert Witness	Other
John Femino, MD, FASAM	Meadows Edge Recovery Center North Kingstown, RI Medical Director	Inflexxion** Dominion Diagnostics**	None	None	None	None	None	None	None
Margaret Jarvis, MD, FASAM, *Chair*	Marworth/Geisinger Health System Waverly, PA Medical Director of Marworth	None	None	U.S. Preventive Medicine	None	None	Geisinger Health System**	Preston vs. Alpha Recovery Centers	Royalties-addiction article
Margaret Kotz, DO, FASAM	University Hospitals of Cleveland Cleveland, OH Case Medical Center Medical Director, Addiction Recovery Services Professor of Psychiatry and Anesthesiology Case Western Reserve University School of Medicine	None	None	None	None	None	None	None	None
Sandrine Pirard, MD, MPH, PhD	John Hopkins Bayview Medical Center Baltimore, MD Psychiatrist	None	None	None	None	None	None	None	None
Robert Roose, MD, MPH	Sisters of Providence Health System Holyoke, MA CMO, Addiction Services	None	None	None	None	None	None	None	None

The above table presents the relationships of the **ASAM Quality Improvement Council (Oversight Committee)** during the past 12 months with industry and other entities that were determined to be relevant to this document. These relationships are current as of the completion of this document and may not necessarily reflect relationships at the time of this document's publication. A person is deemed to have a *significant* interest in a business if the interest represents ownership of 5% or more of the voting stock or share of the business entity, or ownership of $10,000 or more of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of the person's gross income for the previous year. A relationship is considered to be *modest* if it is less than *significant* under the preceding definition. *No financial relationship* pertains to relationships for which there is no monetary reimbursement.**Indicates significant relationship.

Appendix V: External Reviewer Relationships with Industry and Other Entities

External Reviewer	Representation	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, organizational or other financial benefit	Salary	Expert Witness	Other
B. Steven Bentsen, MD, DFAPA	Value Options	Beacon Health Options	None	None	None	None	Beacon Health Options-Medical Director**	None	None	None
		Regional Chief Medical Officer								
Melinda Campopiano, MD	Substance Abuse Mental Health Services Administration (SAMHSA)	SAMHSA	None	None	None	None	None	None	None	None
		Medical Officer								
Timothy Cheney	Faces and Voices of Recovery (FAVOR)	Chooper's Guide	• FAVOR	None	None	None	None	None	None	None
		Managing Partner	• Floridians for Recovery							
			• Maine Harm Reduction Coalition							
			• C4 Recovery Solutions**							
H. Westley Clark, MD	Individual Reviewer	Santa Clara University	None	None	None	None	None	None	None	None
		Dean's Executive Professor, Public Health Program								
Kelly Clark, MD, MBA, FASAM, DFAPA	Individual Reviewer-ASAM Board Member	Clean Slate Addiction Treatment Centers	• Grunenthal US	None	• CVS Caremark	None	None	BHG**	None	None
			• Behavioral Health Group (BHG)**		• Clean Slate**			Clean Slate **		
			• Clean Slate**							
Itai Danovitch, MD	Individual Reviewer– ASAM State Chapter Leader	Cedars-Sinai Medical Center	None	None	None	None	None	None	None	None
		Chairman, Dept of Psychiatry								
Karen Drexler, M.D.	U.S. Department of Veterans Affairs	Department of Veterans Affairs	None	None	None	None	None	None	None	None
		Deputy National Program Director- Addictive Disorders								
Michael Fingerhood, MD	Individual Reviewer	John Hopkins University	None	None	None	None	None	None	None	None
		Associate Professor of Medicine								
Kevin Fiscella, MD, MPH	National Commission on Correctional Health Care (NCCHC)	University of Rochester	None	None	None	None	None	None	None	None
		Professor, Family Medicine, Public Health Science								
Rollin M. Gallagher, MD, MPH	Individual Reviewer	Philadelphia VA Medical Center	None	None	None	None	None	None	None	None
		National Program Director for Pain Management								
D. Ray Gaskin Jr., MD FASAM	Individual Reviewer-Georgia Chapter President	Self-employed	None	• Reckitt Benckiser	None	None	None	None	None	None
		Physician		• Orexo						

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External Reviewer	Representation	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, organizational or other financial benefit	Salary	Expert Witness	Other
Stuart Gitlow, MD, MPH, MBA, FAPA	Individual Reviewer-President, ASAM	Self-employed Physician	Orexo Medical Director (January-June 2014)**	None	None	None	None	None	None	None
Dennis E. Hagarty, MSN, RN, CARN-AP, LCAS	International Nurses Society on Addiction (IntNSA)	Charles George VAMC	None	None	None	None	None	None	None	None
Henrick J. Harwood	National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD)	NASADAD	None	None	None	None	None	None	None	None
		Deputy Executive Director								
Frank P. James, MD JD	Optum/UBH	United HealthCare	None	None	None	None	None	None	None	None
		Associate Medical Director								
Hendree Jones, MD	Individual Reviewer	University of North Carolina	None	None	None	None	None	None	None	None
		Executive Director/Professor OB/GYN								
Miriam Komaromy, MD	Individual Reviewer	University of New Mexico, Echo Institute	None	None	None	None	None	None	None	None
		Associate Director, Echo Institute								
Mark L. Kraus, M.D., FASAM, DABAM	Individual Reviewer-ASAM Board Member	Franklin Medical Group, PC	• BioDelivery Services, International; • Indivior/ Reckitt Benckiser; • PCM Healthcare	• Biodelivery Services International; • Indivior/Reckitt Benckiser; • PCM HealthcareASAM; Coalition on Physician Education on Substance Use Disorders	None	None	None	None	Defendant physician on regarding proper scope of practice	None
		Asst. Clinical Professor of Medicine, Yale University School of Medicine; Chief Medical Officer, Connecticut Counseling Centers								
Joshua D. Lee, MD MSc	Individual Reviewer	NYU School of Medicine	None	None	None	Alkermes; Reckitt Benckiser**	None	None	None	None
		Associate Professor/Physician								
David Mee-Lee, MD	Individual Reviewer	The Change Companies	None	None	None	None	None	None	None	None
		Senior Vice-President								
Frances R. Levin, MD	American Psychiatric Association (APA)—Council on Addiction Psychiatry	Columbia University	GW Pharmaceuticals	None	None	US World Med	None	None	None	None
		Kennedy Leavy Professor of Psychiatry at CUMC								
Petros Levounis, MD	Individual Reviewer	Rutgers NJ Medical School	None	None	None	None	None	None	None	None
		Chair, Department of Psychiatry								
Sharon Levy, MD	American Academy of Pediatrics (AAP)	Boston Children's Hospital	None	None	None	None	None	None	None	None
		Director, Adolescent Substance Abuse Program								

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External Reviewer	Representation	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, organizational or other financial benefit	Salary	Expert Witness	Other
Michelle Lofwall, MD	Individual Reviewer-Past President, ASAM Kentucky Chapter	University of Kentucky	• PCM Scientific (Reckitt Benckiser)	None	None	Braeburn Pharmaceuti-cals	None	None	None	None
		Associate Professor, Behavioral Science and Psychiatry	• CVS Caremark							
Ed Madalis, LPC	Geisinger Health Plan	Geisinger Health Plan	None	None	None	None	None	None	None	None
		Lead Behavioral Health Coordinator								
Steven C. Matson, MD	Individual Reviewer—ASAM Ohio Chapter President	Nationwide Children's Hospital	None	None	None	None	None	None	None	None
		Chief, Division of Adolescent Medicine, Associate Professor of Pediatrics								
Michael Miller, MD, FASAM, FAPA	Individual Reviewer	Medical Director	Curry Rockefeller Group	• Alkermes	None	None	• Braeburn Pharma	None	None	None
		Herrington Recovery Center		• BDSI			• BDSI			
Ivan Montoya	National Institute for Drug Abuse (NIDA)	NIDA Deputy Director, DPMC	None	None	None	None	None	None	None	None
Douglas Nemecek, MD, MBA	CIGNA	CIGNA	None	None	None	None	None	None	None	None
		Chief Medical Officer-Behavioral Health								
Yngvild Olsen, MD	Individual Reviewer—ASAM Maryland Chapter President	Institutes for Behavior Resources, Inc.	None	CORE REMS	None	Friends Research Institute	None	Institutes for Behavior Resources, Inc.**	None	None
		Medical Director								
David Pating, MD	Individual Reviewer	Permanente Medical Group	None	None	None	None	None	None	None	None
		Chief, Addiction Medicine, Kaiser SFO								
Ashwin A. Patkar, MD	Individual Reviewer	Duke University Medical Center Professor of Psychiatry and Community and Family Medicine	• Reckitt Benckiser	BDSI, Alkermes	Generys Biopharma	• PI Forest Research Institute	None	None	None	None
			• BDSI			• Co-I NIDA and SAMHSA grants				
			• Cubist			• PI Titan Pharma–ceuticals **				
			• Titan Pharma							
			• Braeburn Pharm							
Jeffrey Quamme, MD	Individual Reviewer	Connecticut Certification Board	None	None	None	None	None	None	None	None
		Executive Director								

(*Continued*)

External Reviewer	Representation	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, organizational or other financial benefit	Salary	Expert Witness	Other
John A. Renner, Jr., MD	American Psychiatric Association (APA)—Council on Addiction Psychiatry	VA Boston Healthcare System Associate Chief of Psychiatry	National Institute on Drug Abuse, Clinical Trials Network	None	None	None	• Depart-ment of Psychiatry Boston University Center • Psychiatric Assoc, Consultant and Council on Addiction Psychiatry • Academy of Addiction Psychiatry Consultant & Board of Trustees	VA Boston Healthcare System**	None	None
Robert L. Rich, Jr. MD, FAAFP	American Academy of Family Physicians (AAFP)	Community Care of the Lower Cape Fear Medical Director/Reviewer	None	None	None	None	None	Community Care of the Lower Cape Fear	None	None
A. Kenison Roy III, MD	Individual Reviewer-ASAM Board Member	Biobehavioral Medicine Company, LLC Owner/Medical Director	Orexo, Biobehavioral Sciences, Inc. (BDSI)	• Orexo, • BDSI, • Alkermes	Addiction Recov-ery Resources, Inc.**	None	None	None	None	None
Albert A. Rundio, Jr. PhD	International Nurses Society on Addictions (IntNSA)	Drexel University Associate Dean for Post-Licensure Nursing Programs and CNE	None	None	None	None	None	None	None	None
Edwin Salsitz, M.D.	Individual Reviewer	Mount Sinai Beth Israel Physician	None	None	None	None	None	None	None	None
Andrew J. Saxon, MD	American Psychiatry Association (APA)—Council on Addiction Psychiatry	Department of Veterans Affairs Director, Center of Excellence in Substance Abuse Treatment and Education	None	None	None	• NIDA CTN grant** • Alkermes • ReckittBen-cker	None	None	None	None
Ian A Shaffer, MD	Healthfirst	Executive Medical Director & VP	None	None	None	None	None	None	None	None
Dominique Simon	Allies in Recovery	Allies in Recovery Director	None	None	None	None	None	None	None	None
Sandra Springer, MD	Individual Reviewer	Yale School of Medicine Associate Professor of Medicine	None	None	None	NIH-funded research**	None	None	None	Free drug and placebo from Alker-mes

(*Continued*)

External Reviewer	Representation	Employment	Consultant	Speakers Bureau	Ownership/ Partnership/ Principal	Personal Research	Institutional, organizational or other financial benefit	Salary	Expert Witness	Other
Knox Todd, MD. MPH	American College of Emergency Physicians (ACEP)	MD Anderson Cancer Center	Kaleo, Inc.	None	None	None	Depomed, Inc.	None	None	None
		Professor and Chair of Emergency Medicine								
Howard Wetsman, MD	Individual Reviewer-ASAM Board Member	Self-employed	None	None	• Wetsman Forensic Medicine	None	None	None	None	None
		Chief Medical Officer			• KHM LLC dba Sagenex Labs					
					• Rush Medical					
					• Idea Breeder LLC,					
					• Tres Amigos LLC					
					• Keystone Acquisition LLC					
Amanda Wilson, MD	Individual Reviewer	Clean Slate Addiction Treatment Centers	None	None	Clean Slate Centers, Inc. **	None	None	Clean Slate	None	None
		President and CEO						Centers, Inc.**		
Celia Winchell	Food and Drug Administration (FDA)	Medical Team Leader	None	None	None	None	None	None	None	None
		Food and Drug Administration								

The above table presents the relationships of invited external reviewers during the past 12 months with industry and other entities that were determined to be relevant to this document. These relationships are current as of the completion of this document and may not necessarily reflect relationships at the time of this document's publication. A person is deemed to have a *significant* interest in a business if the interest represents ownership of 5% or more of the voting stock or share of the business entity, or ownership of $10,000 or more of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of the person's gross income for the previous year. A relationship is considered to be *modest* if it is less than *significant* under the preceding definition. *No financial relationship* pertains to relationships for which there is no monetary reimbursement.**Indicates significant relationship.

Adopted by the ASAM Board of Directors June 1, 2015.

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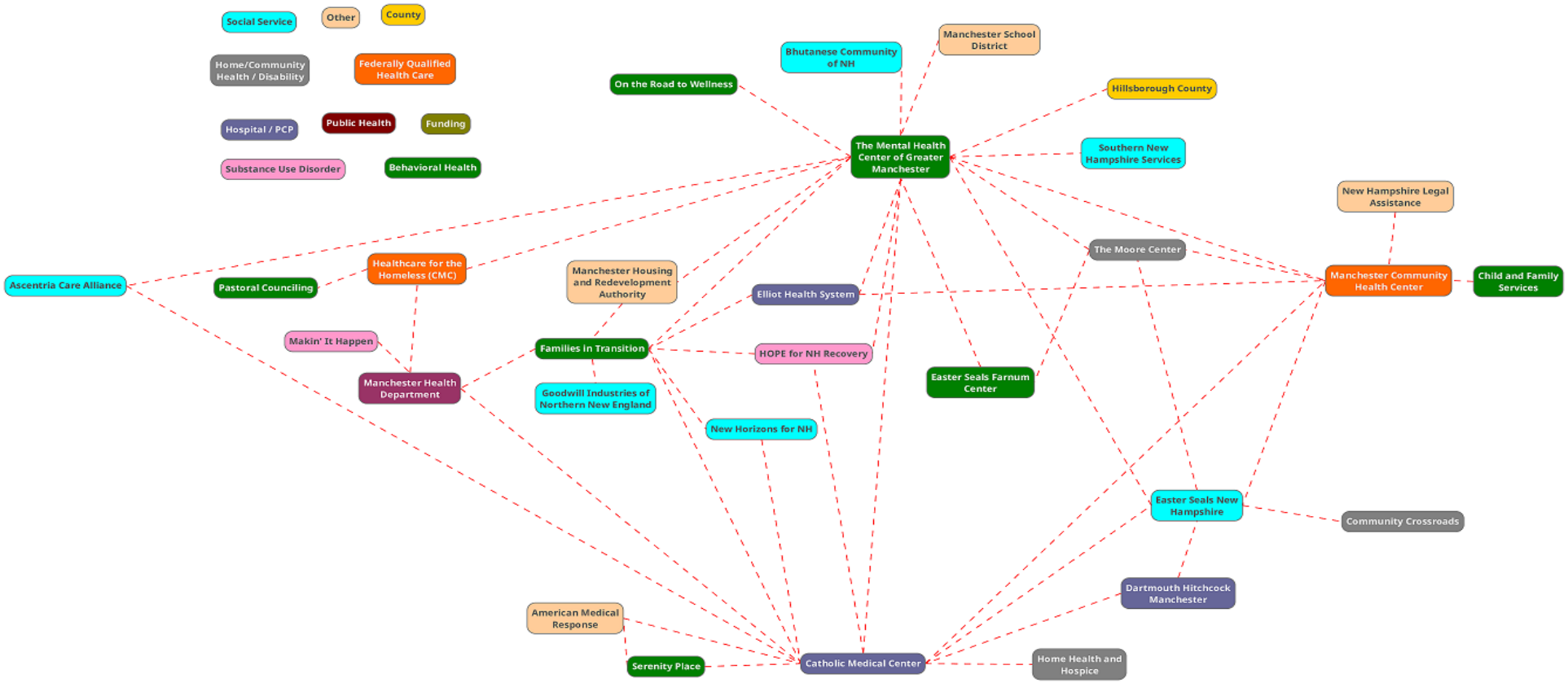
PCMH Patient Data (5/18/16 - 5/18/17)

Sorted by Patient Score (Based on Established Risk Identifiers)

Total Patients: 1672

						ER Visits		Housing		Diabetes		Hypertension			COPD		Behavioral Health		Missed Appts		Patient
ID	Patient Name	DOB	Gender	Age	Race	Visits	Score	Status	Score	A1C	Score	Systolic	Diastolic	Score	Meds	Score	ICD	Score	#	Score	Score
			M	61	Caucasian	39	2	STREET	2			146	92	1			F32.9	1			6
			M	66	Caucasian	121	2	STREET	2			180	100	1							5
			F	49	White/Caucasian	17	2					153	104	1			F32.9	1	11	1	5
			M	56	White/Caucasian	14	2	STREET	2										6	1	5
			F	59	Caucasian	9	2					145	92	1			F31.9 F32.9	1	7	1	5
			M	60	White/Caucasian			STREET	2						3	1	F32.9	1			4
			F	50	White/Caucasian	4	2					157	98	1			F32.9	1			4
			F	55	White/Caucasian	5	2	STREET	2												4
			M	53	White/Caucasian	8	2	STREET	2												4
			M	51	White/Caucasian	5	2			10.80	1						F32.9	1			4
			F	55	White/Caucasian	7	2										F31.81 F32.9 F60.3	1	8	1	4
			M	44	White/Caucasian	4	2										F25.9 F31.9	1	8	1	4
			F	45	More Than One Race			STREET	2						3	1					3
			M	48	Black/African American	3	2								3	1					3
			M	47	White/Caucasian	3	2								3	1					3
			M	61	White/Caucasian			STREET	2						4	1					3
			M	54	White/Caucasian	5	2								3	1					3
			M	51	White/Caucasian			STREET	2						3	1					3
			F	50	White/Caucasian	4	2								3	1					3
			F	51	White/Caucasian							167	102	1	3	1	F31.9 F43.10	1			3
			M	57	White/Caucasian	13	2												5	1	3
			M	50	White/Caucasian	23	2			9.50	1										3
			M	61	White/Caucasian	15	2										F20.9	1			3


Social Service
Other
County
Home/Community Health / Disability
Federally Qualified Health Care
Hospital / PCP
Public Health
Funding
Substance Use Disorder
Behavioral Health
Bhutanese Community of NH
Manchester School District
On the Road to Wellness
Hillsborough County
The Mental Health Center of Greater Manchester
Southern New Hampshire Services
New Hampshire Legal Assistance
The Moore Center
Ascentria Care Alliance
Pastoral Counciling
Healthcare for the Homeless (CMC)
Manchester Housing and Redevelopment Authority
Elliot Health System
Manchester Community Health Center
Child and Family Services
Makin' It Happen
Families in Transition
HOPE for NH Recovery
Manchester Health Department
Goodwill Industries of Northern New England
Easter Seals Farnum Center
New Horizons for NH
Easter Seals New Hampshire
Community Crossroads
Dartmouth Hitchcock Manchester
American Medical Response
Serenity Place
Catholic Medical Center
Home Health and Hospice

	Organization	Economic Stability	Neighborhood/ Physical Environment	Education	Food	Community & Social Context	Medical Health Care	Behavioral Health & Substance Abuse	Social Services	Housing
Member of Integrated Care Team?	**Social Determinants areas of focus**	**Employment, Finance, Budgeting classes, TANF, city welfare, etc**	**Exercise Classes, PALs, Neighborhood Watch, Weed & Seed, etc**	**Voc Rehab, training programs, etc**	**Community Gardens, food pantries, drop-in meals**	**Support groups, networking, Welcoming Immigrants initiatives, etc**	**Primary Care, Inpatient Care, Specialty Care, Nurse Programs, Health Ed**	**Inpatient, Outpatient, IOP, Partial Hosp, Crisis Int, Trans Housing, Detox, MAT**	**Case management, Legal assistance, other**	**Subsidies like Sec 8, Tax Credit prop, homeless shelters, trans living, vouchers, etc.**
Yes	The Bhutanese Community of NH	Job coaching and job placement, employment counseling and assistance		ESL classes: three classes including one on the weekends . After school program: homework help with children 6-13. Youth council for youth. Provide ASL classes for deaf/hard of hearing clients in the Bhutanese community.	Nutrition education program for food resource management, physical activity and food safety education.	Focused on the Bhutanese community		Trained three individuals from the community as Suicide Prevention Trainers through NAMI, referred individuals at mental health risk for professional help, and offered sessions on Mental Health First Aid Training.	Women's engagement program: home visiting, counseling and daily case management. Legal assistance program; helping clients receive legal advice and has an attorney to help with filings. Senior citizen engagement program (case management, socialization, community activities)	
Yes	Catholic Medical Center					Provide classes from nutrition to support groups around medical conditions. Some classes are free, some classes require a fee. Provide interpreting services.	Multitude of specialty medical services from primary care to urgent care. Includes (but not limited to) bariatric, breast cancer care, diabetes management, rehabilitation services, respiratory services, sleep care, stroke care, wound card, urology, radiology, neurosurgery, cardiac care, emergency department, orthopedics, and obstetrics.	Provide behavioral health services to adults on outpatient basis. Have clinicians available for crisis services through the emergency department. Provides outpatient MAT program to pregnant women only.	Social workers are available through the departments to assist with community resources and case management.	
Yes	Center for Life Management			Employment Assistance Program for Businesses. Helping businesses support their employees mental health and stress levels		Provides support groups for teens, adults around mental health and substance use issues. Also providing groups specializing in military families.		Mental health and substance use services, for adults, children and families. Provide individual services, group services, couple services. Emergency services available for crisis. (Will be offering transcranial magnetic stimulation therapy TBD) Reiki therapy.		
Yes	Child and Family Services			Adoption/foster care support and classes. Parent line and parental support programs.	Food resources available through the teen drop in center for homeless youth	School based programming for adolescents (life skills training, violence prevention, information and referral, supportive counseling). Parent line allows clients to call in to speak with a CFS counselor to discuss developmentally appropriate discipline techniques, parental support). Host several support groups at their Manchester site (FASTER, CODA, Grandparents raising grandchildren, grief after substance passing, positive solutions for families)		Provides an adolescent substance abuse program (treatment planning, 24 hour support, LADC counseling, group sessions) Family, children, couples, and youth counseling (available day and evening hours--focusing on any of life's stressor such as divorce, anxiety, fears, PTSD, etc.) . Pregnancy, adoption counseling.	Home visiting for prenatal, elderly populations (support with independent living, home-making). Home-based intensive services. Teen resource center, specializing in homeless and runaway youth (providing case management, referrals, information). School based assistance (life skills training, violence prevention, supportive counseling)	Transitional living program for adolescents

Yes	Crotched Mountain Community Care								Senior citizens and people with disabilities receive care management in home; connect clients to community resources so they can continue to live independently.	
Yes	Dartmouth-Hitchcock-Manchester			Provide classes and trainings but mostly available at the Lebanon location; however some available as a hybrid where can be taken online. Classes include Basic Life Support, Nonviolent crisis intervention, ECG, and moderate sedation courses		Provide support groups but located in Lebanon, NH and Vermont locations. (Veteran support, cancer support groups, bereavement groups and condition-focused groups). Provide interpretation services.	Multitude of specialty medical services from primary care to urgent care. Includes (but not limited to) audiology, bariatric, cancer services, fertility services, diabetes, dieticians, ENT, hematology, ID, genetics, gynecology, gastroenterology, nutrition, neurology, optometry, radiology, and uro/gynecology.		Support services available with nurse care coordination, as well as social workers to help connect patients to resources, as well as plan for safe discharges (main office is in Lebanon, NH but nurses/social workers assist at all sites)	
Yes	Easter Seals New Hampshire/ Farnum	Provide GED, HISET classes. Provides job placement and training for individuals with disabilities						Mental health and substance use services for military and veteran patients, outpatient setting. Farnum Center: provides variety of services for substance use (inpatient, outpatient, detox, intensive outpatient programs, and suboxone clinics) Residential programs available for youth with developmental delays (psychiatric services, in home services, foster care, school support, care management, crisis support).	Specializing in Autism services (care coordination), Early support and educational services for children (developmental screenings, resource coordination, care management), dental services (variety of dental services for adults and children), senior services (day programs, independent living support services, home visiting) military/veteran services (care coordination, veterans count) workforce development, child development (educational programming ages 6 weeks to 5 years old), and camps/recreation services (for clients with disabilities), transportation services (special transit services for elderly)	
Yes	Elliot Health System					Offering some support groups but all cost a fee. (Emotional eating, IBS, women trauma, women's coping skills, women's self care, bereavement)	Multitude of specialty medical services from primary care to urgent care. Includes (but not limited to) neurology, oral health, orthopedics, pain management, pulmonary health, rheumatology, sleep evaluation, sports medicine, trauma and acute care, breast health, cancer services, dermatology, endocrinology, gastro, maternity services, maternal fetal medicine, memory and mobility services, urgent care and wound care.	Outpatient counseling services; psychotherapy. Med evaluation services, consultations. BURT team is located at the hospital for inpatient patients struggling with substance use and mental health.		

Yes	Families in Transition	Employment search advocacy in collaboration with Goodwill Industries of NNE, budgeting,	Outfitters Thrift Store. Training opportunities at the Training Institute for organizations/groups.	Therapeutic Preschool services for homeless children- offered at the Family Center in collaboration with SNHS – Head Start.	Family Shelter, emergency pantries for agency participants	Life skills, youth activities, pro-social family activities recovery support groups	Family and women health care clinic at Family Place in collaboration with CMC – Healthcare for the Homeless (MCHT)	Family Willows- IOP/OP for single women and pregnant/parenting women. Mobile SUD Outpatient team to participants in FIT housing, including individual and child/family therapy. Recovery Housing in late summer 2017, offering 11 one bedroom apartments for women in recovery with children and 8 multiple occupancy rooms for single women in recovery.	Case management services for all supportive housing programs.	Various housing options Family emergency shelter. Transitional and Permanent Supportive Housing for homeless singles and families, Affordable housing.
Yes	Healthcare for the Homeless	Provide supports and assistance with enrolling with Medicaid, Food stamps	Street Outreach Nurse-4 days a week		Refers out- New Horizons	Networks with community resources	Physicians, three nurse practitioners, a psychiatric nurse practitioner, three nurses. Services primarily offered daily at New Horizons shelter. Services also available at other locations; FIT. Dental services, eye care services available. No appt is necessary	Mental health and addiction counseling is available.	Social Worker on staff	
Yes	MCHC/CHS/WSNHC	Medicaid enrollment, Case managers available to assist patients/families with signing up for any public benefits necessary.	Home based nursing services and community health workers; home visits, biweekly phone calls. Multiple clinic locations throughout Manchester.	GED prep, US immigration test prep/Family Literacy program	food pantry at CHS, clothing/diapers/shoes	Translators for various languages. Child care for most programs/literacy night.	Full medical services; prenatal, primary care for pediatrics, adolescents and adult. Specialty care; gynecology, podiatric diabetic. ARNP services. Dental services (limited to children).	Outpatient MAT program (suboxone, vivitrol). Individual counseling for mental health and addictions. Initial assessments to determine appropriate level of care. APS school based services; brief preventive counseling services servicing Manchester elementary, middle and high schools.	Case management at all locations. NH Medical-Legal partnerships offering assistance with legal issues relative to housing, education/special ed./public benefits. Medical services offered to uninsured patients.	Transportation to medical appts, case managers assist with vouchers, locating shelters, app for Section 8 housing, and other public services.
Yes	Upper Room		Community education offered-relative to mental health and suicide prevention			Various support groups for individuals and family. Online support available. Veteran and Military Family supports available		Support groups/ office based and online	Advocacy services available	
Yes	NAMI NH	Assistance towards these services provided through the Seacoast Pathways day program.	Statewide Addiction Crisis Hotline -connects individual or family to help within 24 hours		Drop in peer-led recovery center.	Various support groups for individuals and family. Focus on mental health and addictions.		Clubhouse- peer led mental health support center. Safe Harbor peer led addictions recovery center.	available at Seacoast Pathways Day program	
Yes	Fed Cap/Granite Pathways	Assistance towards these services provided through the Seacoast Pathways day program.	Statewide Addiction Crisis Hotline -connects individual or family to help within 24 hours		Drop in peer-led recovery center.	Various support groups for individuals and family. Focus on mental health and addictions.		Clubhouse- peer led mental health support center. Safe Harbor peer led addictions recovery center.	available at Seacoast Pathways Day program	
Yes	Parkland Medical Center					outpatient support groups for medical and behavioral health.	Full hospital based services	Adult inpatient and outpatient (PHP) mental health program. No info on website relative to addictions, specifically.	CM available	

Yes	The Mental Health Center of Greater Manchester	Clinical Case Managers provide assistance with helping clients connect to services, coordinate with Representative Payees and guardians and assist with budgeting, benefits, and insurance. Supported Employment Specialists assist clients in obtaining and maintaining employment. Peer Specialist/Recovery Coaches assist with applications for community resources. Benefits Specialists assist with Medicaid applications. Supported Employment Specialists assist clients in obtaining and maintaining employment. Peer Specialist/Recovery Coaches assist with applications for community resources. Benefits Specialists assist with Medicaid Linkage to Income Tax preparation to get the Earned Income Credit	Mobile Crisis Response Team: effective 12/16. 24/7 Emergency and Interim Care Services. In-Shape : Health mentors develop exercise, nutrition, smoking cessation and other health improvement plans to improve health status and mitigate effects of long term medication use. A variety of individual and group activities offered on a weekly basis in the community. Social inclusion a primary goal. Residential and Housing Outreach Services to support clients and obtaining and maintaining independent living. Three residential programs staffed 24/7, 50 beds.	Continuing education for professionals and non-clinical staff, including Skill Enrichment Series to ensure Core BH Competencies. Supported Employment Specialists assist in education planning(GED, College) as a step toward employment. Liaison to Vocational Rehabilitation Clinical staff provides licensure supervision to candidates within and outside the agency REAP counselor provides education to community partners on Seniors needs and access to care	Clinical case Managers link clients to food bank and other resources, as well as, assist with grocery shopping and nutrition plans. In-Shape and residential services have acquired community gardens, and assist clients with their tending. In Shape works with the UNH Cooperative Extension to provide cooking classes, and with Hannaford Nutritionist to provide nutrition counseling.	Mental Health Court Various family and individual support groups. Child Impact Classes Peer Specialists (Intentional Peer Support and Certified Recovery Coaches). Contract with the Bhutanese Center of NH for peer outreach and culturally competent support services. Community Advisory Board with MPD. Mental Health First Aide Classes. Stigma Initiative targeting both internal and external presentations. On demand BH Community Presentations(84 done in FY 16). PATh Outreach Worker REAP Services Teach pre-op education program to bariatric surgery candidates at Catholic Medical Center, facilitate bariatric post-op support groups	Psychiatric medication management. PCP Coordination through letter communication , CDC's, and In Shape Health Mentors. Wellness Clinic: Nurses in Community Support Services assist with medication management and education, health education, etc..). Psychiatric NP is part of Healthcare for the Homeless Clinic. Bilingual Social Worker outstationed at MCHC. Psychiatric NP provides BH services at HCHOC , 1x per week. Psychiatric NP stationed at Easter Seals 18 hrs/wk. Psychiatrist stationed at Moore Center 1x per week. Social Worker stationed at YWCA DV Crisis Center 1x per week. Genoa Specialty Pharmacy Services	Cypress Center - an adult 16 bed unit, technically known as an Acute Psychiatric Residential Treatment Program; licensed as a Designated Receiving Facility by the NH Department of Health and Human Services. Three Outpatient Counseling locations in Manchester. Vivitrol Clinic located at 2 Wall St. (assessment, medication , individual and group counseling, nurse coordination). Partner with Farnum to administer Subuxone Clinic. Mobile Crisis Response Crisis Apartments (1-7 day stay). Psychiatric NP provide psychiatric medication management to residential and outpatient clients at Farnum Center. Emergency Psychiatric Treatment in the CMC & EHS ED's Immediate assessment/appointment for identified PHQ-9	IN and OP case management services provided. Mental Health Court and BH intercept model. Case Management services to develop natural supports, enhance social inclusion and access to community resources including legal assistance	Three Residential programs with a total of 50 beds: 12 beds HUD subsidized, 4 beds Section 8, 34 beds MH subsidized. Mobile Crisis Response Crisis Apartments-4 beds. Supported Housing Services (HOT) PATH outreach worker assists New Horizon shelter staff with local Housing First Program REAP counselor assists people over 59 1/2 with housing assistance MHA liaison attends PAC meetings and is contact for any house issues MHA Collaboration - Log St. Apartments
Yes	The Moore Center	Employment services provided to adults with disabilities include: career development, job development, and customized employment with job supports.				Parent to Parent and Respite supports (educational information, workshops, and transitional planning).	Nursing Services includes medication oversight, assistance is supplied through education, one-on-one support, and 24-hour Nursing on-call for medication emergencies.		Case managers available to assist with information and referral to supports and services, leisure and recreational access. Provides a child development program (6 weeks to 6 years) for children of all backgrounds (early intervention services and assessments). Provides a personal care program to help adult individuals live independently at home (non-medical program). Day programming referrals provided.	Provides adult foster homes, and semi-independent residences for adults with developmental disabilities and traumatic brain injuries.
Yes	St Joseph Comm Services (Meals on Wheels)			Nutrition and Health Education	Community dining	Daily contact and safety checks			Transportation	

Yes	Home Health and Hospice Care	Social work team assists with referrals/applications to financial assistance resources.				Bereavement Support Groups	Home care (rehabilitation, Chronic Disease Management, Advanced Illness Management, IV Therapy, Wound care, Lymphedema care, Pediatric and Maternal Care), Hospice, Palliative Care, Private Duty Care Inpatient Hospice care at Community Hospice House	Behavioral Health Services as part of Home Health Services		Community Hospice Housing
Yes	Serenity Place					Family and Peer Support		Substance Abuse Outpatient Counseling, Intensive Outpatient Program, Ambulatory Withdrawal Management, Day Programs, Impaired Driver Care Management Program, Impaired Driver Services Program, Mental Health Services	RAP (Region Access Point for Greater Manchester Area) - Substance Abuse Information, Screening, Evaluation, Case Management, Referrals (on a walk in basis)	Men's Transitional Living Facility
No	American Medical Response			Training Programs (EMT's, Paramedics, Critical Care Nurses, Flight Nurses, Dispatchers, Schedulers, Operations Team)			Emergency Care, Non - Emergency Medical Transportation, Mobile Healthcare, Federal Disaster Response Team		Innovative Medical Transportation Services (health maintenance organizations, health and workers compensation insurance providers and other health plans)	
No	Ascentria Care Alliance (formerly Lutheran Social Services)	Employment support for new Americans. MA: Employment support for parenting teens	Good News Garage (transportation equity) • Car donation • Ride service (VT) Language Bank • Interpretation • Translation	Vocational Services for New Americans		Resettlement services for New Americans, including: • employment support, • specialized assistance for older adults, • health and mental health support • housing placement • English Classes • Vocational Training MA only: • Unaccompanied Refugee Minors Foster Care Program	In-Home Non-Medical Care for older and chronically ill individuals • Medicaid – CFI (400 statewide) • Private non-medical in-home care • Coordination with Case Management	Maine and Massachusetts only: Mental Health • residential • DBT • in-home supports And residential services for individuals with developmental disabilities	Therapeutic Foster Care` • 24/7in-home supports • Full Case Management • Respite Home –Based Services • in-home supports and clinical intervention • For biological parents MA only Adoption • Domestic in	Two transitional living programs for parenting teens providing case management services.(MA) Good News Garage allowing low income families access to transportation.

No	City of Manchester Health Department		Provides assessment, policy development, and assurance of health to Manchester's public through the multitude of services they provide. Have been authors of the "Greater Manchester NH Health Improvement Plan (2016), Manchester Neighborhood Health Improvement Strategy (2014), Manchester Blueprint for Violence Prevention, and Believe in a Healthy Community (2009). Oversees the Manchester Weed and Seed Program (weeding out violence)	Provides health orientation classes and community presentations for New Americans/Refugees/Immigrants NH Institute for Local Public Health Practice	Monitors food protection program	An array of services for the public of Manchester: arbovirus surveillance and control, chronic disease programs (asthma, cancer, cardiovascular, nutrition, and tobacco) dental health programs (oral health screenings and school dental programs) Homeless healthcare program, institutional inspections, lead poisoning prevention, public health investigations, public health preparedness, refugee health, school health (first aid, health education, screenings, medication administration, care for children of special needs), septic systems and water quality	Providing clinics for flu vaccine, HIV/STD, immunizations, lead screenings and tuberculin skin testing (most programs children receiving services are free, adults and other programs have fee no more than $20). Works closely with the Homeless Health Care Program	Can contact the health department to pick up disposed needles in the Manchester Community	Provides case management services in their lead screening program; case manager to follow children who test positive	Public health investigations for housing
No	Community Crossroads	Assist adults with disabilities or brain injuries in job training, placement and maintaining employment	Involved at the community level: offers a Family Support Council (parents w/children with disabilities) to advocate for their needs, Host NH Family Support Conference (providing scholarships for families to attend), Walk by the Sea (annual walk to support their services), work with the Partners in Health (state-wide initiative),	Provide trainings for parents and clients; specifically with a Transition Open House which provides an informational session, packet and checklist to help adults and children through transitional periods (going to school, leaving school, transitioning grades, transitions from child to adult). Also host the Supporting Successful Early Childhood Transition Workshops.		Provide support groups and networking groups to families and clients (swimming, music, sensory workshops). Also provide a SARC Youth Council group that participate in monthly recreational groups. Has a Self-Advocacy group for adults with developmental disabilities and traumatic brain injuries to teach/support each other and advocate for their needs.		Provides behavioral screenings and early support services for children birth to 3. Provides connections to speech, occupational and physical therapies and employs early childhood development specialists. Provides respite and day services for adults with developmental disabilities and traumatic brain injuries.	Provides Family Support Department that supports families of adults and children with developmental disabilities and traumatic brain injuries. Case managers available to connect families to resources and information, coordinate respite, recreational activities, jobs and employment, coordinate special needs during hospital stays, school planning, behavioral modifications, applying for benefits, in home support services, IEPs, etc.	Can apply for funds through this agency to help with environmental modifications. The organization receives grant monies to assist families with adaptive equipment.
No	Derry Friendship House					Provides a 12 step recovery program for individuals and families struggling with substance use in Derry/Londonderry area. Provides a drop in center, and provides about three groups a day including weekends.			Run by volunteers; peer to peer support and can direct toward resources	
No	Granite State Independent Living	For veterans and those with disabilities: job placement services and , community supports and staffing services- employment assistance for those who have SSI/SSDI		For veterans and those with disabilities-classes on employment skills			In-Home care services- in home recovery services, nursing facility transition		Financial planning and disability benefit services-transportation services, disability rights advocate, home modification program- independent living supports and advocacy for vets.	home modification program for those who have a disability

No	Easter Seals New Hampshire	Provide GED, HISET classes. Provides job placement and training for individuals with disabilities							Specializing in Autism services (care coordination), Early support and educational services for children (developmental screenings, resource coordination, care management), dental services (variety of dental services for adults and children), senior services (day programs, independent living support services, home visiting) military/veteran services (care coordination, veterans count) workforce development, child development (educational programming ages 6 weeks to 5 years old), and camps/recreation services (for clients with disabilities), transportation services (special transit services for elderly)	
No	Goodwill Industries of Northern New England	Workforce services: on the job training for adults, seniors, and youth. Employment counseling and training. Job connection		Youth programs: tutoring, study skills, drop out prevention, alternative school services, mentoring, paid and unpaid internships, occupational skills, leadership development, appropriate supportive services. Granite State Education Corps: increase student engagement, mentoring services to decrease truancy, tardiness, bx issues, and drop out rate.	In Maine- provide agricultural assessments- Assessments for modifying, adapting, operations, buildings, equipment/tools.	Multilingual leadership corps- Mentoring community engagement, aspirations, school skills support.	NeuroRehab Services for brain injury services and treatment options		Support for those in need of case management to access services and supports. Veterans fund for •Car Repair •Fees for licensing exams or education courses •Equipment purchases for small business •Travel expenses for work or appointments	Provides housing for those individuals . Who have brain injuries and/or intellectual disabilities. Also in home services for above disabilities.
No	Granite United Way	Allocates money to 750 different nonprofits in: Central NH, Merrimack County, North Country, Northern Region, Southern Region, and the Upper Valley								

No	Greater Derry Community Health Services, Inc.	Manages the emergency aid for families in Londonderry and Hampstead. Emergency aid includes rent, fuel or electric assistance. Can work with staff to complete application.				Contracts with Derry Medical Center and Londonderry Family practice to manage their Behavioral Health Services Department	Manages the outpatient counseling and behavioral health services to those served by Londonderry Family Practice and Derry Medical Center. Specialize in depression/anxiety/chronic illness/new diagnosis conditions. Provide assessment, counseling, and medication services. Program is called "Be-Well".	Community Case Management is available to referred clients through the medical center behavioral health service for resource identification, guidance and coordination as needed.	Case Managers provide information, education, and guidance in accessing health care (Marketplace, Medicaid or other), behavioral health and other services. Includes psychosocial assessment and general evaluation of circumstances with supported referrals as need	
No	NH Catholic Charities	Financial education and financial mentoring classes	Partners with the Food bank to ensure food security to the clients they work with	Our Place: Pregnancy services, childhood development education and parenting skills, and supportive services. Provide curriculum trainings for expecting mothers around discipline, breastfeeding, nurturing parenting, etc.		Support groups available that provide information, training and workshops	Provides some health care services such as short term skill nursing and rehabilitation, long term care, senior living communities, Alzheimer's and dementia care and hospice. Nurses available to meet in home to ensure independent living, nurses also available by phone.	Counseling services for adolescents, adults, individuals, couples, marital and family counseling. Can provide counseling on life adjustments (depression, anxiety, family stress, grief, etc.) as well as substance use and addiction.	Adoption and maternity services (adoption information and counseling, post-adoptive care, legal representation for adoption and home studies). Immigration and Refugee services (casework and support, guidance on immigration issues, low cost legal representation focused on: family based visas, visas for religious personnel, consular processing visas, political asylum, adjustment to lawful permanent residence, self petitions for immigrants with domestic violence/sexual assault and naturalization)	Group home setting available to children (located in Rochester) providing behavioral health, special education teachers and speech and language pathologists. Goal is to help children re-integrate back into a school setting.
No	Hillsborough CountyDept of Corrections)	Work Release program		GED program		educational and self-help programs: Parenting Program for Parents of Preschoolers, Rehabilitation & Self-Improvement	HEALTH SERVICES: Dental and health care-medication services	drug and alcohol awareness program: Residential Substance Abuse Treatment (RSAT)		
No	Hillsborough County (Nursing Home						Rehabilitation Services include full time Physical and Occupational Therapy as well as Speech Therapy services. Orthopedic rehabilitation (hips, knees, joint replacement). Wound Care Management Post cardiac rehabilitation and recovery. Neuro rehabilitation (strokes and mild brain injury). IV therapy for antibiotics, hydration and pain management Family education upon discharge as needed.	Enhanced Living Unit The Enhanced Living Unit (ELU) is a 24 bed unlocked unit designed to meet the needs of individuals whose behaviors require an increased level of structure, behavior management and therapeutic activities. Consulting Specialists include a Dentist, Optometrist, Podiatrist and a Gero Psychiatrist.		

No	HOPE for New Hampshire Recovery	Active in the community: peer support specialists available to those in the ER. Active member of Safe Station. Provides telephone recovery support and community outreach and advocacy. Hosts annual community events.	Family education groups, resource library, health and wellness workshops		Peer support services for recovery from drugs/alcohol. Provides a safe and healthy format to meet others in recovery, family support for all stages of recovery, recovery support groups (12 step, social events, weekend groups).			Peer support specialists can assist in "navigating the system", providing resources and referrals. Telephone recovery support and peer coaching.		
No	International Institute of NE	Job preparation, training, search, placement, and retention services. Financial literacy training. Assistance with city welfare for individuals enrolled in programming.	ESL classes on site. Available to all refugee and immigrant populations.	Contextualized vocational English for Speakers of Other Languages program		Welcome cultural and community orientation, and early basic needs support to refugees; citizenship exam preparation and naturalization application services	Health assessment, healthcare services orientation, and health insurance application assistance	Hands-on referral to mental health support for refugee and immigrant trauma and torture survivors	Case management facilitates ongoing access to basic needs, remove barriers to self-sufficiency, and promote self-efficacy. Special case management services for elderly refugees, asylees, V=Cuban/Haitian entrants, and Certified Victims of Trafficking.	Coordinate housing and home set-up for newly arriving refugees. Provide cultural orientation on rental rights and responsibilities.
No	Life Coping Inc.	Medicaid Services for Elderly, Adult and Children with Disabilities				Social Support and transportation	Licensed Care management services offered as well as guidance provided in Health and Long Term Care		Case management services provided to independent living seniors as well as adults and children with disabilities include needs assessment, consultations, coaching, home maintenance and repair, health management, on-going monitoring, nursing home placement, legal and financial referral, and adult protective services. Nursing home transition services.	
No	Makin' It Happen						The Continuum of Care includes environmental strategies (health promotion), primary care, behavioral health, prevention, intervention, treatment, and recovery.	Substance Use Disorder Continuum of Care works to reduce substance misuse and increase education and access to behavioral healthcare through prevention, treatment and recovery; Suicide Prevention;		

No	Manchester Housing	***Adult Economic Self-Sufficiency Services*** with emphasis on educational programs, case management, individualized training and support, work- based learning opportunities, and overcoming cultural and socioeconomic barriers		***Employment and vocational services*** for the elderly and adults with disabilities; ***Preschool daycare*** partnered with Manchester School District offers children aged 3-4 education opportunities in preparation for kindergarten; ***Youth opportunities*** include recreational and education programs such as computer learning lab; ***Academic Incentive programs*** designed to keeps kids in school and encourage academic success; ***Scholarship Opportunities***		Social activities for the elderly and adults with disabilities	***Resident Enrichment, Health and Wellness, and Elderly Outreach Programs*** provide aggregate savings on prescription drugs and other health care costs for the elderly		***Supportive Services Programs (SSP)*** provide the services needed (meals, housekeeping, health information, coordination of transportation, service coordination, etc.) to allow the elderly and persons with disabilities to maintain their independence	***Public housing apartments*** for low-income families, the elderly, and adults with disabilities; subsidized housing through the ***Section 8 Housing Choice Voucher (HCV) Program*** ; ***Home Ownership Program*** in conjunction with the Housing Choice Voucher Program
No	Manchester School District	***Extended Learning Opportunity Program*** (ELO) offers students to receive credits for learning activities outside the traditional classroom including internships, community service, work-based learning, and various others	Ongoing implementation of the Manchester Community Schools project: Creating Healthier and Safer Neighborhoods in Manchester through the City's Change to Multi-Use, Integrated and Resident-Engaging Community Schools at 3 elementary schools	The District is comprised of a ***developmental preschool program*** , ***14 elementary schools*** , ***four middle schools*** , ***four high schools*** , including a Career and Technical Education Center; Manchester Adult & Community Learning; ***Manchester Program for the Deaf and Hard of Hearing;***	***www.MySchoolBucks.com*** *is a free service* that offers meal account balances and meal participation history on line; ***Free and reduced Lunch program*** available for eligible students	***ELL program*** provides English language instruction and offers students assistance with cultural assimilation; The ***21st Century Community Learning Centers (21st CCLC)*** afterschool program for Kindergarten through middle school	The ***School Health Division*** is staffed by professional school nurses and health assistants committed to the youth of Manchester. School Health Services include First Aid and Illness Care, Health Records , Screening Program, Health Education and Health Counseling, Care of Children with Special Health Care Concerns , and Medication administration	Access to SAP (Substance Abuse Professional) Counselor	***Student Service Department*** provides additional support in the areas of enrollment, transportation, safety, and students with special needs; Access to a school appointed ***Homeless Liaison*** via the McKinney-Vento Act; Accountability Services through the ***District Data Center*** ensures that parents, students, educators, and other stakeholders are provided with accurate, quality, and timely data regarding the school district	
No	Pastoral Counseling			Vocational & Career Counseling		Community Offerings include: Parenting Skills, Anger Management Skills, Basic Counseling Skills for Organizations, Workshops/Seminars, Consultation		***Clinical services*** include counseling for children, teens, and adults in several categories including grief, anxiety, sexual identity, depression, trauma, PTSD, separation/divorce, Family Matters, and Illness; ***Mind & Body Services*** including Stress Management, Victims of Trauma, Addiction/Relapse Prevention, Meditation & Homeless Groups		

No	New Horizons for New Hampshire			Classes and presentations ongoing at ***Angie's Shelter for Women*** on topics including health issues, nutrition, meditation and stress relief, maintaining sobriety, financial basics, employment and self-esteem, and continued success after shelter living	Food pantry provides groceries to families/individuals in Manchester; Soup Kitchen serves daily breakfast for shelter guests and complete dinners on weekdays for seniors, individuals, children and their families	On-site Alcoholic Anonymous and Narcotics Anonymous meetings		Access to mental health and substance use services	Access to case management services, Veteran Services and referral services	***New Horizons*** emergency shelter serving adult men and women; ***Angie's Shelter for Women*** (substance free) ; **Housing First Program** houses most vulnerably homeless (rent paid by ***New Horizons***)
No	New Hampshire Legal Assistance								Civil legal services in several categories including public benefits, domestic violence and disputes, housing, seniors, and the Youth Law Project; representation for vulnerable immigrants; Special Projects include continued enforcement of inmates' rights to mental health care and the educational/vocational training and monitoring NH state compliance to improve the Medicaid dental program for children	
No	On the Road to Wellness		Social gathering classes, encourages client participation in the community			Peer support services focused on "intentional peer support" model. Provides multiple support groups (ex; keeping sober, gratitude, journaling, social gathering, you matter). Provides WRAP services to members in a group setting (goal focused).			Peer to peer supports (can help connect to agencies)	Transitional living program (Hugh's Place) focusing on assistance with benefits, referrals to community services, and finding permanent housing)

No	Rockingham Service Link Resource Center		Works with many of the local, state-wide and state-driven programs such as NH Easy, NHCAREPATH, the NH addiction hotline, and Medicaid/Medicare, Veterans programs	Provide online trainings around the elderly and aging, focusing on caregivers (Rockingham ServiceLink does not provide on line trainings. We do provide a six week evidence based program / training called Powerful Tools for Caregivers.		Provides two support groups for caretakers (Hillsborough and Concord) Facilitate monthly caregiver support group (Rockingham)			Providing referrals and resources to the elderly population. Can refer to many of the categories listed on this spreadsheet; health, behavioral health, substance use, housing resources, food resources, education, etc. Do not receive a set case manager, but can call the hotline number and speak with someone who can provide resource referral via phone Reworked the above description Provides information and referrals, assistance accessing services and follow up. Services are provided to all individuals needing long term supports and services. This includes, the elderly population, family caregivers, and Veterans. Can refer to many of the categories listed on this spreadsheet; health, behavioral health, substance use, housing resources, food resources, education, etc. Do provide case management services but does provide short term care coordination services. Services are provided on the phone, in person in the office or other community location, in the home, via email	
No	Southern NH Services	Providing services for Workforce Development and Economic Development: New Hampshire Employment Program, NHEP Workplace success program, financial capability program.		Provides English for New Americans classes. Also providing child development programming (Head Start, Early Head Start, Child Care, Child Care Resource and Referral) and Adult Education Programs (located in Portsmouth)	Hosts the WIC program, Commodity Supplemental Food Program for the elderly, Emergency Food Assistance Program, Seniors Farmers Market Program, Community Gardens, Emergency food pantries, summer food service program & Holiday programs				Community and Support Services through the Western Hillsborough County Family Services and Senior education workshops	Providing energy and fuel assistance to low income families (including weatherization programs, heating repair and replacement program, gift of warmth program). Provides other housing services including Supportive housing for the elderly, Robinson House and Marys house for those recovering from Addiction, Homeless Housing Assess and Revolving Loan Fund, Housing Security Guarantee Program, LIHTC Senior Housing Program and Lead Paint Hazard Control Program

No	St. Joseph Community Services (St. Joseph's Hospital)			Program called "Dinner with a Doc" that covers an array of health topics. Community Health Education classes (for example: Alzheimer's educational classes)		Support groups (Mental Health Support, Caregivers group, al-anon, Alzheimer's support group, etc)	Multitude of services ranging from primary care to specialty care (stroke care, sleep disorder, respiratory therapy, cancer center, endocrinology, gastroenterology, midwifery, neurology, obstetrics, orthopedics, palliative care, physical medicine, pulmonary services, surgery, urgent care, lab services, nutrition, and rehabilitation (inpatient and outpatient)		SAGE-Program for Elderly for social and educational events	Prescription Assistance programs so patients can afford their RX. Joseph's Closet can provide medical equipment to patients in the Nashua area (example, bariatric equipment, canes, ankle and leg boots, crutches, etc)
??	Meals on wheels (SJCS)		Works with multiple community sponsors to provide their services such as the food bank, United Way, and local grocery stores		Provides hot lunches to elderly and home bound residents. Provide daily contact and safety checks	Provides community meals to residents 60 + years which provides not only a healthy nutritious meal but also social interactions, group activity, promotion of overall wellness and health. They provide four community meals in Manchester			Can provide information and referrals to other community agencies; provide referrals to agencies that will promote and support independent living. Most services are run by volunteer (drivers, cooks, etc)	Can provide transportation to community meals but this is limited

Projects: 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

For this project, Network4Health is addressing transitions from institutional settings and youth programming to the community by using the Critical Time Intervention (CTI).

The project plan, included as Attachment_C1.1a, details activities for the project through 2020. As project planning and implementation continues, Network4Health will add more details to the plan. The attached project plan provides a step-by-step, detailed approach to implementing this program by major task areas including:

- Recruitment of staff;
- Training of staff;
- Program administration; and
- Monitoring of program.

The full program description that Network4Health has developed for the CTI program is included as Attachment C1_1.1b.

C-2. IDN Community Project: Evaluation Project Targets

Enrollment into the CTI program will begin in November and will ramp up over the course of the first year. According to our advisors from NY and NC, the maximum number of clients per CTI Coach is around 16. We are hoping to hire 6 CTI Coaches, 2 coaches for each of the identified CTI transitions. Enrollment into the program for the first few years will approximate that shown in the table below. We estimate that over the course of the waiver the CTI program will serve over 300 people.

CTI Quarters	11/17-1/18	2/18-4/18	5/18-7/18	8/18-10/18	11/18-1/19	2/19-4/19	5/19-7/19
Admissions	Up to 24	Up to 30	Up to 30	Up to 30	Up to 33	Up to 33	Up to 30
Average Caseload	Up to 4	Up to 9	Up to 14	Up to 15	Up to 15.5	Up to 16	Up to 16
Cumulative # served	Up to 24	Up to 54	Up to 84	Up to 114	Up to 147	Up to 180	Up to 210

We are in discussions with the other IDNs to determine whether or not we will use the same framework and metrics to evaluate the individual CTI programs. Network4Health is leaning towards a quasi-experimental evaluation to measure performance using a pre-post design. For this design, most pre-program measures will be collected upon entry to the program via self-report. To the extent possible we also will attempt to validate these reports with data from client's medical record and/or state utilization files. We will measure key outcomes during the client's participation in each of the three phases of the CTI program as well as up to one year following the client's full transition to the

community. Performance measures include process measures such as the number of individuals served by the program, the time each client is enrolled in the program, and the number of community supports accessed by each client.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Individuals served any time in program	Up to 333	Up to 24	Up to 84	Up to 147
Number of individuals completed program	Up to 333	Up to 24	Up to 84	Up to 147

In the last quarter of 2017, Network4Health will develop additional performance measures focused on continuity of care between treatment settings. For example, these measures may include:

- continuity from inpatient to outpatient care (# days from hospital to first outpatient visit)
- continuity of outpatient care (# of patients receiving any mental health or substance abuse care following hospitalization)
- outpatient treatment intensity (number of mental health and substance abuse visits at 30 days)
- outpatient treatment intensity (number of mental health and substance abuse visits at 180 days)
- outpatient continuity of care (number of 2-month periods during first 6 months after discharge in which patient had two or more mental health or substance abuse outpatient visits)

In addition to the performance measures above, Network4Health will also monitor the impact of the CTI initiative on preventable emergency room visits and preventable hospital admissions, as well as the impact of the program on incarcerations and homelessness. We also expect to have assessment tools that allow for monitoring of client self-reporting related to psychological distress, social supports and patient satisfaction, among other things.

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.

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
Critical Time Intervention (CTI) Director/ Supervisor	Up to 1	0	Up to 1	Up to 1	Up to 1
Critical Time Intervention (CTI) Coaches	Up to 6	0	Up to 6	Up to 6	Up to 6
Care Transitions Administrative Support Worker	Up to 1	0	Up to 1	Up to 1	Up to 1

C-4. IDN Community Project: Budget

The budget below provides a high-level view of expected costs associated with implementing the CTI program. The Director of CTI program will be funded through Project Design and Capacity Funds, all other program staff will be funded through this budget. The budget assumes a start-up period during the first year and will serve over 300 people by the end of the waiver period.

TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
C1: Care Transitions Revenue (New)	$ 451,560	$ 451,560	$ 477,120	$ 477,120
C1: Care Transitions Revenue (Rollover)		$ 170,482	$ 97,340	$ 35,024
Total Revenue	$ 451,560	$ 622,042	$ 574,460	$ 512,144
Salaries and benefits	$210,000	$ 426,300	$439,089	$428,598
Technology (Laptops, phones, software)	$ 27,000	$ 22,500	$22,500	$ 22,500
Barrier Reduction Funds (Client Emergency funds and Interpretation Services)	$ 37,578	$ 62,578	$63,856	$ 46,356
Occupancy Costs	$ 6,500	$13,324	$ 13,991	$ 14,690
Subtotal	$ 281,078	$ 524,702	$ 539,436	$512,144
Variation to Budget (Transfer Funds to Proceeding Year)	$ 170,482	$ 97,340	$ 35,024	$ -

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.

The Mental Health Center of Greater Manchester (MHCGM) is the only participating organization that will be hiring staff for this project and we have an agreement executed with them. However, we have worked closely with two of the hospitals and the two County Departments of Corrections as part of our implementation planning. We have met with the New Hampshire Hospital and the Director of Social Work there attended our Statewide CTI kick off in June. The two community mental health centers and a large youth outpatient clinic have also been involved in the planning as they will be the primary referral sources for our youth transition work. Our plans are to have the new CTI Director create the final referral protocols and agreements with the hospitals, the county DOC and the youth outpatient programs. We will add other potential referral sources (such as the NH Correctional Facility for Woman and the NHCF for Men) once the program is established. We do not have precise estimates of the number of referrals by institution although we believe referrals may exceed capacity. Given that our coaches will be limited to only one type of transition (due to fidelity requirements), we will have two coaches for hospital discharge, two for

community reentry, and two for youth transition (Each caseload target 16). The advisory committee will provide ongoing monitoring of admissions and could determine the need to adjust the plans if there is an imbalance in referrals by transition type.

Organization/Provider	Agreement Executed (Y/N)
The Mental Health Center Of Greater Manchester	Yes

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.

We will utilize four standard assessment tools for this program. Ideally, the same tools will be used across all five IDNs implementing CTI in NH. The first tool, the Comprehensive Core Standard Assessment will be used across the IDN for all clients served. The Intake Assessment, will collect baseline data on the client when referred to the CTI intervention. This will allow us to monitor progress of the client on several key indicators pre-post intervention. The Recovery Assessment Tool will measure the client's personal recovery, and the final tool will measure client satisfaction.

Standard Assessment Tool Name	Brief Description
Comprehensive Core Standard Assessment	The CTI program will use the Core Standard Assessment that will be used across the IDN for demonstration projects. The Core Standard Assessment will include various socio-demographic factors and screen for standard social determinants of health as well as other physical and mental health conditions present, client's strengths and needs, and pertinent social, family and medical history.
Intake Assessment	The Self-Reporting Assessment will be facilitated by the Critical Time Intervention Coach or Director upon referral into the CTI program and will assess, at a minimum, the number of hospitalizations, number and type of contacts with community organizations, number of emergency room visits, number of homeless days, number of incarcerations and interactions with law enforcement within the previous 12 months. The Intake Assessment will also include an explanation of the program and a document for the client to sign to ensure they understand the program's components and agree to enroll.
Recovery Assessment Tool	Network4Health is coordinating with the other 4 IDNs that are implementing CTI and hope to use the same evidence-based tool that measures personal recovery. We are currently considering two instruments: the "Illness Management and Recovery Scale" or the "RSA-R Recovery Scale." Both instruments are in the public domain, can be self-administered, take a consumer perspective to recovery, yield quantitative data from which we can monitor our progress, and

	have sound psychometric properties including internal consistency, validity and reliability. The goal is to have clients complete the tool upon entrance to and at exit from the CTI program.
Client Satisfaction Tool	We will be utilizing a self-administered participant satisfaction tool when the individual exits the CTI program. It is our hope to use the same tool across all 5 IDNs implementing CTI. We will, at a minimum, include clients' program experiences (communication with CTI Coach and other program staff, the responsiveness of staff, communication about the 3 stages of the program, discharge information, overall rating of program, and would they recommend it to friends and/or family members.

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

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

CTI is an evidence-based program with protocols for patient assessment, treatment and management. The intervention is divided into 3 phases: transition, tryout, and transfer of care. Before the client begins the program, they are assessed for eligibility and the program is explained to them. This phase is called Pre-CTI. The protocols for each phase are noted below. Network4Health will need to adapt these protocols somewhat based on our population and organizational structure. These adaptations are currently under development and will be finalized prior to the program launch in December 2017.

Protocol Name	Brief Description	Use (Current/Under development)
Eligibility	Clients are referred to the program if experiencing one of three identified transitions including: discharge from inpatient settings or frequent emergency department visits, release from correctional settings, or transition from youth behavioral health care delivery system to adult behavioral health care system and 3 or more of the following challenges: lack of positive social support/natural supports network inability to perform activities of daily living adequately, lack of basic subsistence needs (food stamps, benefits, medical care, transportation) inability to manage money, substance use with negative impact, employment challenges (e.g. unemployment, underemployed, or lack of employment skills) or suicide risk.	Under development

Enrollment	The CTI intervention is explained to the patients and if the patient agrees to enrollment they are enrolled in program.	Under development
Patient Transition	The patient is assessed at baseline using the screening and assessment instruments to assess patient's social and health needs and to develop an individualized service plan. The CTI Coach is very involved with the client during this period accompanying him/her to most community appointments and helping them navigate community resources and relationships. CTI Coach focuses on patient's most urgent needs.	Adapted protocol under development
Patient Tryout	During months 4-6 the CTI protocol begins to transition the client to their developing support system. The CTI Coach has fewer meetings with client but helps to trouble shoot any areas that still need resolution.	Under development
Patient Transfer of Care	During months 7-9, the CTI protocol requires the CTI Coach to remain involved with the client but provides little direct service. The CTI Coach allows the client to solve problems and together they develop and begin to implement a plan for long-term goals.	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 all documents used by the IDNs.

The CTI project includes the team members noted in the table below. [redacted] the Executive Director of Network4Health is a non-voting member of the team. [redacted] the Project Manager, is responsible for overseeing the operations and administrative responsibilities including reporting to the state for the project. [redacted] are the team co-leads. They ensure that the program is on track and being implemented as envisioned. They have been approved as team co-leads by the Network4Health Steering Committee. There are 11 team members representing the various community organizations participating in the CTI project.

Team members are responsible for actively participating in all scheduled meetings either in person or by telephone. They provide direction and oversight as it relates to specific tasks and provide direction and oversight to all major operational aspects of the CTI. They proactively work with their respective peer organizations that are Network4Health partners and actively represent them on the team. They responsibly and cooperatively work with the Partnership Team, the Steering Committee, the Project Management Team, the other individual Project Workgroups, IDN staff, and project stakeholders to successfully implement the plans to meet the overall objectives of Network4Health, in general and CTI more specifically.

Team members are responsible for all activities related to formulating an implementation plan and assuring implementation of the plan, including but not limited to:

- utilizing the project blue print described in Network4Health's Project Plan;

- obtaining all necessary data needed to formulate an implementation plan;
- creating an implementation plan (subject to Steering Committee approval) by target dates established by Network4Health;
- conducting implementation by target dates established by Network4Health;
- monitoring performance and propose (to the Steering Committee) alterations in the team plan as necessary;
- assuring coordination of team plan implementation with other Network4Health projects; and
- engaging in efforts to include the broader community in planning, implementation and monitoring.

Project Team Member	Roles and Responsibilities
[redacted]	Team Co-lead
[redacted]	Team Co-lead
[redacted]	Executive Director of Network4Health
[redacted]	Project Manager
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member

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

Network4Health will use a multi-pronged training plan to educate its personnel in the CTI intervention. We will include specific training on the CTI model as described below. We will also provide staff training on data collection to ensure that we have a robust data tracking system from which to measure our outcomes. In addition, we will arrange for training on the Illness Management and Recovery (IMR) intervention which will help our CTI coaches interact with their clients through the recovery process. This is an evidence-based practice, which can work harmoniously with the CTI intervention. The budget for training is included in the budget for A1.

The Center for the Advancement of Critical Time Intervention (CACTI) will provide much of the training and technical assistance in support of the New Hampshire's planned implementation of the CTI model in various regions of the state. Following initial planning discussions with local personnel, CACTI proposes to provide some or all of the following services:

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

- CACTI staff member(s) will attend this meeting to present background, evidence and brief overview of the CTI model and address questions from attendees. 10-15 participants from each of the 5 participating regions. Invitations also extended to DHHS and MSLC.

Phase 2 ***1st*** **Staff Training (7/1/17- 12/31/17)**

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

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

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

2nd **Staff Training (1/1/18- 6/30/18)**

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

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

- **Community of Practice Meetings (7/1/17-6/30/19)**
    - CoP meetings will occur monthly following program implementation. These meetings of case managers and/or supervisors will allow providers to receive technical support during the implementation phase. A locally-based CACTI consultant will facilitate these meetings, with the goal of reducing their role as they help local trainers assume primary leadership responsibilities. Meetings may be held in-person or via web/phone depending on feasibility/cost issues.

- **Coaching Support for Individual Organizations (6/31/17-12/31/20)**
    - CACTI will provide monthly telephone consultation to case managers and supervisors at individual provider organizations. This will ensure program staff ample opportunity to receive and offer feedback, and will provide assistance in identifying and overcoming challenges specific to their organization. Feedback may

be provided on data collected via self-assessment tools that organizations can use to monitor fidelity to the CTI model.

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

- A combined CACTI/T3 team will provide a two-and-a-half-day in person Train-the-Trainer training to locally identified personnel who will assume responsibility for ongoing staff training and consultation after CACTI's role ends. Participants should have completed basic training in the CTI model and have prior training experience.

ID	Task Mode	Task Name	Duration	Start	Finish
1		**Care Transitions**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
2		**Recruitment**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
3		Develop job descriptions for all Care Transitions positions	132 days	Sat 7/1/17	Sun 12/31/17
4		Finalize job descriptions	132 days	Sat 7/1/17	Sun 12/31/17
5		Recruit 1 Critical Time Intervention Director	132 days	Sat 7/1/17	Sun 12/31/17
6		Recruit 1 Care Transitions Administrative Support Worker	132 days	Sat 7/1/17	Sun 12/31/17
7		Recruit 6 Critical Time Intervention Coaches	132 days	Sat 7/1/17	Sun 12/31/17
8		**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
9		Evaluate open positions if applicable	131 days	Mon 1/1/18	Sat 6/30/18
10		Confirm need to recruit for open positions	131 days	Mon 1/1/18	Sat 6/30/18
11		Recruit for open positions as needed	131 days	Mon 1/1/18	Sat 6/30/18
12		**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
13		Evaluate open positions if applicable	132 days	Sun 7/1/18	Mon 12/31/18
14		Confirm need to recruit for open positions	132 days	Sun 7/1/18	Mon 12/31/18
15		Recruit for open positions as needed	132 days	Sun 7/1/18	Mon 12/31/18
16		Identify criteria for potential Train-the-Trainer Candidates	132 days	Sun 7/1/18	Mon 12/31/18
17		Recruit up to 2-3 individuals to attend Train-the-Trainer training and provide ongoing CTI training to N4H	132 days	Sun 7/1/18	Mon 12/31/18
18		**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**
19		Evaluate open positions if applicable	130 days	Tue 1/1/19	Sun 6/30/19
20		Confirm need to recruit for open positions	130 days	Tue 1/1/19	Sun 6/30/19
21		Recruit for open positions as needed	130 days	Tue 1/1/19	Sun 6/30/19
22		**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**
23		Evaluate open positions if applicable	132 days	Mon 7/1/19	Tue 12/31/19
24		Confirm need to recruit for open positions	132 days	Mon 7/1/19	Tue 12/31/19
25		Recruit for open positions as needed	132 days	Mon 7/1/19	Tue 12/31/19

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Task	External Milestone	Manual Summary Rollup	
Split	Inactive Task	Manual Summary	
Milestone	Inactive Milestone	Start-only	
Summary	Inactive Summary	Finish-only	
Project Summary	Manual Task	Deadline	
External Tasks	Duration-only	Progress	

ID	Task Mode	Task Name	Duration	Start	Finish
26		**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
27		Evaluate open positions if applicable	130 days	Wed 1/1/20	Tue 6/30/20
28		Confirm need to recruit for open positions	130 days	Wed 1/1/20	Tue 6/30/20
29		Recruit for open positions as needed	130 days	Wed 1/1/20	Tue 6/30/20
30		**Milestone reporting period**	**0 days**	**Tue 6/30/20**	**Tue 6/30/20**
31		Evaluate open positions if applicable	132 days	Wed 7/1/20	Thu 12/31/20
32		Confirm need to recruit for open positions	132 days	Wed 7/1/20	Thu 12/31/20
33		Recruit for open positions as needed	132 days	Wed 7/1/20	Thu 12/31/20
34		**Milestone reporting period**	**0 days**	**Thu 12/31/20**	**Thu 12/31/20**
35		**Training**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
36		CTI training for Coaches	132 days	Sat 7/1/17	Sun 12/31/17
37		CTI training for supervisor	132 days	Sat 7/1/17	Sun 12/31/17
38		Multi regional Community of Practice meetings monthly	132 days	Sat 7/1/17	Sun 12/31/17
39		N4H Coaching from CACTI monthly via phone	132 days	Sat 7/1/17	Sun 12/31/17
40		**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
41		CTI training for Coaches	131 days	Mon 1/1/18	Sat 6/30/18
42		Multi regional Community of Practice meetings monthly	131 days	Mon 1/1/18	Sat 6/30/18
43		N4H Coaching from CACTI monthly via phone	131 days	Mon 1/1/18	Sat 6/30/18
44		**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
45		Train-the-Trainer training through CACTI	132 days	Sun 7/1/18	Mon 12/31/18
46		Multi regional Community of Practice meetings monthly	132 days	Sun 7/1/18	Mon 12/31/18
47		N4H Coaching from CACTI monthly via phone	132 days	Sun 7/1/18	Mon 12/31/18
48		**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**
49		Multi regional Community of Practice meetings monthly	130 days	Tue 1/1/19	Sun 6/30/19
50		N4H Coaching from CACTI monthly via phone	130 days	Tue 1/1/19	Sun 6/30/19
51		**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**

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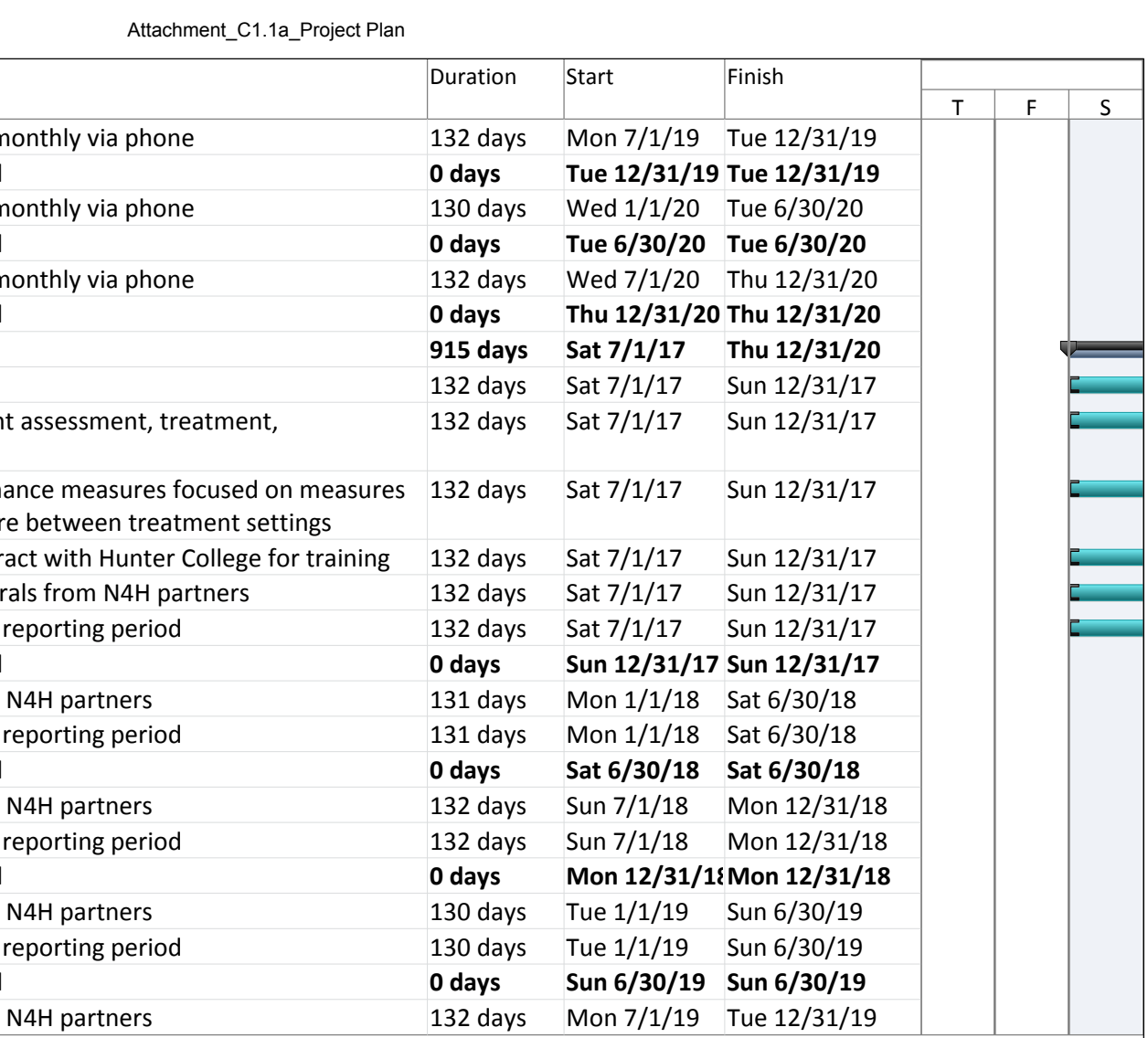
Task	External Milestone	Manual Summary Rollup	
Split	Inactive Task	Manual Summary	
Milestone	Inactive Milestone	Start-only	
Summary	Inactive Summary	Finish-only	
Project Summary	Manual Task	Deadline	
External Tasks	Duration-only	Progress	

ID	Task Mode	Task Name	Duration	Start	Finish
52		N4H Coaching from CACTI monthly via phone	132 days	Mon 7/1/19	Tue 12/31/19
53		**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
54		N4H Coaching from CACTI monthly via phone	130 days	Wed 1/1/20	Tue 6/30/20
55		**Milestone reporting period**	**0 days**	**Tue 6/30/20**	**Tue 6/30/20**
56		N4H Coaching from CACTI monthly via phone	132 days	Wed 7/1/20	Thu 12/31/20
57		**Milestone reporting period**	**0 days**	**Thu 12/31/20**	**Thu 12/31/20**
58		**Program Administration**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
59		Finalize assessment tools	132 days	Sat 7/1/17	Sun 12/31/17
60		Finalize protocols for patient assessment, treatment, management and referrals	132 days	Sat 7/1/17	Sun 12/31/17
61		Develop additional performance measures focused on measures focused on continuity of care between treatment settings	132 days	Sat 7/1/17	Sun 12/31/17
62		Finalize multi regional contract with Hunter College for training	132 days	Sat 7/1/17	Sun 12/31/17
63		Begin accepting client referrals from N4H partners	132 days	Sat 7/1/17	Sun 12/31/17
64		Perform data collection for reporting period	132 days	Sat 7/1/17	Sun 12/31/17
65		**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
66		Accept client referrals from N4H partners	131 days	Mon 1/1/18	Sat 6/30/18
67		Perform data collection for reporting period	131 days	Mon 1/1/18	Sat 6/30/18
68		**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
69		Accept client referrals from N4H partners	132 days	Sun 7/1/18	Mon 12/31/18
70		Perform data collection for reporting period	132 days	Sun 7/1/18	Mon 12/31/18
71		**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**
72		Accept client referrals from N4H partners	130 days	Tue 1/1/19	Sun 6/30/19
73		Perform data collection for reporting period	130 days	Tue 1/1/19	Sun 6/30/19
74		**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**
75		Accept client referrals from N4H partners	132 days	Mon 7/1/19	Tue 12/31/19



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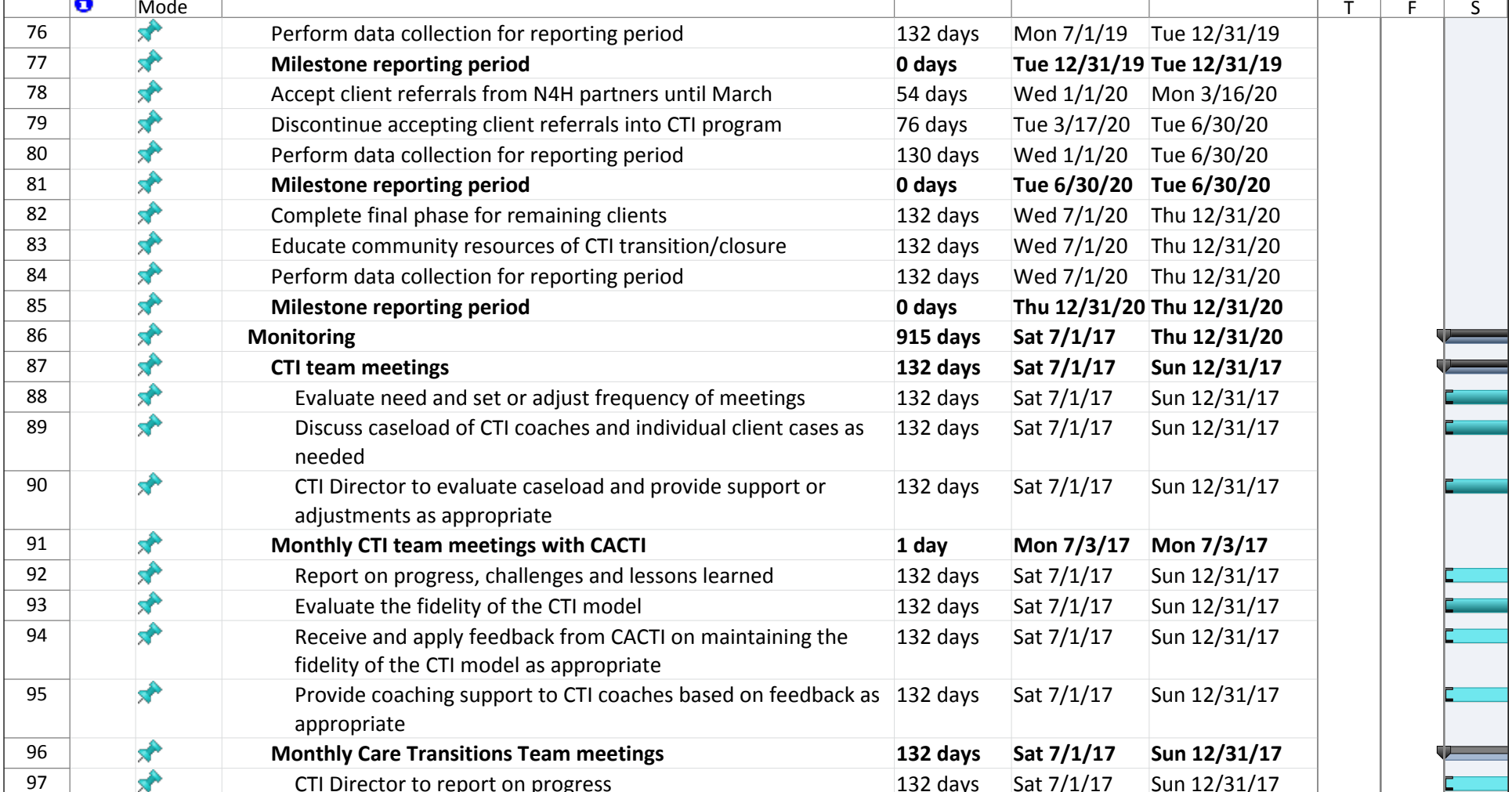
Task	External Milestone	Manual Summary Rollup
Split	Inactive Task	Manual Summary
Milestone	Inactive Milestone	Start-only
Summary	Inactive Summary	Finish-only
Project Summary	Manual Task	Deadline
External Tasks	Duration-only	Progress

ID	Task Mode	Task Name	Duration	Start	Finish
76		Perform data collection for reporting period	132 days	Mon 7/1/19	Tue 12/31/19
77		**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
78		Accept client referrals from N4H partners until March	54 days	Wed 1/1/20	Mon 3/16/20
79		Discontinue accepting client referrals into CTI program	76 days	Tue 3/17/20	Tue 6/30/20
80		Perform data collection for reporting period	130 days	Wed 1/1/20	Tue 6/30/20
81		**Milestone reporting period**	**0 days**	**Tue 6/30/20**	**Tue 6/30/20**
82		Complete final phase for remaining clients	132 days	Wed 7/1/20	Thu 12/31/20
83		Educate community resources of CTI transition/closure	132 days	Wed 7/1/20	Thu 12/31/20
84		Perform data collection for reporting period	132 days	Wed 7/1/20	Thu 12/31/20
85		**Milestone reporting period**	**0 days**	**Thu 12/31/20**	**Thu 12/31/20**
86		**Monitoring**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
87		**CTI team meetings**	**132 days**	**Sat 7/1/17**	**Sun 12/31/17**
88		Evaluate need and set or adjust frequency of meetings	132 days	Sat 7/1/17	Sun 12/31/17
89		Discuss caseload of CTI coaches and individual client cases as needed	132 days	Sat 7/1/17	Sun 12/31/17
90		CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
91		**Monthly CTI team meetings with CACTI**	**1 day**	**Mon 7/3/17**	**Mon 7/3/17**
92		Report on progress, challenges and lessons learned	132 days	Sat 7/1/17	Sun 12/31/17
93		Evaluate the fidelity of the CTI model	132 days	Sat 7/1/17	Sun 12/31/17
94		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
95		Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
96		**Monthly Care Transitions Team meetings**	**132 days**	**Sat 7/1/17**	**Sun 12/31/17**
97		CTI Director to report on progress	132 days	Sat 7/1/17	Sun 12/31/17



ID	Task Mode	Task Name	Duration	Start	Finish
98		Provide directional feedback for CTI team	132 days	Sat 7/1/17	Sun 12/31/17
99		**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
100		**CTI team meetings**	**131 days**	**Mon 1/1/18**	**Sat 6/30/18**
101		Evaluate need and set or adjust frequency of meetings	131 days	Mon 1/1/18	Sat 6/30/18
102		Discuss caseload of CTI coaches and individual client cases as needed	131 days	Mon 1/1/18	Sat 6/30/18
103		CTI Director to evaluate caseload and provide support or adjustments as appropriate	131 days	Mon 1/1/18	Sat 6/30/18
104		**Monthly CTI team meetings with CACTI**	**131 days**	**Mon 1/1/18**	**Sat 6/30/18**
105		Report on progress, challenges and lessons learned	131 days	Mon 1/1/18	Sat 6/30/18
106		Evaluate the fidelity of the CTI model	131 days	Mon 1/1/18	Sat 6/30/18
107		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	131 days	Mon 1/1/18	Sat 6/30/18
108		Provide coaching support to CTI coaches based on feedback as appropriate	131 days	Mon 1/1/18	Sat 6/30/18
109		**Care Transitions Team meetings**	**131 days**	**Mon 1/1/18**	**Sat 6/30/18**
110		Evaluate need and set or adjust frequency of meetings	131 days	Mon 1/1/18	Sat 6/30/18
111		CTI Director to report on progress	131 days	Mon 1/1/18	Sat 6/30/18
112		Provide directional feedback for CTI team	131 days	Mon 1/1/18	Sat 6/30/18
113		**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
114		**CTI team meetings**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**
115		Evaluate need and set or adjust frequency of meetings	132 days	Sun 7/1/18	Mon 12/31/18
116		Discuss caseload of CTI coaches and individual client cases as needed	132 days	Sun 7/1/18	Mon 12/31/18
117		CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Sun 7/1/18	Mon 12/31/18

ID	Task Mode	Task Name	Duration	Start	Finish	T	F	S
118		**Monthly CTI team meetings with CACTI**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**			
119		Report on progress, challenges and lessons learned	132 days	Sun 7/1/18	Mon 12/31/18			
120		Evaluate the fidelity of the CTI model	132 days	Sun 7/1/18	Mon 12/31/18			
121		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Sun 7/1/18	Mon 12/31/18			
122		Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Sun 7/1/18	Mon 12/31/18			
123		**Care Transitions Team meetings**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**			
124		Evaluate need and set or adjust frequency of meetings	132 days	Sun 7/1/18	Mon 12/31/18			
125		CTI Director to report on progress	132 days	Sun 7/1/18	Mon 12/31/18			
126		Provide directional feedback for CTI team	132 days	Sun 7/1/18	Mon 12/31/18			
127		**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**			
128		**CTI team meetings**	**130 days**	**Tue 1/1/19**	**Sun 6/30/19**			
129		Evaluate need and set or adjust frequency of meetings	130 days	Tue 1/1/19	Sun 6/30/19			
130		Discuss caseload of CTI coaches and individual client cases as needed	130 days	Tue 1/1/19	Sun 6/30/19			
131		CTI Director to evaluate caseload and provide support or adjustments as appropriate	130 days	Tue 1/1/19	Sun 6/30/19			
132		**Monthly CTI team meetings with CACTI**	**130 days**	**Tue 1/1/19**	**Sun 6/30/19**			
133		Report on progress, challenges and lessons learned	130 days	Tue 1/1/19	Sun 6/30/19			
134		Evaluate the fidelity of the CTI model	130 days	Tue 1/1/19	Sun 6/30/19			
135		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	130 days	Tue 1/1/19	Sun 6/30/19			
136		Provide coaching support to CTI coaches based on feedback as appropriate	130 days	Tue 1/1/19	Sun 6/30/19			
137		**Care Transitions Team meetings**	**130 days**	**Tue 1/1/19**	**Sun 6/30/19**			

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Task		External Milestone		Manual Summary Rollup	
Split		Inactive Task		Manual Summary	
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Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID	Task Mode	Task Name	Duration	Start	Finish	T	F	S
138		Evaluate need and set or adjust frequency of meetings	130 days	Tue 1/1/19	Sun 6/30/19			
139		CTI Director to report on progress	130 days	Tue 1/1/19	Sun 6/30/19			
140		Provide directional feedback for CTI team	130 days	Tue 1/1/19	Sun 6/30/19			
141		**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**			
142		**CTI team meetings**	**132 days**	**Mon 7/1/19**	**Tue 12/31/19**			
143		Evaluate need and set or adjust frequency of meetings	132 days	Mon 7/1/19	Tue 12/31/19			
144		Discuss caseload of CTI coaches and individual client cases as needed	132 days	Mon 7/1/19	Tue 12/31/19			
145		CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Mon 7/1/19	Tue 12/31/19			
146		**Monthly CTI team meetings with CACTI**	**132 days**	**Mon 7/1/19**	**Tue 12/31/19**			
147		Report on progress, challenges and lessons learned	132 days	Mon 7/1/19	Tue 12/31/19			
148		Evaluate the fidelity of the CTI model	132 days	Mon 7/1/19	Tue 12/31/19			
149		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Mon 7/1/19	Tue 12/31/19			
150		Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Mon 7/1/19	Tue 12/31/19			
151		**Care Transitions Team meetings**	**132 days**	**Mon 7/1/19**	**Tue 12/31/19**			
152		Evaluate need and set or adjust frequency of meetings	132 days	Mon 7/1/19	Tue 12/31/19			
153		CTI Director to report on progress	132 days	Mon 7/1/19	Tue 12/31/19			
154		Provide directional feedback for CTI team	132 days	Mon 7/1/19	Tue 12/31/19			
155		**Milestone reporting period**	**1 day**	**Tue 12/31/19**	**Tue 12/31/19**			
156		**CTI team meetings**	**130 days**	**Wed 1/1/20**	**Tue 6/30/20**			
157		Evaluate need and set or adjust frequency of meetings	130 days	Wed 1/1/20	Tue 6/30/20			
158		Discuss caseload of CTI coaches and individual client cases as needed	130 days	Wed 1/1/20	Tue 6/30/20			

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ID	Task Mode	Task Name	Duration	Start	Finish	T	F	S
159		CTI Director to evaluate caseload and provide support or adjustments as appropriate	130 days	Wed 1/1/20	Tue 6/30/20			
160		**Monthly CTI team meetings with CACTI**	**130 days**	**Wed 1/1/20**	**Tue 6/30/20**			
161		Report on progress, challenges and lessons learned	130 days	Wed 1/1/20	Tue 6/30/20			
162		Evaluate the fidelity of the CTI model	130 days	Wed 1/1/20	Tue 6/30/20			
163		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	130 days	Wed 1/1/20	Tue 6/30/20			
164		Provide coaching support to CTI coaches based on feedback as appropriate	130 days	Wed 1/1/20	Tue 6/30/20			
165		**Care Transitions Team meetings**	**130 days**	**Wed 1/1/20**	**Tue 6/30/20**			
166		Evaluate need and set or adjust frequency of meetings	130 days	Wed 1/1/20	Tue 6/30/20			
167		CTI Director to report on progress	130 days	Wed 1/1/20	Tue 6/30/20			
168		Provide directional feedback for CTI team	130 days	Wed 1/1/20	Tue 6/30/20			
169		**Milestone reporting period**	1 day	**Tue 6/30/20**	**Tue 6/30/20**			
170		**CTI team meetings**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**			
171		Evaluate need and set or adjust frequency of meetings	132 days	Wed 7/1/20	Thu 12/31/20			
172		Discuss caseload of CTI coaches and individual client cases as needed	132 days	Wed 7/1/20	Thu 12/31/20			
173		CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Wed 7/1/20	Thu 12/31/20			
174		**Monthly CTI team meetings with CACTI**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**			
175		Report on progress, challenges and lessons learned	132 days	Wed 7/1/20	Thu 12/31/20			
176		Evaluate the fidelity of the CTI model	132 days	Wed 7/1/20	Thu 12/31/20			
177		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Wed 7/1/20	Thu 12/31/20			

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ID	Task Mode	Task Name	Duration	Start	Finish	T	F	S
178		Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Wed 7/1/20	Thu 12/31/20			
179		**Care Transitions Team meetings**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**			
180		Evaluate need and set or adjust frequency of meetings	132 days	Wed 7/1/20	Thu 12/31/20			
181		CTI Director to report on progress	132 days	Wed 7/1/20	Thu 12/31/20			
182		Provide directional feedback for CTI team	132 days	Wed 7/1/20	Thu 12/31/20			
183		**Milestone reporting period**	**1 day**	**Thu 12/31/20**	**Thu 12/31/20**			

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Transformation Waiver Section 1115
Critical Time Intervention (CTI) Program Description

Service Definition and Required Components
Critical Time Intervention (CTI) is an intensive 9 month case management model designed to assist adults age 18 years and older and youth 16 or 17 years old with a behavioral health disorder 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 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.

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

A. A Network4Health Partner client who experiences a behavioral health disorder, and
B. Has at least three of the following functional impairments:
   - At risk of homelessness or homeless
   - Lack of positive social support/natural supports network
   - Inability to perform activities of daily living adequately
   - Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
   - Inability to manage money
   - Substance use with negative impact
   - Unemployment/underemployed/lack of employment skills
   - Suicide risk

AND

Individuals eligible for CTI are navigating critical transitions.
Critical transitions include the following:
- Discharge from inpatient settings or frequent emergency department visits
- Release from correctional settings
- Transition from youth behavioral health care delivery system to adult behavioral health care system.

As an evidence-based practice there are four core principles that define CTI and set it apart from other services:
1. Focuses on a critical transition period, and is time-limited
2. Enhances continuity of care and prevents recurrent homelessness and hospitalizations.
3. Identifies and strengthens formal and natural community supports.
4. Complements rather than duplicates existing services.

Pre-CTI: Pre-CTI services are provided in order to establish an initial relationship and describe the planned intervention before the transition begins.

Transformation Waiver Section 111
Critical Time Intervention (CTI) Program Description

CTI is divided into three identified phases lasting three months each.

Phase 1: Transition to the Community – In this phase, there is frequent contact with the individual in the community, focusing on active engagement with behavioral health services, and identifying and addressing housing-related issues in order to prevent future episodes of homelessness or housing instability. A transition plan is implemented while providing emotional support.

Phase 2: Tryout – In this phase, the team increasingly encourages individuals to manage problems independently after connecting them 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 and agreed upon care plan safely in place.

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	CTI specialist 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.	CTI specialist monitors the effectiveness of the support network; Helps to modify network as necessary; Continues case management activities as necessary; Continues community based visits; Provides psychoeducation about self-management and successful navigation	CTI specialist provides consultation but little direct service. The worker lets the individual solve their own problems. The worker ensures key caregivers/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); May hold a party or some other ceremonial recognition

Transformation Waiver Section 1115
Critical Time Intervention (CTI) Program Description

	Focuses on urgent/basic needs such as food, immediate medical care, shelter, warm clothing or blankets, access to essential medications; 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.); Introduces the individual to vocational services.	of the service systems and Completes any Phase I activities that still need resolutions. Less frequent meetings, and provides social crisis interventions and troubleshooting.	of successful transition out of CTI services. A final meeting is held to formally recognize the end of interventions and relationship.

Individuals receiving CTI are served until transitioned to and engaged with the next provider through the structured and time-limited 3 phase model. CTI works to keep individuals engaged in services. CTI allows for the possibility that the individual may not be actively engaged in services. CTI may re-engage with individuals after they disengage in active services, or become unavailable for some period of time. If an individual is not actively engaged in services and then returns, the CTI worker doesn't pick up on where they left off but starts on the phase the individual would have been in should they have stayed in continuous service.

At the end of the nine months, individuals who were receiving CTI should be engaged with desired and appropriate community-based services which can provide ongoing support.

Provider Requirements

The provider organization offering Critical Time Intervention shall be a member of N4H. This partner agrees to support a high fidelity implementation of CTI.

The partner shall make available one private office space for the Care Transitions Director/Clinical Supervisor and meeting space for the team.

Prior to implementation, the provider organization will ensure that all team members have completed, at a minimum, the Critical Time Intervention training provided by a certified trainer approved by N4H within 60 days of hire.

Transformation Waiver Section 111
Critical Time Intervention (CTI) Program Description

Staffing Requirements
This service will be provided by a team of seven full-time equivalent positions-a Care Transitions Director/Clinical Supervisor and Transitions Coaches.

The Care Transitions Director/Clinical Supervisor must be a full-time, dedicated, master level, mental health professional that has at least two years of experience with the knowledge, skills, and abilities required by the population to be served. Licensure as a Licensed Clinical Social Worker, Licensed Mental Health Counselor or Licensed Alcohol and Drug Abuse Counselor is preferred.

Transition Coaches must have a bachelor's degree and one year experience working with individuals who experience behavioral health disorders or have "lived experience" either as a service recipient or family member and have attended a peer support, recovery coaching or family support training program.

The maximum caseload ratio for a full-time CTI worker is 1:20. Due to the varying level of intensity of work during each phase, admission to the team should be staggered to maintain a caseload of individuals who are in each phase.

Staff Training and Supervision Requirements
As noted above, the provider organization ensures that all team members have completed the Critical Time Intervention training provided by a N4H approved trainer 60 days from the date of hire.

In addition to the basic Critical Time Intervention training, all staff providing this service must have the following training within the first year of employment.

- Stages of Change Training
- Introduction to Motivational Interviewing
- Ethics
- Cultural Competence and Language Access
- Person Centered Planning
- Suicide Prevention

These initial training requirements may be waived if the employee can produce written documentation certifying their successful completion of the required trainings within the past 12 months.

Other desired topics of additional training may include:

- Integrated Care Core Competencies
- General Overview of NH health care delivery system.

- Family Psychoeducation;
- Recovery Oriented Approaches
- Recovery Planning
- Benefits Counseling
- Individual Placement and Support/Supported Employment
- Limited English Proficiency (LEP), blind or visually impaired, deaf and hard of hearing accommodations
- Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: Pathways Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models
- Trauma Informed Care
- Wellness and Integrated Health Care
- Wellness Management and Recovery interventions (includes WRAP, IMR/WMR)
- Money management and budgeting skills

All team members shall receive weekly clinical supervision from the team's clinical supervisor.

Clinical Supervision is the provision of guidance, feedback, and training to team members to assure that quality services are provided to the individuals served and to maintain and facilitate the skills of the supervisee to assure all members of the team are utilizing and maintaining fidelity to the evidence-based CTI model.

CTI Teams meet weekly for clinical supervision and to share practical strategies for working with individuals and their complex needs. Each meeting should include the following:

- 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.

Additional individual clinical supervision sessions between the Transitions Director/Clinical Supervisor and a team member shall occur as needed.

The Care Transitions Director/Clinical Supervisor shall maintain documentation of both supervision and training activities. Transitions Director/Clinical Supervisor must document supervision.

Transformation Waiver Section 1115
Critical Time Intervention (CTI) Program Description

Intervention Type and Setting

CTI is intended to be flexible in its approach to meet the needs of adults in their current settings and locations, and during transition to new settings. CTI should mobilize available resources rather than duplicate existing services. It is expected that a significant amount of service delivery will occur in various non-traditional community settings such as "on the street" encounters with homeless individuals.

This intervention can be delivered as part of the discharge planning process from facilities.

Program Requirements

The individual receiving CTI drives the direction of the service by establishing goals that may include: housing, employment, access to mental health, substance abuse and medical treatment, access to benefits, improving family and social support, budgeting and money management, and building independent living skills.

Because of the financial difficulties individuals receiving CTI services are likely to experience, the intervention may include obtaining and completing documentation critical to support individuals during life transitions, including but not limited to: photo identification, housing application fees, birth certificates, criminal background checks, and credit checks.

CTI is an individual community-based service requiring frequent contact to build/re-establish a trusting, meaningful relationship to engage or re-engage the individual into services and/or assess for needs. The service is designed to:

- Promote recovery, hope, and empowerment
- Assess for and provide linkage to the appropriate supports
- Identify methods to maximize independent living skills
- Assist in accessing benefits and appropriate formal services
- Assist in identifying and linking to informal community supports such as social networks and improved family relationships
- Reduce frequency and duration of hospitalizations
- Reduce frequency of Emergency Department visits
- Reduce utilization of crisis services
- Reduce criminal justice system involvement and days incarcerated
- Provide continuity of care regardless of life circumstances or recovery environment
- Promote adherence to prescribed medications and treatment
- Promote harm reduction, linkage to recovery treatment, and support sustained recovery maintenance

Although the CTI model is time limited and has a prescriptive 3 phase approach, the number of contacts made by the Transitions Coach per week is tailored to the individual's current needs. The CTI staff will provide multiple contacts per week as needed. CTI varies in intensity to meet the

changing needs of the individuals served and contacts are expected to taper in volume and frequency throughout the duration of the three phases.

During Phase 1, a Transitions Coach must have at least six community-based meetings per month with an individual being served for a total of at least eighteen community-based meetings for Phase 1. Of the eighteen, two community-based meetings must be with an individual's provider and/or informal supports.

During Phase 2, a Transitions Coach must have at least two community-based meetings per month with an individual being served for a total of at least six community-based meetings in Phase 2. Of the six community-based meetings, two must be with an individual's provider and/or informal supports. During Phase 2, a Transition Coach meets less frequently with an individual being served but phone and collateral contacts increases.

During Phase 3, a Transitions Coach transfers care and responsibilities to both the individual being served and the formal and informal caregivers. During Phase 3, a Transitions Coach must have a minimum of two community-based meetings with an individual being served. The Transitions Coach role during this phase shifts to monitoring via phone calls with the individual and the individuals provider/informal caregivers.

Entrance Process
Referrals for CTI services may come from any N4H Partner or anyone else who recognizes the need for engagement and transition services on behalf of an individual.

The approved N4H Comprehensive Core Standardized Assessment (CCSA) is required for entrance into this service. The CTI team can obtain a CCSA that has been completed in the previous 12 months and contains relevant current information. The Transitions Director/Clinical Supervisor may complete an abbreviated assessment and obtain any other available clinical materials upon referral to CTI. However, the N4H CCSA must be completed within 30 days of acceptance to the service.

If completing an abbreviated assessment, the format of the abbreviated assessment is determined by the individual provider based on the clinical presentation. Although the abbreviated assessment does not have a designated format, the assessment must be completed by a licensed professional and must include the following elements:

a) the individual's presenting problem;
b) the individual's needs and strengths;
c) a pertinent social, family, and medical history; and
d) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the individual's needs.

The CTI provider will be responsible for the development of a CTI Phase Plan. The CTI goals should be very simple, addressing no more than 3 areas at a time and evolving with respect to the individual's progress, participation, and choices.

The CTI team will pro-actively assist individuals in the prevention of social crisis episodes. The CTI team is not expected to be on call as a "first responder" for crisis events, but is expected to assist the individual in the development of a detailed crisis plan, and to assure that the plan is as widely distributed to key partners to the extent allowed by the individual.

Discharge Criteria
The individual is discharged nine months from the Phase 1 start date;

OR
The individual no longer wishes to receive CTI support and has refused CTI services after reasonable attempts have been made to engage him/her in treatment and no safety issues or concerns are present;

OR
The individual is clearly in need of a higher level of care and has been connected to the service.

Fidelity Monitoring
CTI teams will complete the CTI Self-Assessment every 6 months beginning from the date the team starts. Documentation of completed Self-Assessments must be made available upon request. The Self-Assessment is a quality improvement tool used to measure adherence to the CTI model.

Expected Outcomes
The expected outcomes for this service are specific to the goals identified in the individual's CTI Service Plan, and may include, but are not necessarily limited to, the following:

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

Teams will utilize a provided tracking tool to document outcomes. This tool is completed ongoing and the information must be provided to the N4H Data Analyst quarterly.

Documentation Requirements

Documentation shall include but is not limited to a CTI Phase Plan, CTI Phase Date Form, CTI Progress Notes, CTI Supervision and Caseload Review Forms. All participants must have a completed N4H Comprehensive Screening Assessment. All participants with an N4H Shared Community Care Plan shall have critical time intervention services identified.

A documented discharge plan shall be discussed with the individual and included in the service record.

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.

If a narrative is needed to complement the project plan or provide further explanation, please include it.

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

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

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.*

For this project, Network4Health is expanding access to substance use treatment services by developing a partial hospitalization program that will be located at Serenity Place, a network provider. The program will begin admitting patients in January 2018. The project plan goes through 2018, but is more heavily focused on activities in 2017 leading up to the program opening. As the project continues, Network4Health will add more details to the plan for 2018. The project plan (Attachment_D3.1) provides a step-by-step, detailed approach to implementing this program, including:

- identifying and procuring space for the program; build out space as needed, and providing necessary equipment;
- hiring and recruitment;
- on-boarding and training;
- designing and implementing an EHR using the EPIC system;
- adapting assessment and screening tools for the PHP;
- developing all policies, protocols and work flows for implementing the PHP, including intake, assessment, treatment and referral protocols, and billing;
- developing a program evaluation and monitoring plan;
- developing a data reporting plan; and,
- developing a marketing plan for the program.

In addition to adding this service, Network4Health will also help to ensure expanded capacity for ambulatory and non-hospital inpatient medical monitored residential services, as well as hospital inpatient medically managed withdrawal management services, as indicated for individuals with mental health, substance use or co-occurring disorders. Medication assisted treatment (MAT) and tobacco

cessation are also provided across the system, as is comprehensive outpatient counseling for substance use disorders. These services are offered today by our Network4Health partners, and as described throughout our submission, services will be expanded through our efforts to address workforce issues, including reducing open positions and providing essential training and development for our staff. All providers will be working towards greater coordination and/or integration through our B1 project and implementing initiatives to move practices along the SAMHSA integrated care continuum, including integration of behavioral health assessment and services within practices. Our E4 project is focused specifically on increasing our partner's abilities to treat co-occurring disorders and is designed to enhance the capacity/competencies of serving people with co-occurring substance use disorders.

Examples of current services provided through Network4Health partners include ambulatory behavioral health services providing aftercare for substance-dependent clients discharged from acute detox; provision of outpatient detox; individual case management and peer support services; treatment for co-occurring disorders within a substance use setting; psychiatric services; comprehensive mental health outpatient services, including individual, family and group therapy and medication services. Examples of ongoing therapy groups include trauma recovery, anger management and relapse resistance. Providers utilize ASAM criteria to ensure that patients are receiving the appropriate level of care.

Through our B1 project, primary care practices will become coordinated and/or integrated and will receive extensive training including but not limited to how and when to give mental health assessments, recognizing triggers for involving behavioral health, and understanding the behavioral health referral process.

Network4Health partners strive to bring a person-centered approach that builds on each individual's strengths with counseling, therapies and medication management in the least restrictive community setting. Smoking cessation education and counseling is also provided across the system. Our goal is to help behavioral health patients make meaningful progress toward real recovery. Currently, Serenity Place and the Elliot Health System are partnering to expand access to medication assisted treatment.

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
PERFORMANCE SPECIFICATIONS	PHP to comply with applicable requirements, including licensure, Bureau of Drug and Alcohol Programs (BDAP) principles, as appropriate, and credentialing requirements of BHHS by 12/31/2017			
	Serenity Place to enroll in NH Medicaid program for its PHP service by 12/31/2017			
	Serenity Place to enroll in Medicare for its PHP service by 12/31/2017			
Length of Stay	Revaluate program participants every 30 days, at a minimum.			
STRUCTURAL SPECIFICATIONS	Include psychiatric treatment as part of PHP program by 6/30/2018.			
Number of Individuals Served	Up to 88 (total individuals in 2018)		Up to 36	Up to 88

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.

The information in this chart is in addition to the open positions identified within the workforce gap analysis.

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
Program Director	Up to 1	0	Up to 1	Up to 1	Up to 1
BH (MH & SUD) Clinicians - LMHC Counselor and/or LADC/MLADC Counselor	Up to 2	0	Up to 2	Up to 2	Up to 2
Care Coordinator (ie, Case Manager) -BSW, LMA or RN	Up to 1	0	Up to 1	Up to 1	Up to 1
Care Enhancer (ie, Peer Support Specialist) - Patient Advocate; CRSW or other national certification	Up to 1	0	Up to 1	Up to 1	Up to 1
Care Coordinator – RN for medication management	Up to 1	0	Up to 1	Up to 1	Up to 1
Psychiatric Clinician - Psychiatrist or Psychiatric Advanced Practice Nurse	Up to .6	0	Up to .6	Up to .6	Up to .6
Care Enhancer (ie, Outreach worker*) – Community Health Worker	Up to 1	0	0	Up to 1	Up to 1

*Note that a current Serenity Place Outreach Worker will serve this role until there are enough patients to justify a full time position. We do not expect that to happen by December 31, 2017.

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.

The budget below provides a high-level view of expected costs associated with implementing the PHP program, anticipating serving up to 88 individuals in 2018 and adding additional capacity over time. The Director of the SUD Expansion (IPH) position will be funded through Project Design and Capacity Funds, all other program staff will be funded through this budget. The budget assumes that the PHP program will run five days a week and over the period of the waiver will expand to up to five sites and serve up to 440 patients when at full capacity in 2020. Beginning in CY18 the PHP will generate revenue from billing Medicaid and other payers.

TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
D3 Revenue (New)	$ 451,560	$ 451,560	$ 477,120	$ 477,120
D3 Revenue (Rollover)		$ 351,653	$ (47,277)	$ 3,548
Generated Revenue from Billing		$ 220,880	$ 662,640	$ 1,104,400
Total Revenue	$ 451,560	$ 1,024,093	$ 1,092,483	$ 1,585,068
Salaries and Benefits	$ 95,117	$ 570,700	$ 856,050	$ 1,141,400
Sub-contractor Reimbursement	$ -	$ 11,440	$ 34,320	$ 57,200
On-boarding	$ 1,000	$ 2,000	$ 2,500	$ 3,000
EMR licensing and implementation	$ -	$ 423,000	$ -	$ -
Lease	$ -	$ 12,000	$ 72,000	$ 120,000
Equipment	$ 500	$ 12,000	$ 30,000	$ 34,000
Supplies	$ 1,440	$ 14,640	$ 31,920	$ 37,200
Food/Snacks	$ -	$ 15,840	$ 47,520	$ 79,200
Travel	$ -	$ 2,400	$ 3,600	$ 4,800
Marketing	$ 750	$ 750	$ 1,125	$ 1,500
Training	$ 1,100	$ 6,600	$ 9,900	$ 13,200
Subtotal	$ 99,907	$ 1,071,370	$ 1,088,935	$ 1,491,500
Variation to Budget (Transfer Funds to Proceeding Year)	$ 351,653	$ (47,277)	$ 3,548	$ 93,568

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

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

Serenity Place and the Elliot Health System have partnered to develop this initial partial hospitalization program. Over time additional Network4Health partners may become key organizations in this project if and when PHPs are added.

Organization/Provider	Agreement Executed (Y/N)
Serenity Place	Y
Elliot Health System	Y

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.

In determining which patients are most appropriate for PHP services, Network4Health will utilize screening tools as the initial component of assessment. A screen is only a brief method of determining whether a particular condition is present. A positive screen should trigger a detailed assessment that will confirm whether the condition or disorder is indeed present. In turn, assessment of both disorders will inform and develop integrated treatment planning for all detected disorders.

The aim of screening is to increase the detection of co-occurring disorders and to indicate when a detailed assessment of co-occurring disorders is warranted. The aim of assessment of co-occurring disorders is to garner information that will inform effective integrated treatment planning.

In practice, the distinction between screening and assessment is not and should not be clear-cut. Many screening tools also provide useful assessment information. Once a clinician has incorporated routine screening into their practice the transition from screening to assessment will be imperceptible to the client. The screening processes, if sensitively deployed, also can provide a further opportunity to build engagement with clients.

Network4Health will encourage routine screening for co-occurring disorders by mental health and substance treatment agencies. Often even experienced clinicians do not recognize or screen for co-occurring disorders. If patients are only treated for one of their illnesses, the short and long term effectiveness of the treatment is reduced. There is also the potential for large scale human and financial savings if we improve screening for co-occurring illness and develop better treatment responses. In addition, we need to focus on diagnosing and treating high-prevalence mental health disorders that often go undiagnosed including anxiety and depression. These diagnoses can often lead to dependent substance abuse if not treated successfully.

In addition to more routine screening, Network4Health will implement comprehensive assessments for anyone who initially screens positive for co-occurring illness. An assessment is a more time-intensive process that may confirm whether the co-occurring condition or disorder is present. The assessment will also describe illness severity, the impact the co-occurring illness has on the client and relevance to the client's life, and the client's perceptions, attitudes and beliefs about the condition or disorder. The assessment will also be the first step in informing the client about the illness and developing an integrated treatment plan.

The table below includes the assessment and screening tools that Network4Health partners are currently using or may adopt to identify individuals who may be appropriate for the partial hospitalization program.

Standard Assessment Tool Name	Currently Using/ May Adopt	Brief Description
(1). **K10**	May adopt	**The K10** or Kessler Psychological Distress Scale is a 10-item scale is intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period. High K10 scores also may be an indicator of possible Serious Mental Illness.

Standard Assessment Tool Name	Currently Using/ May Adopt	Brief Description
(2). **PsyCheck**	May Adopt	***The PsyCheck S***creening Tool is a mental health screening instrument designed for use by non-mental health specialists. It is not designed to be a diagnostic assessment and will not yield information about specific disorders' (Lee et al., 2007). It screens for: •Likely presence of mental health symptoms that may be addressed within specialist AOD treatment services. •Anxiety and depression but also provides some indication of suicide risk and history of psychotic illness.
(3) **Modified Mini Screen (MMS)**	Currently Using	**The MMS** is designed to identify people in need of an assessment in the domains of mood disorders, anxiety disorders and psychotic disorders. It is not diagnostic per se, but is intended as an indicator of when a more thorough mental health assessment is required.
(4) **Mental Health Screening Form**	Currently Using	**The Mental Health Screening Form i**s a 17-item screen that examines lifetime history of mental health. Questions 1–4 are about the client's history of psychiatric treatment. Each of questions 5—17 is associated with a particular mental health diagnosis. Positive responses to these items suggest the need for more intensive assessment or consultation with a mental health professional.

Standard Assessment Tool Name	Currently Using/ May Adopt	Brief Description
(5) **ASSIST**	May adopt	**The ASSIST** screens for: • substances people ever used (lifetime use) • substances used in past three months • problems related to substance use • risk of harm (current or future) • dependence • intravenous drug use. **The ASSIST can …** • warn people of their risk of developing problems related to their substance use • provide an opportunity to start a discussion about substance use • identify substance use as a contributing factor to the presenting illness • be linked to a brief intervention to help high-risk substance users to cut down or stop their drug use and avoid the harmful consequences of their substance use. **The ASSIST can distinguish between three main groups:** • low-risk substance users or abstainers • those whose patterns of use put them at risk of problems/who have already developed problems/who are at risk of developing dependence • those who are dependent on a substance.
(6) **AUDIT**	Currently using	**The AUDIT Screens for:** • Alcohol use disorders (past-year time frame). This instrument is a 'Gold standard' for providing an indication of both hazardous/harmful alcohol use as well as alcohol dependence.
(7) **DAST 20**	Currently Using	**The DAST 20:** 1) provides a brief, simple, practical, but valid method for identifying individuals who are using psychoactive drugs; and 2) yields a quantitative index score regarding the degree of problems related to drug use and misuse. DAST 20 scores are highly diagnostic with respect to a DSM diagnosis of psychoactive drug dependence.

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.

Assessment and diagnosis are particularly important in developing a treatment plan and in determining specific problem areas that can be effectively targeted for treatment interventions. Key diagnostic instruments include the Diagnostic Interview Schedule — Fourth Edition (DIS-IV) and the Structured Clinical Interview for DSM-IV (SCID). The American Society of Addiction Medicine (ASAM, 2001) has developed a set of Patient Placement Criteria (PPC) that can be used in matching individuals to different levels of treatment and that includes guidelines for placement of persons with co-occurring disorders.

Network4Health will provide staff involved in the screening and assessment of co-occurring disorders and AOD Disorders with ongoing training. Training will be provided in detecting signs and symptoms of co-occurring disorders, understanding complicated symptom presentation (e.g., mimicking, masking), using integrated screening and assessment instruments, employing strategies to enhance accuracy during interviews, drug testing, differential diagnosis, and initiating referral for assessment and treatment.

Assessment is typically conducted through a clinical interview and may include psychological, laboratory, or other testing, and compilation of collateral information from family, friends, and others close to the individual. Assessment provides a comprehensive examination of psychosocial needs and problems, including the severity of mental and substance use disorders, conditions associated with the occurrence and maintenance of these disorders, problems affecting treatment, individual motivation for treatment, and areas for treatment interventions. Assessment is an ongoing process that often includes engagement, identification of strengths and weaknesses, examination of motivation and readiness for change, review of cultural and other environmental needs, diagnosis, and determination of the appropriate setting and intensity/scope of services necessary to address co-occurring disorders and related needs. Goals of the assessment process include:

- Examination of the scope and severity of mental and substance use disorders, and conditions associated with the occurrence and maintenance of these disorders;
- Development of diagnoses according to formal classification systems (e.g., DSM-V);
- Identification of the full spectrum of psychosocial problems that may need to be addressed in treatment;
- Determination of the level of service needs related to mental health and substance misuse problems;
- Identification of the patient's level of motivation and readiness for treatment;
- Examination of individual strengths, areas of functional impairment, cultural and linguistic needs, and other environmental supports that are needed;
- Evaluation of risk for behavioral problems, violence, or recidivism that may affect placement in various institutional or community settings; and
- Provision of a foundation for treatment planning.

The table below provides the protocols that are or will be utilized as part of the partial hospitalization program and a brief description of each protocol.

Protocol Name	Brief Description	Use (Current/Under Development)
(1). Drug testing	Two types of testing schedules are typically used once it is determined that drug testing is appropriate for a particular individual: spot testing and random drug testing. Spot testing is usually performed if it is suspected that an individual is currently intoxicated and particularly if a certain incident or event occurred. Random drug testing allows programs to discourage use while minimizing the cost of consistent and frequent testing. Individuals do not know when they will be called in for testing, and as a result they are less likely to tamper with the drug testing process.	**Currently used**
(2). Self-Reported Information	Self-reported patient information has been found to have good reliability and specificity, but does not always help to identify the full range of symptoms of co-occurring disorders. Self-reported information is more accurate in detecting alcohol use than drug use because of the illicit nature of drugs.	**Currently used**
(3). Use of Collateral Information	Whenever possible, interview and test results should be supplemented by collateral information obtained from family members, friends, housemates, and other informants who have close contact with the individual. Observation by family members, friends, or direct care staff may also provide important collateral information that is as accurate as that obtained from interviews or standardized instruments	**Currently Used**
(4). Addiction Severity Index	This is one of the most widely used substance abuse instruments for screening, assessment, and treatment planning. The 155-item instrument was designed as a structured interview to examine alcohol and drug dependence, the frequency of use, and other psychosocial areas that have been affected by using substances.	**Currently Used**

Protocol Name	Brief Description	Use (Current/Under Development)
(5). American Society of Addiction Medicine – Patient Placement Criteria (ASAM PPC-2R)	The ASAM PPC-2R guidelines recognize that for persons with co-occurring disorders, the disorder that causes the most functional impairment should be considered in making the placement to a particular type of treatment setting. Treatment programs described in the PPC-2R may be either "dual diagnosis capable" or "dual diagnosis enhanced" to address persons with co-occurring disorders who have less stable or more stable mental health problems. For each level of treatment, criteria are specified (within dimensions two to six) for dual diagnosis capable and enhanced programs.	**Currently used**

Protocol Name	Brief Description	Use (Current/Under Development)
(6). Physical Detoxification Services for Withdrawal From Specific Substances	The three components of the detoxification process are 1) Evaluation—This component includes screening and assessment in order to detect the presence and concentration of substances and identify co-occurring medical and psychological conditions. The evaluation phase also includes determination of the client's social situation in order to select appropriate level of treatment after detoxification. The evaluation serves as the basis for the initial substance abuse treatment plan upon completion of detoxification. 2) Stabilization—This component includes assisting the individual through acute intoxication and withdrawal to a medically stable, fully supported drug-free state. Medications may be used during this stage .The process introduces individuals to treatment and their role in recovery. Significant others are involved for support as appropriate, maintaining confidentiality. Fostering readiness and entry into treatment involves preparing the individual for entry into treatment: This component stresses the importance of follow-through regarding the complete substance abuse treatment continuum of care. It also educates the client about the treatment process and the disease of addiction. Sometimes the stabilization phase includes the use of written treatment contracts. *3*) Client entry into treatment—This component involves preparing the client for entry into treatment by stressing the importance of following through with the complete continuum of care. For clients who have demonstrated a pattern of completing detoxification services and then failing to engage in substance abuse treatment, a written treatment contract may encourage entrance into a continuum of treatment and care. This contract, which is not legally binding, is voluntarily signed by individuals when they are stable enough to do so at the beginning of treatment. In it, the client agrees to participate in a continuing care plan, with details and contacts established prior to the completion of detoxification.	**Currently used**

Protocol Name	Brief Description	Use (Current/Under Development)
(7). Intake, Referral, and Billing	The referral process will begin with our admissions department who will coordinate the client's intake. A detailed intake assessment will be done with the client and a verification of benefits will be carried out. The client will be greeted by a friendly and compassionate clinician who will aid in making their transition into treatment as comfortable as possible. Following the completion of their assessment we will make treatment recommendations to the client and his or her family.	**Under Development**
(8). Treatment	Once the client has been admitted to one of our programs, our multidisciplinary team of specialists works with him or her to develop a customized and comprehensive treatment plan. The treatment plan utilizes a multi-modal approach to challenge maladaptive thoughts and behaviors and faulty beliefs and teach alternative ways of having needs met and restore hope. Treatment begins with a medical history check, a physical assessment and a comprehensive review of academic performance, nutrition, drug history, strengths, weaknesses and past family interactions in preparation for family therapy. Throughout the client's treatment, the primary therapist will be in close communication with the client in order to ensure the best possible continuity of care. Upon discharge the client will be transferred back to a lower level of care for continued treatment.	**Under Development**

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] Elliot Health System	Executive Sponsor • Champion the project and the team. • Responsible for the overall success of the project. • Provide high-level oversight, direction, and support. • Empower the project owner/business sponsor and project manager.

	• Ensure project meets goals. • Address any significant budget issues. • Approve any major scope changes. • Ensure resources are available to deliver within the scope and schedule, as needed. • Approve project initiation and conclusion. • Meet regularly throughout effort and review project progress. • Approve the project charter(s).
[redacted], Elliot Health System [redacted] Makin' It Happen [redacted] Serenity Place	Project Co-leads • Ensure project objectives are being met. • Responsible for the overall success of the project. • Partner to oversee project deliverables, schedule, budget, and human resources. • Champion the project and the team. • Provide high-level updates to Steering Committee as needed. • Approve or recommend scope changes. • Review and provide approval at key junctures of the project. • Approve needed changes to policies and procedures as identified by the project team. • Meet regularly with project manager and the project team as needed.
[redacted] Elliot Health System	Project Manager • Responsible for the overall success of the project. • Manage and lead the project team. • Recruit project staff and consultants, where necessary. • Manage coordination of the partners and working groups engaged in project work. • Facilitate scope definition as part of the project charter. • Facilitate project plan development to set expectations for deliverables and schedule. o Develop and maintain a detailed project schedule. o Manage project deliverables in line with the project plan. o Record and manage project issues and escalate where necessary. o Resolve cross-functional issues at project level. o Manage project scope and change control and escalate issues where necessary. o Monitor project progress and performance. o Provide status reports to the project sponsor and EPMO.

	• Coordinate with, and update progress to project executive sponsor, co-leads, and project team. • Coordinate phase sign-offs. • Work closely with stakeholders to ensure the project meets business needs. • Manage project close out and evaluation and ensure appropriate transition to operations.
[redacted], Derry Friendship Center [redacted], DHC-Manchester [redacted], HOPE for NH Recovery [redacted], MHCGM [redacted], Office of Catholic Identity, CMC [redacted] HOPE for NH Recovery [redacted], Crotched Mountain [redacted] Families in Transition [redacted], Farnum Center at Easter Seals	Team Members • Actively support and endorse project. • Ensure quality outcomes. • Participate in project team meetings as needed. • Actively participate in project activities as needed to support the successful delivery of project outcomes. • Ensure cross-team communication and collaboration. • Identify cross-team issues and coordinate issue resolution. • Document operations process flows, gaps and recommended changes. • Work with the co-leads to ensure the needs of the Network can be supported. • Ensure that all team members have the information they need to complete their work successfully. • Provide recommended changes for policies and procedures based on the project outcomes. • Review project deliverables for completeness, quality, and compliance with established project standards. • Problem solve and embrace change. • Step in and help whenever needed.

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

Ongoing training will be provided for staff involved in the screening and assessment of co-occurring disorders and AOD Disorders. Training should be provided in detecting signs and symptoms of co-occurring disorders, understanding complicated symptom presentation (e.g., mimicking, masking), using integrated screening and assessment instruments, employing strategies to enhance accuracy during interviews, drug testing, differential diagnosis, and initiating referral for assessment and treatment.

As it readies to open the PHP, Serenity Place will offer a training series which will occur over several weeks for each staff person beginning working within the program. A training protocol is included as

Attachment_D3.9. Education will be delivered weekly through educational modules which will support newly hired staff through the Core Competencies of the 12 Core Functions of Substance Use Disorder Treatment as well as NBCC Counselor Competencies. Content of these modules will be delivered in a formal training environment weekly in a conference space. Participants will be provided with modules weekly. These documents will contain the following, steps, protocols and processes to complete tasks, decision trees, further academic resources for continuing education as well as weekly question and answer forums to express concerns and barriers as training develops.

Modules Table of Content may include the following clinical topics.

- Terminology
- Relationship Building and Boundaries in Clinical Practice
- Ethics (Overview of NBCC and NH MLADC Expectations and Core Competencies)
- Assessment Tools Utilized (Including instructions for delivery, scoring and application and interpretation/findings)
- Basic Counseling Skills
- Serenity Place Policies and Procedures for reporting SI, HI
- Serenity Place Policies and Procedures for Urinalysis
- Serenity Place Policies and Procedures for completion summaries and aftercare referral
- Collateral Contacts
- Tracking Outcomes (Survey Monkey)
- DSM-5 Primer

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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
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				

Project: D3 SUD Expansion

Friday
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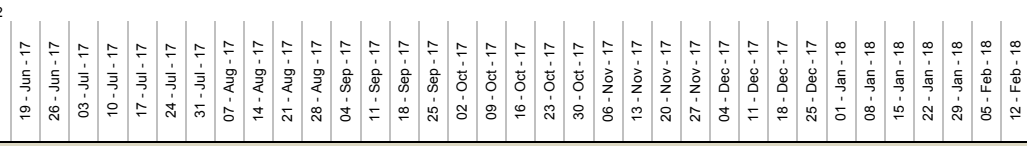
Elliot Health System

Project Lead: [redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
1	**Hiring/Recruiting**		**7/1/17**	**3/31/20**	1004	717
1.1	Complete job descriptions		7/1/17	8/11/17	41	30
1.2	Advertise (via respective organization)		7/1/17	12/31/17	183	130
1.3	Conduct Interviews		7/15/17	12/31/17	169	120
1.4	Evaluate Additional Staffing Needs for Phase 2		10/1/18	12/31/18	91	66
1.5	Evaluate Additional Staffing Needs for Phase 3		1/1/20	3/31/20	90	65
2	**On-boarding**		**6/26/17**	**12/1/17**	158	115
2.1	Onboarding requirements		6/26/17	8/30/17	65	48
2.2	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	66
3	**Electronic Medical Record**		**2/1/18**	**12/31/19**	698	499
3.1	Generate EMR quote from Epic		2/1/18	6/30/18	149	107
3.2	Negotiate contract with Epic		7/1/18	12/31/18	183	131
3.3	Design and Implement EMR		1/1/19	12/31/19	364	261
4	**Forms/Assessment**		**7/1/17**	**12/31/17**	183	130
4.1	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
4.2	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	109
5	**Policies and Protocols**		**8/1/17**	**10/31/17**	91	66
5.1	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
5.1.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	13
5.2	Develop and approve Treatment Management Policy Policy & Protocol		9/1/17	9/15/17	14	11
5.3	Develop and approve Referral Policy Policy & Protocol		9/15/17	10/1/17	16	11
5.4	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
6	**Billing**		**6/26/17**	**11/1/17**	128	93
6.1	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	20
6.2	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	73
7	**Program Evaluation**		**6/19/17**	**9/1/17**	74	55
7.1	Determine program metrics		6/19/17	6/30/17	11	10
7.2	Develop program evaluation		7/1/17	7/15/17	14	10
7.3	Identify sister programs for fidelity		7/15/17	7/31/17	16	11
7.4	Create evaluation schedule		8/1/17	9/1/17	31	24
8	**Fit-up/Construction**		**10/1/17**	**9/1/20**	1066	762
8.1	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
8.2	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
8.2.1	Negotiate Lease		4/1/19	4/30/19	7	22
8.2.2	New space fit-up/construction		5/1/19	9/1/19	7	88
8.3	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
8.3.1	Negotiate Lease		4/1/20	4/30/20	7	22
8.3.2	New space fit-up/construction		5/1/20	9/1/20	7	88
9	**Process Workflow**		**8/1/17**	**9/15/17**	45	34
9.1	Develop Intake workflow		8/1/17	8/15/17	14	11
9.2	Develop Referral workflow		8/16/17	8/30/17	14	11
9.3	Develop Billing workflow		9/1/17	9/15/17	14	11
10	**Training**		**7/1/17**	**1/8/20**	921	658
10.1	Identify Training needs		7/1/17	7/30/17	29	20
10.2	Develop training material		11/1/17	11/30/17	29	22
10.2.1	Safety		11/1/17	11/30/17	29	22
10.2.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	22
10.2.3	Justice		11/1/17	11/30/17	29	22
10.3	Basic training – 5 day orientation for all staff: 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	4
10.4	Electronic training for the EMR		1/1/20	1/8/20	7	6
11	**Data Reporting**		**7/1/17**	**1/31/19**	579	414
11.1	Process metric submission		7/1/17	7/31/17	30	21
11.2	Process metric submission		1/1/18	1/31/18	30	23
11.3	Performance metric Submission		7/1/18	7/31/18	30	22
11.4	Performance metric Submission		1/1/19	1/31/19	30	23
12	**Marketing**		**9/15/17**	**12/31/17**	107	76
12.1	Develop brochures		9/15/17	10/30/17	45	32
12.2	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44



Project: D3 SUD Expansion

Friday
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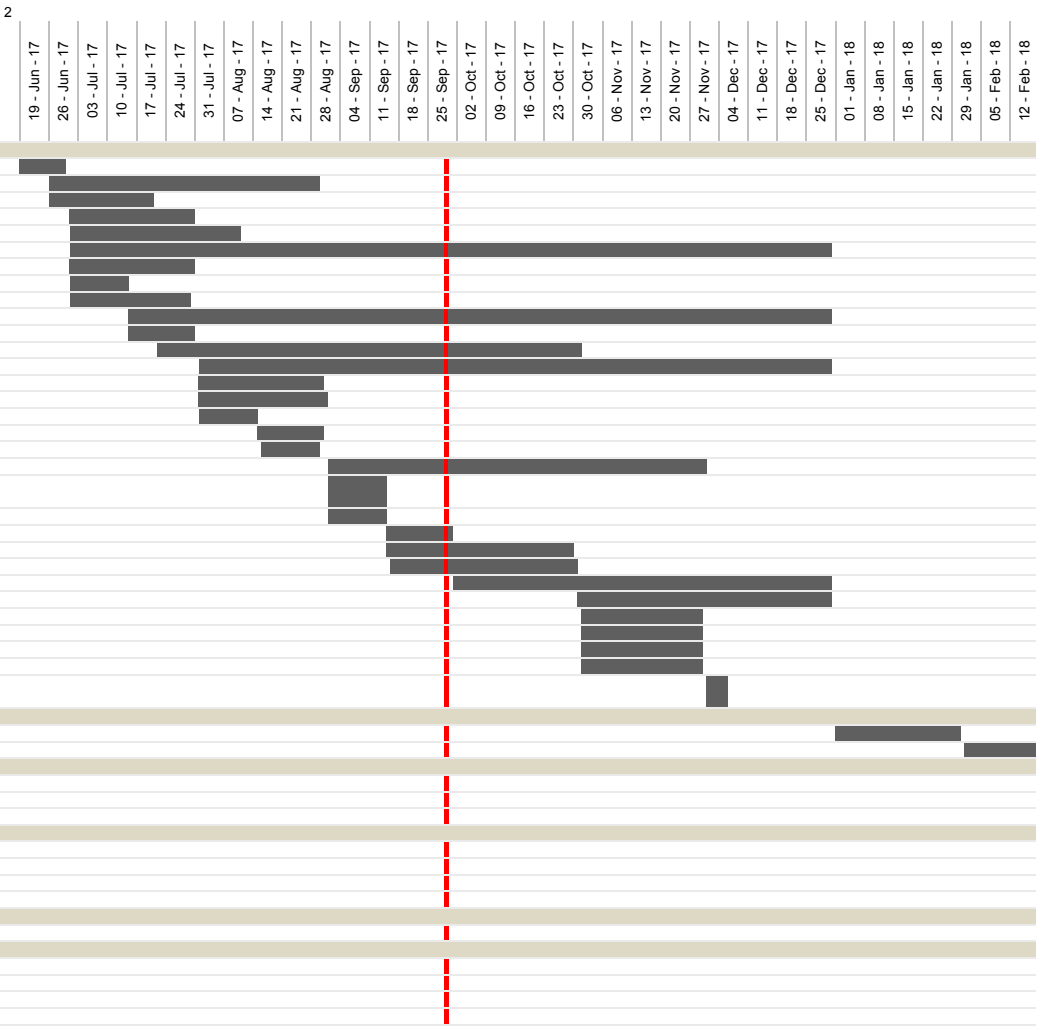
Elliot Health System

Project Lead: [redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
1	**July-December 2017 - Milestones**		7/1/17	12/31/17	183	130
1.1	Determine program metrics		6/19/17	6/30/17	11	10
1.2	Onboarding requirements		6/26/17	8/30/17	65	48
1.3	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	20
1.4	Process metric submission		7/1/17	7/31/17	30	21
1.5	Complete job descriptions		7/1/17	8/11/17	41	30
1.6	Advertise (via respective organization)		7/1/17	12/31/17	183	130
1.7	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
1.8	Develop program evaluation		7/1/17	7/15/17	14	10
1.9	Identify Training needs		7/1/17	7/30/17	29	20
1.10	Conduct Interviews		7/15/17	12/31/17	169	120
1.11	Identify sister programs for fidelity		7/15/17	7/31/17	16	11
1.12	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	73
1.13	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	109
1.14	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
1.15	Create evaluation schedule		8/1/17	9/1/17	31	24
1.16	Develop Intake workflow		8/1/17	8/15/17	14	11
1.16.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	13
1.17	Develop Referral workflow		8/16/17	8/30/17	14	11
1.18	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	66
1.19	Develop and approve Treatment Management Policy Policy & Protocol		9/1/17	9/15/17	14	11
1.20	Develop Billing workflow		9/1/17	9/15/17	14	11
1.21	Develop and approve Referral Policy Policy & Protocol		9/15/17	10/1/17	16	11
1.22	Develop brochures		9/15/17	10/30/17	45	32
1.23	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
1.24	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
1.25	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44
1.26	Develop training material		11/1/17	11/30/17	29	22
1.26.1	Safety		11/1/17	11/30/17	29	22
1.26.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	22
1.26.3	Justice		11/1/17	11/30/17	29	22
1.27	Basic training – 5 day orientation for all staff: 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	4
2	**January-June 2018 - Milestones**		1/1/18	6/30/18	180	130
2.1	Process metric submission		1/1/18	1/31/18	30	23
2.2	Generate EMR quote from Epic		2/1/18	6/30/18	149	107
3	**July-December 2018 - Milestones**		7/1/18	12/31/18	183	131
3.1	Negotiate contract with Epic		7/1/18	12/31/18	183	131
3.2	Performance metric Submission		7/1/18	7/31/18	30	22
3.3	Evaluate Additional Staffing Needs for Phase 2		10/1/18	12/31/18	91	66
4	**January-June 2019 - Milestones**		1/1/19	6/30/19	180	129
4.1	Performance metric Submission		1/1/19	1/31/19	30	23
4.2	Design and Implement EMR		1/1/19	12/31/19	364	261
4.3	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
4.4	Negotiate Lease		4/1/19	4/30/19	7	22
5	**July-December 2019 - Milestones**		7/1/19	12/31/19	183	132
5.1	New space fit-up/construction		5/1/19	9/1/19	7	88
6	**January-June 2020 - Milestones**		1/1/20	6/30/20	181	130
6.1	Electronic training for the EMR		1/1/20	1/8/20	7	6
6.2	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
6.3	Negotiate Lease		4/1/20	4/30/20	7	22
6.4	New space fit-up/construction		5/1/20	9/1/20	7	88



Project: D3 SUD Expansion

Friday
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Elliot Health System

Project Lead: [redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

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4.1	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
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5	**Policies and Protocols**		**8/1/17**	**10/31/17**	91	66
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8.1	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
8.2	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
8.2.1	Negotiate Lease		4/1/19	4/30/19	7	22
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9	**Process Workflow**		**8/1/17**	**9/15/17**	45	34
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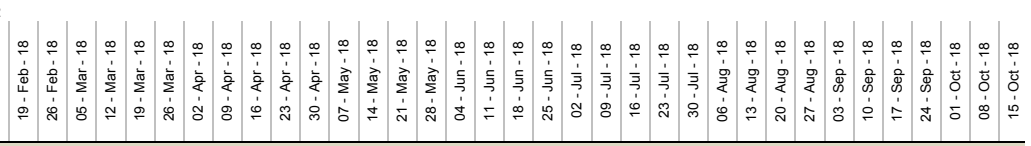

Project: D3 SUD Expansion

Friday
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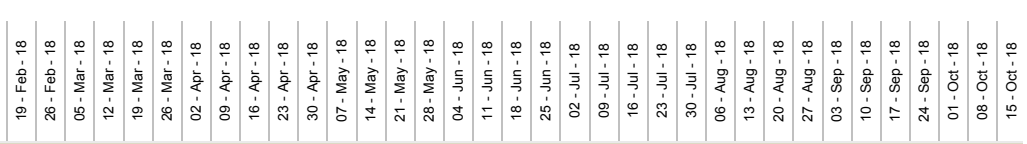
Elliot Health System

Project Lead: [redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
1	**July-December 2017 - Milestones**		7/1/17	12/31/17	183	130
1.1	Determine program metrics		6/19/17	6/30/17	11	10
1.2	Onboarding requirements		6/26/17	8/30/17	65	48
1.3	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	20
1.4	Process metric submission		7/1/17	7/31/17	30	21
1.5	Complete job descriptions		7/1/17	8/11/17	41	30
1.6	Advertise (via respective organization)		7/1/17	12/31/17	183	130
1.7	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
1.8	Develop program evaluation		7/1/17	7/15/17	14	10
1.9	Identify Training needs		7/1/17	7/30/17	29	20
1.10	Conduct Interviews		7/15/17	12/31/17	169	120
1.11	Identify sister programs for fidelity		7/15/17	7/31/17	16	11
1.12	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	73
1.13	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	109
1.14	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
1.15	Create evaluation schedule		8/1/17	9/1/17	31	24
1.16	Develop Intake workflow		8/1/17	8/15/17	14	11
1.16.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	13
1.17	Develop Referral workflow		8/16/17	8/30/17	14	11
1.18	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	66
1.19	Develop and approve Treatment Management Policy Policy & Protocol		9/1/17	9/15/17	14	11
1.20	Develop Billing workflow		9/1/17	9/15/17	14	11
1.21	Develop and approve Referral Policy Policy & Protocol		9/15/17	10/1/17	16	11
1.22	Develop brochures		9/15/17	10/30/17	45	32
1.23	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
1.24	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
1.25	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44
1.26	Develop training material		11/1/17	11/30/17	29	22
1.26.1	Safety		11/1/17	11/30/17	29	22
1.26.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	22
1.26.3	Justice		11/1/17	11/30/17	29	22
1.27	Basic training – 5 day orientation for all staff: 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	4
2	**January-June 2018 - Milestones**		1/1/18	6/30/18	180	130
2.1	Process metric submission		1/1/18	1/31/18	30	23
2.2	Generate EMR quote from Epic		2/1/18	6/30/18	149	107
3	**July-December 2018 - Milestones**		7/1/18	12/31/18	183	131
3.1	Negotiate contract with Epic		7/1/18	12/31/18	183	131
3.2	Performance metric Submission		7/1/18	7/31/18	30	22
3.3	Evaluate Additional Staffing Needs for Phase 2		10/1/18	12/31/18	91	66
4	**January-June 2019 - Milestones**		1/1/19	6/30/19	180	129
4.1	Performance metric Submission		1/1/19	1/31/19	30	23
4.2	Design and Implement EMR		1/1/19	12/31/19	364	261
4.3	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
4.4	Negotiate Lease		4/1/19	4/30/19	7	22
5	**July-December 2019 - Milestones**		7/1/19	12/31/19	183	132
5.1	New space fit-up/construction		5/1/19	9/1/19	7	88
6	**January-June 2020 - Milestones**		1/1/20	6/30/20	181	130
6.1	Electronic training for the EMR		1/1/20	1/8/20	7	6
6.2	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
6.3	Negotiate Lease		4/1/20	4/30/20	7	22
6.4	New space fit-up/construction		5/1/20	9/1/20	7	88



Project: D3 SUD Expansion

Friday
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Elliot Health System

Project Lead: [redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
1	**Hiring/Recruiting**		**7/1/17**	**3/31/20**	1004	717
1.1	Complete job descriptions		7/1/17	8/11/17	41	30
1.2	Advertise (via respective organization)		7/1/17	12/31/17	183	130
1.3	Conduct Interviews		7/15/17	12/31/17	169	120
1.4	Evaluate Additional Staffing Needs for Phase 2		10/1/18	12/31/18	91	66
1.5	Evaluate Additional Staffing Needs for Phase 3		1/1/20	3/31/20	90	65
2	**On-boarding**		**6/26/17**	**12/1/17**	158	115
2.1	Onboarding requirements		6/26/17	8/30/17	65	48
2.2	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	66
3	**Electronic Medical Record**		**2/1/18**	**12/31/19**	698	499
3.1	Generate EMR quote from Epic		2/1/18	6/30/18	149	107
3.2	Negotiate contract with Epic		7/1/18	12/31/18	183	131
3.3	Design and Implement EMR		1/1/19	12/31/19	364	261
4	**Forms/Assessment**		**7/1/17**	**12/31/17**	183	130
4.1	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
4.2	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	109
5	**Policies and Protocols**		**8/1/17**	**10/31/17**	91	66
5.1	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
5.1.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	13
5.2	Develop and approve Treatment Management Policy Policy & Protocol		9/1/17	9/15/17	14	11
5.3	Develop and approve Referral Policy Policy & Protocol		9/15/17	10/1/17	16	11
5.4	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
6	**Billing**		**6/26/17**	**11/1/17**	128	93
6.1	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	20
6.2	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	73
7	**Program Evaluation**		**6/19/17**	**9/1/17**	74	55
7.1	Determine program metrics		6/19/17	6/30/17	11	10
7.2	Develop program evaluation		7/1/17	7/15/17	14	10
7.3	Identify sister programs for fidelity		7/15/17	7/31/17	16	11
7.4	Create evaluation schedule		8/1/17	9/1/17	31	24
8	**Fit-up/Construction**		**10/1/17**	**9/1/20**	1066	762
8.1	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
8.2	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
8.2.1	Negotiate Lease		4/1/19	4/30/19	7	22
8.2.2	New space fit-up/construction		5/1/19	9/1/19	7	88
8.3	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
8.3.1	Negotiate Lease		4/1/20	4/30/20	7	22
8.3.2	New space fit-up/construction		5/1/20	9/1/20	7	88
9	**Process Workflow**		**8/1/17**	**9/15/17**	45	34
9.1	Develop Intake workflow		8/1/17	8/15/17	14	11
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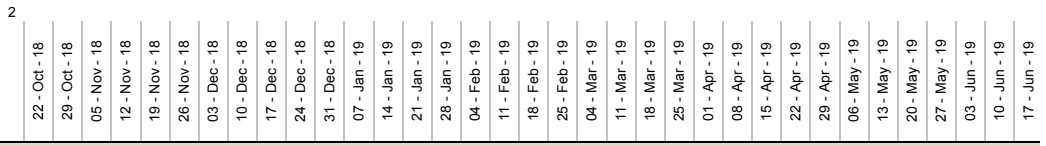
10	**Training**		**7/1/17**	**1/8/20**	921	658
10.1	Identify Training needs		7/1/17	7/30/17	29	20
10.2	Develop training material		11/1/17	11/30/17	29	22
10.2.1	Safety		11/1/17	11/30/17	29	22
10.2.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	22
10.2.3	Justice		11/1/17	11/30/17	29	22
10.3	Basic training – 5 day orientation for all staff: 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	4
10.4	Electronic training for the EMR		1/1/20	1/8/20	7	6
11	**Data Reporting**		**7/1/17**	**1/31/19**	579	414
11.1	Process metric submission		7/1/17	7/31/17	30	21
11.2	Process metric submission		1/1/18	1/31/18	30	23
11.3	Performance metric Submission		7/1/18	7/31/18	30	22
11.4	Performance metric Submission		1/1/19	1/31/19	30	23
12	**Marketing**		**9/15/17**	**12/31/17**	107	76
12.1	Develop brochures		9/15/17	10/30/17	45	32
12.2	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44



Project: D3 SUD Expansion

Friday
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Elliot Health System

Project Lead: [redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
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4.3	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
4.4	Negotiate Lease		4/1/19	4/30/19	7	22
5	**July-December 2019 - Milestones**		7/1/19	12/31/19	183	132
5.1	New space fit-up/construction		5/1/19	9/1/19	7	88
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6.1	Electronic training for the EMR		1/1/20	1/8/20	7	6
6.2	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
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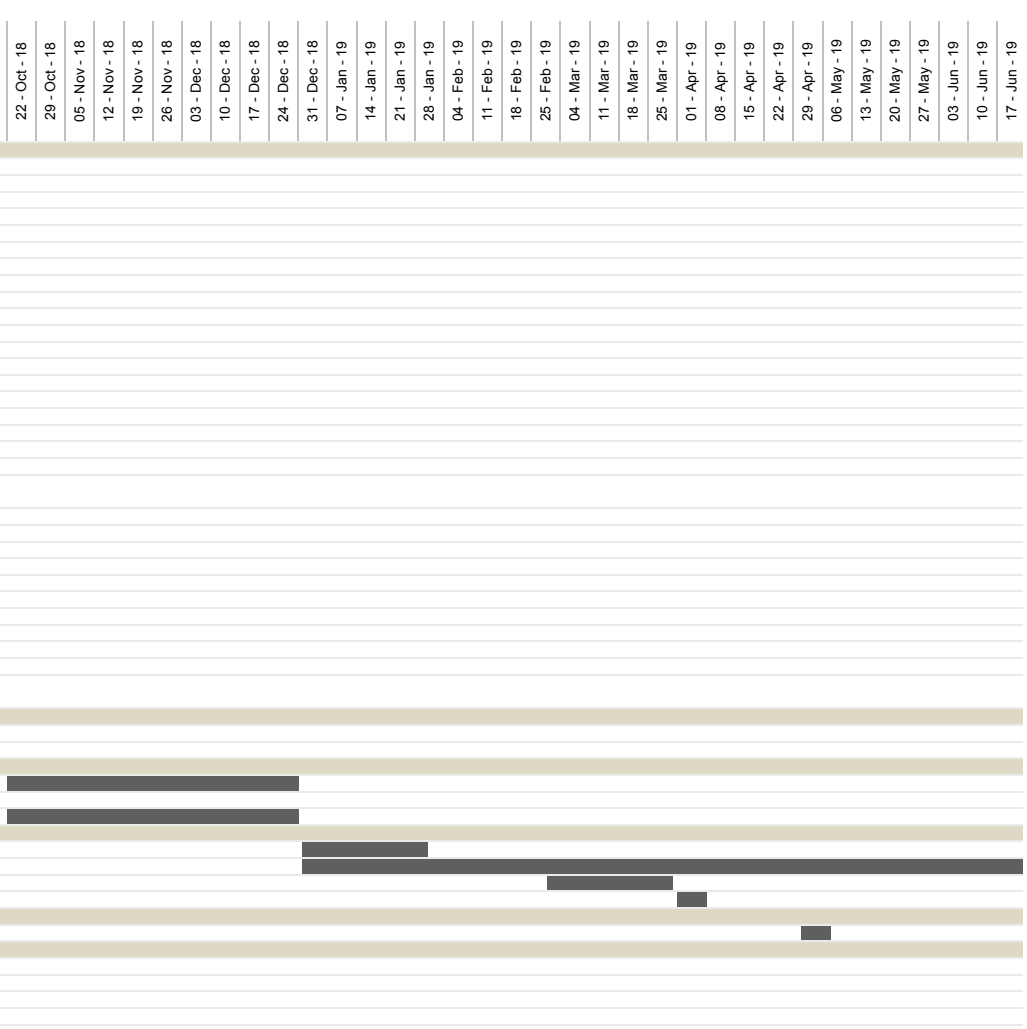

Project: D3 SUD Expansion

Friday
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Elliot Health System

Project Lead: [redacted]
Start Date: 1/1/2019
Proposed End Date: 12/31/20

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3	**Electronic Medical Record**		**2/1/18**	**12/31/19**	698	499
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3.2	Negotiate contract with Epic		7/1/18	12/31/18	183	131
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4.1	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
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5	**Policies and Protocols**		**8/1/17**	**10/31/17**	91	66
5.1	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
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5.4	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
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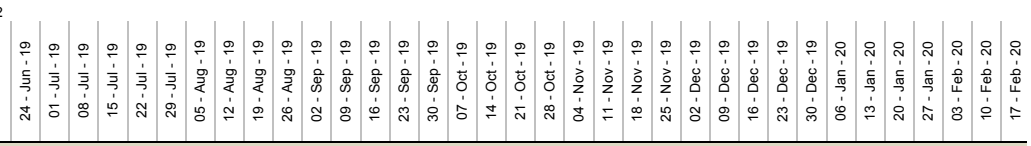

Project: D3 SUD Expansion

Friday
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Elliot Health System

Project Lead: [redacted]
Start Date: 1/1/2019
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
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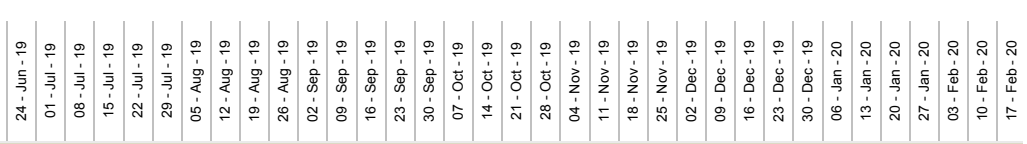
1.23	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
1.24	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
1.25	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44
1.26	Develop training material		11/1/17	11/30/17	29	22
1.26.1	Safety		11/1/17	11/30/17	29	22
1.26.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	22
1.26.3	Justice		11/1/17	11/30/17	29	22
1.27	Basic training – 5 day orientation for all staff: 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	4
2	**January-June 2018 - Milestones**		1/1/18	6/30/18	180	130
2.1	Process metric submission		1/1/18	1/31/18	30	23
2.2	Generate EMR quote from Epic		2/1/18	6/30/18	149	107
3	**July-December 2018 - Milestones**		7/1/18	12/31/18	183	131
3.1	Negotiate contract with Epic		7/1/18	12/31/18	183	131
3.2	Performance metric Submission		7/1/18	7/31/18	30	22
3.3	Evaluate Additional Staffing Needs for Phase 2		10/1/18	12/31/18	91	66
4	**January-June 2019 - Milestones**		1/1/19	6/30/19	180	129
4.1	Performance metric Submission		1/1/19	1/31/19	30	23
4.2	Design and Implement EMR		1/1/19	12/31/19	364	261
4.3	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
4.4	Negotiate Lease		4/1/19	4/30/19	7	22
5	**July-December 2019 - Milestones**		7/1/19	12/31/19	183	132
5.1	New space fit-up/construction		5/1/19	9/1/19	7	88
6	**January-June 2020 - Milestones**		1/1/20	6/30/20	181	130
6.1	Electronic training for the EMR		1/1/20	1/8/20	7	6
6.2	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
6.3	Negotiate Lease		4/1/20	4/30/20	7	22
6.4	New space fit-up/construction		5/1/20	9/1/20	7	88



Project: D3 SUD Expansion

Friday
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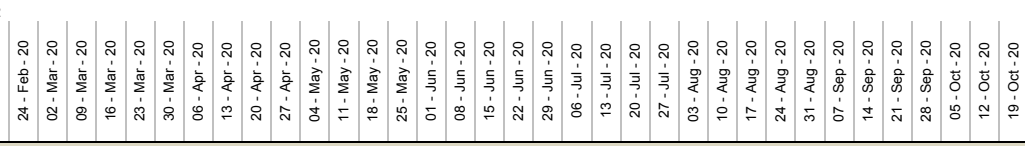
Elliot Health System

Project Lead: [redacted]
Start Date: 1/1/2019
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
1	**Hiring/Recruiting**		**7/1/17**	**3/31/20**	1004	717
1.1	Complete job descriptions		7/1/17	8/11/17	41	30
1.2	Advertise (via respective organization)		7/1/17	12/31/17	183	130
1.3	Conduct Interviews		7/15/17	12/31/17	169	120
1.4	Evaluate Additional Staffing Needs for Phase 2		10/1/18	12/31/18	91	66
1.5	Evaluate Additional Staffing Needs for Phase 3		1/1/20	3/31/20	90	65
2	**On-boarding**		**6/26/17**	**12/1/17**	158	115
2.1	Onboarding requirements		6/26/17	8/30/17	65	48
2.2	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	66
3	**Electronic Medical Record**		**2/1/18**	**12/31/19**	698	499
3.1	Generate EMR quote from Epic		2/1/18	6/30/18	149	107
3.2	Negotiate contract with Epic		7/1/18	12/31/18	183	131
3.3	Design and Implement EMR		1/1/19	12/31/19	364	261
4	**Forms/Assessment**		**7/1/17**	**12/31/17**	183	130
4.1	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
4.2	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	109
5	**Policies and Protocols**		**8/1/17**	**10/31/17**	91	66
5.1	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
5.1.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	13
5.2	Develop and approve Treatment Management Policy Policy & Protocol		9/1/17	9/15/17	14	11
5.3	Develop and approve Referral Policy Policy & Protocol		9/15/17	10/1/17	16	11
5.4	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
6	**Billing**		**6/26/17**	**11/1/17**	128	93
6.1	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	20
6.2	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	73
7	**Program Evaluation**		**6/19/17**	**9/1/17**	74	55
7.1	Determine program metrics		6/19/17	6/30/17	11	10
7.2	Develop program evaluation		7/1/17	7/15/17	14	10
7.3	Identify sister programs for fidelity		7/15/17	7/31/17	16	11
7.4	Create evaluation schedule		8/1/17	9/1/17	31	24
8	**Fit-up/Construction**		**10/1/17**	**9/1/20**	1066	762
8.1	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
8.2	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	21
8.2.1	Negotiate Lease		4/1/19	4/30/19	7	22
8.2.2	New space fit-up/construction		5/1/19	9/1/19	7	88
8.3	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	22
8.3.1	Negotiate Lease		4/1/20	4/30/20	7	22
8.3.2	New space fit-up/construction		5/1/20	9/1/20	7	88
9	**Process Workflow**		**8/1/17**	**9/15/17**	45	34
9.1	Develop Intake workflow		8/1/17	8/15/17	14	11
9.2	Develop Referral workflow		8/16/17	8/30/17	14	11
9.3	Develop Billing workflow		9/1/17	9/15/17	14	11
10	**Training**		**7/1/17**	**1/8/20**	921	658
10.1	Identify Training needs		7/1/17	7/30/17	29	20
10.2	Develop training material		11/1/17	11/30/17	29	22
10.2.1	Safety		11/1/17	11/30/17	29	22
10.2.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	22
10.2.3	Justice		11/1/17	11/30/17	29	22
10.3	Basic training – 5 day orientation for all staff: 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	4
10.4	Electronic training for the EMR		1/1/20	1/8/20	7	6
11	**Data Reporting**		**7/1/17**	**1/31/19**	579	414
11.1	Process metric submission		7/1/17	7/31/17	30	21
11.2	Process metric submission		1/1/18	1/31/18	30	23
11.3	Performance metric Submission		7/1/18	7/31/18	30	22
11.4	Performance metric Submission		1/1/19	1/31/19	30	23
12	**Marketing**		**9/15/17**	**12/31/17**	107	76
12.1	Develop brochures		9/15/17	10/30/17	45	32
12.2	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44



Project: D3 SUD Expansion

Friday
(vertical red line)

Elliot Health System

Project Lead: [redacted]
Start Date: 1/1/2019
Proposed End Date: 12/31/20

WBS	Tasks	Task Lead	Start	End	Duration (Days)	Working Days
1	**July-December 2017 - Milestones**		7/1/17	12/31/17	183	130
1.1	Determine program metrics		6/19/17	6/30/17	11	10
1.2	Onboarding requirements		6/26/17	8/30/17	65	48
1.3	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	20
1.4	Process metric submission		7/1/17	7/31/17	30	21
1.5	Complete job descriptions		7/1/17	8/11/17	41	30
1.6	Advertise (via respective organization)		7/1/17	12/31/17	183	130
1.7	Identify Assessment and Screening tools		7/1/17	7/31/17	30	21
1.8	Develop program evaluation		7/1/17	7/15/17	14	10
1.9	Identify Training needs		7/1/17	7/30/17	29	20
1.10	Conduct Interviews		7/15/17	12/31/17	169	120
1.11	Identify sister programs for fidelity		7/15/17	7/31/17	16	11
1.12	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	73
1.13	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	109
1.14	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	23
1.15	Create evaluation schedule		8/1/17	9/1/17	31	24
1.16	Develop Intake workflow		8/1/17	8/15/17	14	11
1.16.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	13
1.17	Develop Referral workflow		8/16/17	8/30/17	14	11
1.18	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	66
1.19	Develop and approve Treatment Management Policy Policy & Protocol		9/1/17	9/15/17	14	11
1.20	Develop Billing workflow		9/1/17	9/15/17	14	11
1.21	Develop and approve Referral Policy Policy & Protocol		9/15/17	10/1/17	16	11
1.22	Develop brochures		9/15/17	10/30/17	45	32
1.23	Develop and approve Billing Policy Policy & Protocol		9/16/17	10/31/17	45	32
1.24	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	65
1.25	Visit referral sources (ie, road show)		10/31/17	12/31/17	61	44
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6.3	Negotiate Lease		4/1/20	4/30/20	7	22
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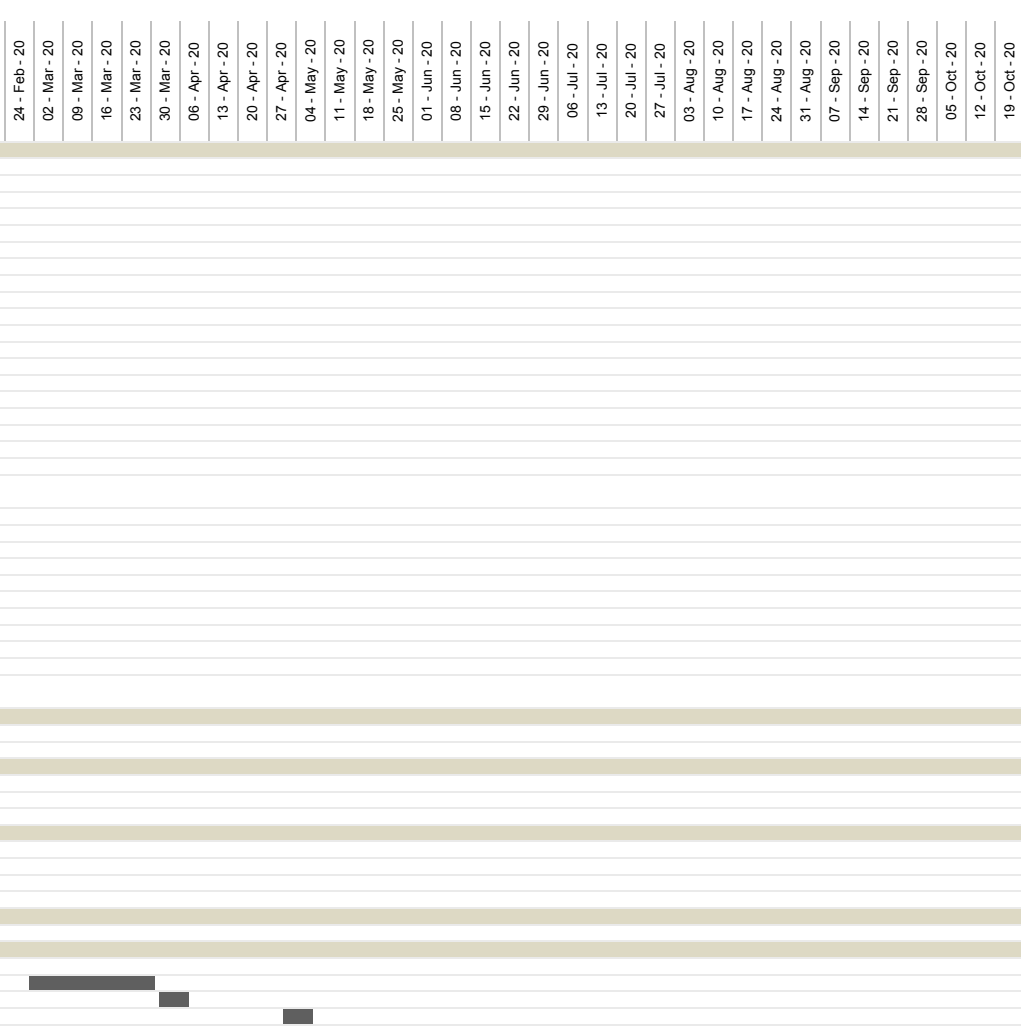


Building the Continuum of Integrated Treatment for Co-Occurring Disorders Training Protocol

INTEGRATED TREATMENT

An approach that involves simultaneous treatment of both disorders in a setting designed to accommodate both problems in a unified and comprehensive treatment program.

CORE PRINCIPLES OF INTEGRATED TREATMENT

Principles of Integrated Treatment:

Integration of Services

Comprehensiveness

Long-Term Perspective (time-unlimited services)

Motivation-Based Treatment

Multiple Therapeutic Modalities

Serenity Place provides training, technical assistance and consultation for all employees, clinical and non -clinical in all its community programs and organizations. Serenity Place is a leader in designing and implementing innovative models of family-centered, trauma-informed behavioral health treatment, and on training in these models.

Serenity Place provides training, and offers consultation, supervision, and capacity building. Some examples of our training include:

- Integrating a trauma-informed approach throughout behavioral health treatment
- Substance Use: Motives and Consequences
- Co-occurring disorders (Anxiety, Schizoaffective, Bi-polar etc.): Intervention Strategies
- Family-based approaches to behavioral health treatment
- Inclusion of tobacco cessation and nicotine addiction treatment within substance use disorder treatment programs.
- Principles of Treatment and many more

Serenity Place staff hold advanced degrees in social policy, social work, psychology, and education and social work. In developing training programs, Serenity Place is seeking approval for continuing education credits.

Serenity Place staff can provide expert training and consultation on:

- Substance Use
- Tobacco Cessation
- Tobacco Treatment in Substance Use Disorder Treatment
- Co-Occurring Disorders and Violence/Trauma
- Children & Parenting
- Children Affected by Parental Substance Use
- Parenting and Child Development
- Pregnancy and Post-Partum Issues and Substance Use
- Healthcare: Substance Use and Pregnancy
- Healthcare: Women, Substance Use and Primary Care

Training for PHP staff will focus on the following Dimensions:

Dimensions of Capability	Levels of Capability
I - Program Structure	Does program structure and policies help or inhibit providing services for individuals with co-occurring disorders?
II - Program Milieu	Are the staff and physical environment welcoming and receptive to individuals with co-occurring disorders?
III - Clinical Process: Assessment	How does program staff make distinctions between symptoms, substance-induced disorders, or actual psychiatric disorders that may need treatment?
IV - Clinical Process: Treatment	How does program address co-occurring assessment, treatment, and monitor interactive courses of both disorders? Procedures for intoxicated/high patients, relapse, withdrawal, or active users. Stage-wise treatment.
V - Continuity of Care	How does program maintain treatment continuity and monitoring of ongoing recovery issues for both disorders? Use of community-based peer support groups?
VI - Staffing	Does program staff have licensure, certification, and competency in assessing and treating individuals with co-occurring disorders? Peer/Alumni supports?
VII - Training	Are staff trained to detection and triage for co-occurring disorders? Clinical staff have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders?

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.*

Through our integration focused project (E4) Network4Health aims to support the increase of dual diagnosis identification and evidence-based integrated treatment competencies for patients with both a severe mental illness and substance use disorder at participating Network4Health organizations. The Integrated Treatment of Co-occurring Disorders (ITCOD) project team will use two parallel approaches to enhance the identification and treatment of patients with co-occurring disorders. These approaches are detailed in our project plan, included as Attachment_E4.1, and in the narrative that follows.

First, Network4Health will focus on assessing and improving treatment provided to individuals with co-occurring disorders at up to 11 Network4Health partner organizations that are **Primary Integrated Treatment of Co-occurring Disorders Partners**. Specifically, the ITCOD Project will develop a team of New Hampshire-based subject matter experts in dual diagnosis capability assessments and integrated treatment of co-occurring disorders program structure. The team will utilize existing resources at our participating organizations to develop enhanced skills in evaluation and co-occurring disorder programs led by a Network4Health Clinical Director focused exclusively on helping Network4Health organizations increase their dual diagnosis capabilities.

As envisioned, upon receipt of a Dual Diagnosis Capability in Addiction Treatment (DDCAT) or Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) assessment report and dual diagnosis capability continuum designation (Addiction-only services, Mental-health only services, Dual-diagnosis capable, Dual-diagnosis enhanced), participating organizations will work in conjunction with the Network4Health ITCOD team to document a Dual Diagnosis Capability Quality Improvement Plan (DDC

QIP). Their 1 year DDC QIP will target training, process improvement, procedure modifications or other consultative services to help increase the organizations competencies and program structure for the identification and integrated treatment of patients with co-occurring disorders. The DDC QIP of each participating organization will be reviewed and recommended for funding by the ITCOD Project Advisory Board. Final DDC QIP funding approval will be decided by the Network4Health Steering Committee and the agreement of the participating organization to meet specified project activities.

The project plan details the timeframe for these participants to conduct specified project activities. It also includes training and consultative services to support participants in meeting the project goals. The Evidence Based Practices group at Case Western Reserve University will provide training and consulting services to our Network4Health Clinical Director and DDC Assessors on the appropriate use of the DDCAT and DDCMHT Indices and quality improvement plan development.

Second, through this project, Network4Health will provide evidence-based training for relevant components of identification and treatment for patients with co-occurring severe mental health and substance use disorders. A subset of the ITCOD Project Advisory team, the Dual Diagnosis Capability Primary Care and Community Support Team will be responsible for the development of a yearly ITCOD Primary Care and Community Support Organization Training Program. The team will focus on education and training activities that meet the needs of organizations who frequently work with patients with co-occurring disorders, but are not the primary mental health or substance use disorder treatment providers. The group will likely focus initial work in the following areas:

- Definition and distribution of Dual Diagnosis Capability Toolkits
- Population Health Assessment (SBIRT, PHQ-9's, PHQ-2's) Implementation and Usage Training
- Certified Recovery Support Worker (CRSW) Training
- Motivational Interviewing Training - including technique usage for patients with co-occurring disorders as well as the application within other areas of care such as chronic disease management.

The ITCOD Project Team completed a review of participating Network 4 Health organizations to identify treatment programs to be assessed utilizing the Dual Diagnosis Capability assessments. The project team has chosen to focus initial intensive efforts on the below list of primary integrated treatment of co-occurring disorders partners. Additional parallel efforts will be made to educate more than 30 Network4Health's primary care and community support organization partners regarding evidence based components of integrated treatment of co-occurring disorders, particularly the screening and assessment of patients. We anticipate that as organizations and programs evolve over the course of the project, additional treatment programs will be ready to participate in a Dual Diagnosis Capability Index assessment.

To support organizations participating in this project Network4Health will recruit and hire an ITCOD Clinical Project Director and assessors. In addition, the project plan anticipates holding a bi-annual ITCOD practice improvement community for those organizations participating in the organizational assessments. The goal of the practice improvement community will be to create a platform to share the ongoing dual diagnosis capability quality improvement efforts and identify increased opportunities for shared learning. The project plan also includes the development and distribution of a bi-annual ITCOD newsletter to all Network4Health providers.

Network4Health has also developed an evaluation plan focused on tracking training and education programs initiated under the project, and the number of staff trained through these programs, as well

as the number of organizations assessed for fidelity to evidence-based practices for integrated treatment of co-occurring disorders and number of patients served. To ensure that Network4Health has necessary data, the project plan also details data reporting requirements and timeframes.

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.*

Network4Health will be completing the first 4 organizational assessments for Dual Diagnosis Capabilities in the July-December 2017 timeframe. While our partner organizations will continue their existing treatment of patients with co-occurring diagnoses, for the purposes of Network4Health's E4 project, our plan is that for the July - December 2017 reporting period, we will not be reporting on the volume of patients with co-occurring disorders served at our partner organizations. For each subsequent reporting period, ending 6/30/18, we will require that upon completion of an organizational assessment each partner reports on the volume of patients identified with a co-occurring SUD and severe mental illness in their organization for the duration of the program.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of staff trained in identifying individuals with co-occurring conditions and referring them for treatment.	Targets will be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization.			
The number of staff trained as Program Leaders for Integrated Treatment of co-occurring disorders programs.	Up to 25 in 2018			
The number of organizations assessed for fidelity to evidence based practice for the integrated treatment of co-occurring disorders. The measure will include a total count of organizations assessed by the DDCAT or DDCMHT index, as well as the count of organizations by dual diagnosis capability continuum designation: • Addiction-only services (AOS) • Mental Health-only services (MHOS)	December 2017: Up to 4 June 2018: Up to 5 December 2018: Up to 3			

• Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE)				
The number of patients served in evidence based integrated treatment of co-occurring disorders programs	Targets will be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization.			

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.

A number of staff will be hired to support the ITCOD project, including the Co-occurring Disorders Clinical Director (funded out of the Project Design and Capacity Funds) and up to 4 dual diagnosis capability assessors who will be trained on the delivery of DDCAT and DDCMHT organizational assessments and the planning and implementation processes associated with each.

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
Co-occurring Disorders Clinical Director	Up to 1	0	Up to 1	Up to 1	Up to 1
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	Up to 4 x .2 FTE	Up to 4 x .2 FTE	Up to 4 x .2 FTE

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.

The budget chart below provides an overview of Network4Health's budget for the ITCOD project. It includes funding for staff recruitment, hiring and other costs (technology needs; office space), development and delivery of trainings and toolkits, organizational assessments, consultative services, and participation offset funding (for time lost in training and assessment). It also includes funds for organizations to use to further their co-occurring disorders capability quality improvement plan. Maximum funding available for organizations is $50,000 for the first year of a plan, plus $20,000 for continuation after a re-assessment.

TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
E4 Revenue (New)	$451,560	$451,560	$477,120	$477,120
E4 Revenue (Rollover)		$294,506	$66,575	$45,659
Total Revenue	$451,560	$746,066	$543,695	$522,779
Dual Diagnosis Capability Assessor Participation Offset (Training and Assessment Time)	$21,681	$56,846	$45,619	$45,619
Dual Diagnosis Capability Program Leader Training (2018) Attendee Participation Offset (up to 25)		$23,100		
Dual Diagnosis Program Leader Training (2019) and Attendee Participation Offset (up to 16)			$22,659	
Co-Occurring Disorders Capability Quality Improvement Plan Funds	$105,000	$567,000	$399,000	$441,000
N4H Assessor Training Course Development and Delivery		$5,250	$3,150	$3,150
Integrated Treatment Tools & Training for Primary Care and Community Support Organizations	$26,250	$26,250	$26,250	$26,250
IT Budget COD Clinical Director (Laptop, Phone, etc.)	$3,150	$1,050	$1,050	$1,050
Occupancy Offset (COD Clinical Director)	$1,575	$1,575	$1,575	$1,575
Subtotal	$157,656	$681,071	$499,303	$518,644
Variation to Budget (Transfer Funds to Proceeding Year)	$293,904	$64,393	$42,210	$686

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.

Network4Health has executed agreements with many of the organizations that will be the first to undergo assessments. The remainder of the organizations will execute agreements prior to a DDCAT/DDMCHT organizational assessment being scheduled for that organization. We aim to have these agreements executed by December 31, 2017. In addition, Granite Pathways and Southern New Hampshire services have executed an agreement for participation on the Advisory Board and the Primary Care/Community Support Team.

Organization/Provider	Agreement Executed (Y/N)
Mental Health Center of Greater Manchester (MHCGM)	Y
Center for Life Management	Y
Families in Transition	Y
Serenity Place	Y
Catholic Medical Center	Y
The Farnum Center (Easter Seals NH)	Y
Elliot Health System, Behavioral Health Services	N
Manchester Community Health Center	N
NH Child and Family Services	N
Granite Pathways	Y
Southern New Hampshire Services	Y

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

The list of assessment tools below includes all tools approved for use by the Network4Health ITCOD project team. By approving these tools, the team will help to ensure that all network providers are using evidence based assessment tools, most of which are approved by SAMHSA (and noted as SAMHSA TIP 42). The team does not intend to dictate to network providers that all tools must be used. During organizational assessments and creation of a Quality Improvement Plan, Network4Health providers will select specific assessments to be used.

Standard Assessment Tool Name	Brief Description
Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Organizational Assessment Tool	The DDCAT index is designed to determine how effectively substance use treatment programs provide services for patients with co-occurring mental health disorders. The index is comprised of 35 items that explore an organization's policies, clinical practices, and workforce capacities (e.g., staff education, training, licensure, experience, availability). These items are organized into seven domains that include the following: • Program structure • Program milieu • Clinical practice/assessment • Clinical practice/treatment • Continuity of care • Staffing • Training Consultants review and score the data they have collected with the indexes and categorize the organization along a continuum of capability. The continuum for addiction-service organizations assessed with the DDCAT index includes: • Addiction-only services (AOS)

	• Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE) The index is recognized as a reliable and valid tool for assessing outpatient, residential and hospital-based treatment programs (Gotham, Brown, Comaty, Joseph E., McGovern, & Claus, 2013). An important purpose of the DDCAT evaluation process is to encourage treatment programs to improve every aspect of their care.
Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index Organizational Assessment Tool	Similar to the DDCAT, the DDCMHT index is designed to determine how effectively mental health treatment programs provide services for patients with co-occurring substance use disorders. The DDCMHT utilizes the same 35 items across the 7 domains described above for DDCAT and organizations are scored across the following continuum of capability. • Mental-health-only services (MHOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE)
The Mental Health Screening Form-III (Assessment/Screening)	Screening assessment for clients seeking SUD treatment to identify any co-occurring disorders. SAMHSA TIP 42)
Simple Screening Instrument for Substance Abuse (SSI-SA) (Assessment/Screening)	Designed for use within a clinical setting for clients receiving or seeking treatment and for administration and use under the standard conditions found in most substance abuse and/or mental health clinics. SAMHSA TIP 42)
PHQ-9 Depression Screening (Assessment/Screening)	The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
PHQ-2 Depression Screening (Assessment/Screening)	The PHQ-2, comprising the first 2 items of the PHQ-9, inquires about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.
Generalized Anxiety Disorder Screening (GAD 7) (Assessment/Screening)	Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (GAD).
Addiction Severity Index (ASI) (Assessment/Screening)	The ASI is a general screening tool used extensively for treatment planning and outcome evaluation. (SAMHSA TIP 42)
Alcohol Use Disorders Identification Test (AUDIT) (Assessment/Screening)	The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health. The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. (SMHSA TIP 42)
Beck Depression Inventory–II (BDI–II) **(Assessment/Screening)**	Used to screen for the presence and rate the severity of depression symptoms. The BDI–II consists of 21 items to assess the intensity of depression. The BDIII can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. (SAMHSA TIP 42)
CAGE and CAGE-AID Questionnaire **(Assessment/Screening)**	The purpose of the CAGE Questionnaire is to detect alcoholism. CAGE-AID detects alcoholism and drug use. The CAGE Questionnaire is a useful bedside, clinical desk instrument. It is a very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present. (SAMHSA TIP 42).
Circumstances, Motivation, and Readiness Scales (CMR Scales)	SAMHSA TIP 42

(Assessment/Screening)	The instrument is designed to predict retention in treatment and is applicabl to both residential and outpatient treatment modalities. The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment.
Clinical Institute Withdrawal Assessment (CIWA-Ar) **(Assessment/Screening)**	Converts DSMIIIR items into scores to track severity of withdrawal; measures severity of alcohol withdrawal. Aid to adjustment of care related to withdrawal severity. (SAMHSA TIP 42)
Drug Abuse Screening Test (DAST) **(Assessment/Screening)**	The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and mis-use. Screening and case finding: Level of treatment and treatment/goal planning. (SAMHSA TIP 42)
Global Appraisal of Individual Needs (GAIN) (Assessment/Screening)	The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling. (SAMHSA TIP 42)
Level of Care Utilization System (LOCUS) (Assessment/Screening)	To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time. (SAMHSA TIP 42)
Michigan Alcoholism Screening Test (MAST) (Assessment/Screening)	Used to screen for alcoholism with a variety of populations. (SAMHSA TIP 42)
M.I.N.I. Plus (Assessment/Screening)	Assists in the assessment and tracking of patients with greater efficiency and accuracy. (SAMHSA TIP 42)
Psychiatric Research Interview for Substance and Mental Disorders (PRISM) (Assessment/Screening)	The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and cooccurring disorder treatment samples. (SAMHSA TIP 42)
Readiness to Change Questionnaire (Assessment/Screening)	Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. (SAMHSA TIP 42)
Recovery Attitude and Treatment Evaluator (RAATE) (Assessment/Screening)	Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. (SAMHSA TIP 42)
Structured Clinical Interview for DSM-IV Disorders (SCID-IV) (Assessment/Screening)	Obtains Axis I and II diagnoses using the DSMIV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence." (SAMHSA TIP 42)
Substance Abuse Treatment Scale (SATS) (Assessment/Screening)	To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder. (SAMHSA TIP 42)
University of Rhode Island Change Assessment (URICA) (Assessment/Screening)	The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items. (SAMHSA TIP 42)
Clinical Opiate Withdrawal Scale (COWS) (Assessment/Screening)	The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Assessment/Screening)	Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Promoted by SAMHSA and US Preventive Services Task Force
PHQ-A (Assessment/Screening)	Identifying depression in adolescents 11-17
Brief Psychiatric Rating Scale (BPRS) (Assessment/Screening)	A rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored.
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (Assessment/Screening)	Screening to detect and manage substance use and related problems in primary and general medical care settings

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.

The chart below includes examples of evidence-based treatment protocols for patients with co-occurring disorders. As noted above for assessments and screenings, treatment, management and referral protocols will be identified by each organization in alignment with evidence-based best practices as part of the DDCAT/DDCMHT organizational assessments. Dual Diagnosis Capability Quality Improvement Plans will help to identify any protocols that should be added, enhanced or modified. Each of the protocols are based on best practices, so marked as current, but we will not know whether they are in use until after the completion of assessments.

Protocol Name	Brief Description	Use (Current/Under Development)
Integrated Treatment for Co-Occurring Disorders (formerly IDDT) (Treatment)	Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery	Current
Multidisciplinary Team (Treatment)	The service team may include the following roles: Team Leader, Nurse, Case Manager, Employment Specialist, SA Specialist, Housing, Counselor, Criminal Justice, Physician/Psychiatrist. The list is not exclusive and may include additional roles as required for a client.	Current
Stage-Wise Interventions (Treatment)	Consumers recovering from substance use disorders and serious mental illnesses go through stages, each of which marks readiness for a specific treatment. Integrated treatment specialists must assess consumers' stage of treatment and tailor services accordingly: Engagement, Persuasion, Active Treatment, Relapse Prevention	Current
Motivational Interventions	Motivational interventions include motivational interviewing, motivational counseling, motivational treatment.	Current

(Treatment)	These interventions help consumers identify personal recovery goals.	
Supported Employment (Treatment)	Motivational interviewing helps consumers identify their goals for daily living, as well as strategies (activities) for achieving those goals.	Current
Assertive Community Treatment (Treatment)	Successful integrated treatment of COD programs utilize assertive outreach to keep clients engaged in relationships with service providers, family members, and friends.	Current
Assertive Outreach (Treatment)	Service providers who utilize assertive outreach meet with consumers in community locations that are familiar to consumers, such as in their homes or at their favorite coffee shops or restaurants.	Current
Substance Abuse Counseling (Treatment)	Counseling that provides recovery skills	Current
Group Treatment (Treatment)	Research indicates that individuals with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders.	Current
Self Help Groups (Treatment)	Self-help groups are excellent sources of social support for individuals who are motivated to achieve and maintain abstinence.	Current
Family Psychoeducation (Treatment)	Family psychoeducation fosters social support. It includes consumers, caregivers (family members and friends), and service providers in the treatment process.	Current
Pharmacological Treatment (Treatment)	medications are effective in the treatment of persons with severe mental illness and co-occurring disorders. Medications generally include the following: Antipsychotics, Mood stabilizers and Antidepressants	Current
Interventions to Promote Health (Treatment)	Research indicates that individuals with co-occurring disorders are at increased risk for poor health. Treatment team members encourage consumers to live healthy lifestyles	Current

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.

During implementation, the ITCOD Project team will transition to a new project structure to address implementation activities:

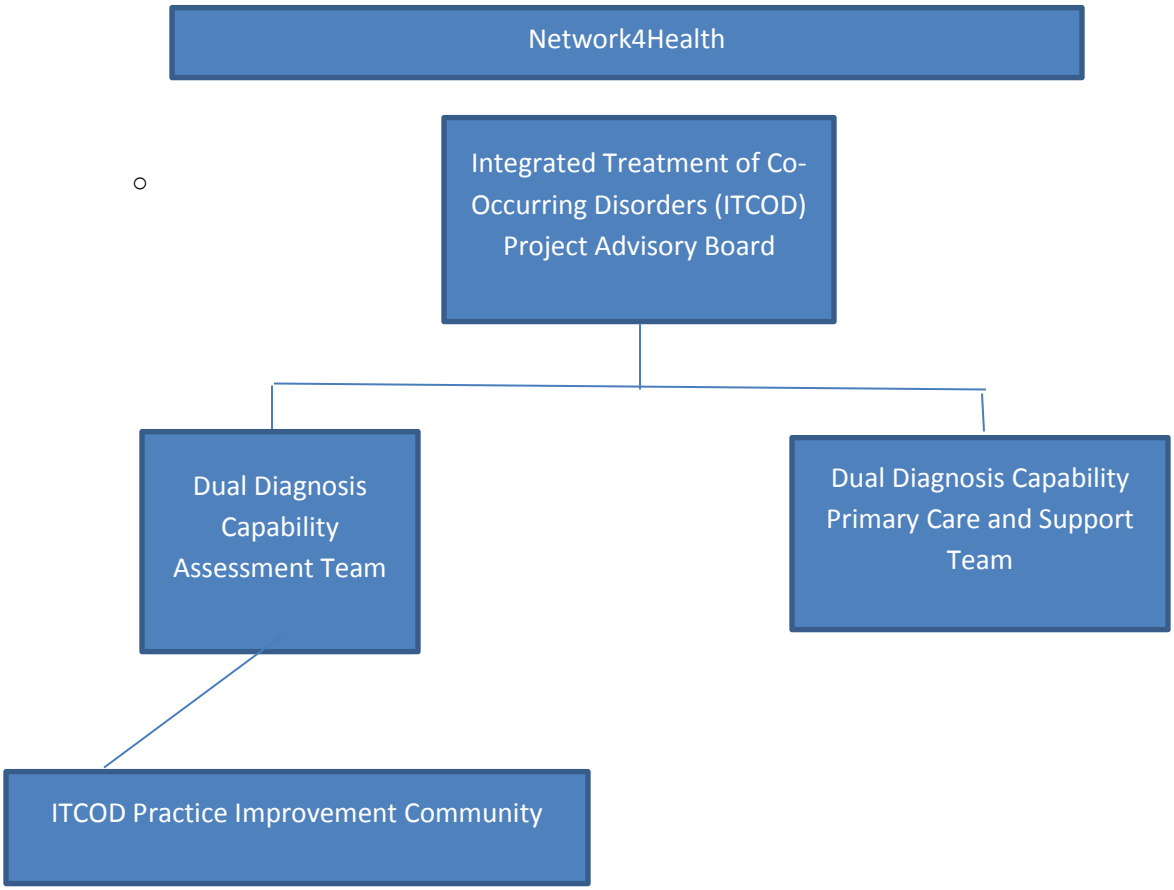
Network 4 Health Integrated Treatment of Co-occurring Disorders (ITCOD) Project Advisory Team: Many of the dedicated planning phase partner organizations have agreed to remain with the ITCOD as members of the ITCOD Project Advisory Board. The Project Advisory Board will monitor progress on project activities, milestones and data reporting. The team will also be the funding approval mechanism for the Co-occurring Disorders Quality Improvement Plans for each organization participating in the DDCAT/DDCMHT organization assessments. The advisory board will provide strategic input to project barriers, issues, risks and project re-alignment when required. The team will meet monthly to follow project progress and as needed for approval of Quality Improvement Plans.

Network 4 Health Dual Diagnosis Capability (DDC) Assessment Team: Network 4 Health will develop a Dual Diagnosis Capability (DDC) Assessment Team using experienced clinical and supervisory staff members currently working within our partner organizations. The team will be led by the N4H Co-occurring Disorders Clinical Director. In 2017, up to 4 team members and the Co-occurring Disorders Clinical Director will be trained as DDCAT/DDCMHT Assessors. The team will work together to provide DDCAT and DDCMHT assessments to participating organizations. The team will have initial training and consultative support from dual diagnosis capability experts from Case Western Reserve University's Center for Evidence Based Practices. Additional training to enhance the DDC Assessment Team or replace due to turnover will be done using a train the trainer model in later years.

Integrated Treatment of Co-occurring Disorders (ITCOD) Practice Improvement Community: Organizations participating in the N4H DDCAT/DDCMHT assessment process will be asked to join bi-yearly meetings of the N4H ITCOD Practice Improvement Community. The goal will be to create a platform to share the ongoing dual diagnosis capability quality improvement efforts and identify increased opportunities for shared learning. Named participants for this community will be collected as organizations are scheduled for their DDCAT/DDCMHT assessment.

Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team: The N4H DDC Primary Care and Community Support Team will be responsible for the development of a yearly ITCOD Primary Care and Community Support Organization Training Program. The team will focus on education and training activities that meet the needs of organizations who frequently work with patients with co-occurring disorders, but are not the main mental health or substance use disorder treatment providers. The group will focus initial work in the following areas:

- Definition and distribution of Dual Diagnosis Capability Toolkits
- Population Health Assessment (SBIRT, PHQ-9's, PHQ-2's) Implementation and Usage Training
- Certified Recovery Support Worker (CRSW) Training
- Motivational Interviewing Training, including the use for patients with co-occurring disorders, but how it also has application within other areas of primary care practices such as chronic disease management



The chart below provides specific project team members and their roles and responsibilities.

Project Team Member	Roles and Responsibilities
[redacted] Network 4 Health	Executive Director, Network 4 Health *The Executive Director has overarching responsibility for the scope and direction of the Network 4 Health projects*.
[redacted] Network 4 Health	Co-Occurring Disorders Clinical Director, Network 4 Health *Provides clinical and subject matter leadership for the activities of the project. Works with all network partners to assure enhanced identification of individuals who experience co-occurring disorders, referral to needed services and capacity for care delivery that utilizes evidence based and best practice approaches to care.*
[redacted] Network 4 Health	Project Manager, Network 4 Health *Monitors project activities and schedule. Supports scheduling of trainings, meetings and other project related events as required. Responsible for project status reporting to the ITCOD Project Advisory Team, Steering Committee and DHHS.*
[redacted] Mental Health Center of Greater Manchester	Co-lead, ITCOD Project Advisory Team *See ITCOD Project Advisory Team description above.*

(MHCGM)	
[redacted] Center for Life Management	Co-lead, ITCOD Project Advisory Team: *See ITCOD Project Advisory Team description above.* Dual Diagnosis Capability Assessor: *See Dual Diagnosis Capability Assessment Team above* DDC Primary Care and Support Team Member: *See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team*
[redacted] MHCGM	Dual Diagnosis Capability Assessor: *See Dual Diagnosis Capability Assessment Team above* ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above*
[redacted] MHCGM	Dual Diagnosis Capability Assessor: *See Dual Diagnosis Capability Assessment Team above*
[redacted] Catholic Medical Center (CMC)	Dual Diagnosis Capability Assessor: *See Dual Diagnosis Capability Assessment Team above* ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted]CMC	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Farnum Center/ Easter Seals NH	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Granite Pathways	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.* DDC Primary Care and Support Team Member: *See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team*
[redacted] Serenity Place	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Southern NH Services/Rockingham Cap	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] The Upper Room	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Elliott Health System	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Elliot Health System	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Recovery NH	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Parkland Medical Center	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Retired PCP Dartmouth Hitchcock System	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*
[redacted] Parkland Medical Center	ITCOD Project Advisory Team Member: *See ITCOD Project Advisory Team description above.*

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

The Center for Evidence Based Practices at Case Western Reserve University (CEBP) will provide initial training and technical assistance in support of Network4Health's planned use of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index to support our partner organizations understanding of their programs dual diagnosis and treatment capabilities. The planned CEBP services include:

Dual Diagnosis Capability Assessor Training and Evaluation Shadowing

- DDCAT and DDCMHT Training *(Schedule: 9/4/2017 – 12/27/2017)*:
    - Conducting the evaluation
    - Item rating & consensus
    - Introduction to report writing
    - Introduction to report delivery & action planning
- Evaluations and Shadowing *(Schedule: 9/4/2017 – 12/04/2017)*
    - The CEBP consultants will conduct the first 4 Network4Health DDCAT/DDCMHT assessments with members of the Network4Health DDC Assessment Team shadowing and learning from their work. SAMHSA's DDCAT and DDCMHT Toolkits recommend shadowing an experienced DDCAT/DDCMHT Assessor as "one of the best training methods". The CEBP team will be responsible for pre-evaluation data gathering, a 1-day on-site evaluation with each of the 4 organizations, rating consensus call facilitation and assessment report delivery.

Dual Diagnosis Capability Assessor Technical Assistance *(Schedule: 9/4/2017 – 12/28/2018)*

- CEBP will provide 30 hours of telephone, web or video conference consultation to the N4H DDC Assessment Team to support the ongoing Network4Health DDCAT/DDCMHT assessments. Consultation may include:
    - Evaluation rating consensus meeting shadowing
    - Review of, and feedback on, written report narratives and recommendations
    - Report delivery: mock report delivery, report delivery shadowing, debriefing
    - Initial action planning session preparation

Dual Diagnosis Capability Program Leaders Training *(Schedule: 1/8/2018 – 3/30/2018)*

- CEBP will plan and deliver a 2 day in-person training to provide supervisors and program managers with the opportunity to familiarize themselves with the DDCAT/DDCMHT indices and the planning and implementation processes associated with each. Participants in this training will also learn about the implications of DDCAT/DDCMHT for supervising improved treatment strategies and models of care for individuals with co-occurring mental illness and substance use disorders. Other key evidence based tools for the integrated treatment of co-occurring conditions, such as motivational interviewing, may also be introduced in this training. All organizations participating in the N4H ITCOD sponsored DDCAT/DDCMHT assessments will be asked to identify at least one Dual Diagnosis Capability Program Leader for their organization. The training can accommodate up to 60 participants.

In addition to our use of CEBP services, Network4Health will strive to promote and expand training services currently available within our partner organizations. When necessary, additional outside training organizations will be identified to support the following needs:

N4H Assessor Training Course Development and Delivery

- The Network4Health Dual Diagnosis Capability Assessment Team will develop a training curriculum and materials to support in-house training of additional Dual Diagnosis Capability Assessors to ensure continued staffing of the Network 4 Health Dual Diagnosis Capability (DDC) Assessment Team in later years of the project.

Co-Occurring Disorders Quality Improvement Plan (COD QIP) Training and Technical Assistance

- Upon receipt of a DDCAT or DDCMHT assessment report and dual diagnosis capability continuum designation (Addiction-only services, Mental-health only services, Dual-diagnosis capable, Dual-diagnosis enhanced), participating organizations will document a Co-occurring Disorders Quality Improvement Plan (COD QIP). The one-year COD QIP will target training, process improvement, procedure modifications or other consultative services to help increase the organizations competencies and program structure for the identification and integrated treatment of patients with co-occurring disorders. Where feasible, the Network4Health ITCOD Advisory Board will work to make trainings in support of a COD QIP available across participating organizations. Trainings and services may include:
    - DDCAT/DDCMHT Overview
    - ITCOD (formerly IDDT) Clinical
    - ITCOD (formerly IDDT) Implementation and Organizational Change
    - Motivational Interviewing
    - Stages of Change
    - Critical Time Intervention (CTI)
    - Cognitive Behavior Therapy (CBT)
    - LEAP (Listen, Empathize, Agree, Partner)
    - Medication Assisted Treatment
    - Suboxone Treatment Protocol

Co-Occurring Disorders Training for Primary Care and Community Support Organizations

- The Dual Diagnosis Capability (DDC) Primary Care and Community Support Team will provide evidence based training for relevant components of identification and treatment for patients with co-occurring severe mental health and substance use disorders. A subset of the ITCOD Project Advisory team, the Dual Diagnosis Capability Primary Care and Community Support Team will be responsible for the development of a yearly ITCOD Primary Care and Community Support Organization Training Program. The team will focus on education and training activities that meet the needs of organizations who frequently work with patients with co-occurring disorders, but are not the primary mental health or substance use disorder treatment providers. The group will likely focus initial work in the following areas:
    - Definition and distribution of Dual Diagnosis Capability Toolkits
    - Population Health Assessment (SBIRT, PHQ-9's, PHQ-2's) Implementation and Usage Training
    - Certified Recovery Support Worker (CRSW) Training
    - Motivational Interviewing Training - including technique usage for patients with co-occurring disorders as well as the application within other areas of care such as chronic disease management.

Training Plan

Training or Training Related Activity	*Participants*	*Completion By…*
DDCAT/DDCMHT Assessment Capacity Development		
Deliver DDCAT/DDCMHT Assessor Training	**Up to 5**	**12/27/2017**
Deliver Up To 30 Hours DDCAT/DDCMHT Consulting	**Up to 5**	**12/28/2018**
Design DDCAT/DDCMHT "Train the Trainer" Assessor Training	**Up to 5**	**12/31/2018**
Program Leader Development		
Deliver Co-Occurring Disorders Program Leader Training	**Up to 50**	**3/30/2018**
Primary Care and Support Organization Development		
Define 2018 ITCOD Training Program for Primary Care and Support Organizations	**See Deliver 2018**	**12/29/2017**
Define 2019 ITCOD Training Program for Primary Care and Support Organizations	**See Deliver 2019**	**12/31/2018**
Define 2020 ITCOD Training Program for Primary Care and Support Organizations	**See Deliver 2020**	**12/31/2019**
Deliver 2018 ITCOD Training for Primary Care and Support Organizations	**Up to 50**	**12/31/2018**
Deliver 2019 ITCOD Training for Primary Care and Support Organizations	**Up to 50**	**12/31/2019**
Deliver 2020 ITCOD Training for Primary Care and Support Organizations	**Up to 50**	**12/21/2020**

This information is also included as Attachment_E4.9.

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 E4-ITCOD

	Task Name	Duration	Start	Finish	Predecessors
1	**N4H: Integrated Treatment of Co-occurring Disorders Implementation**	913d	06/30/17	01/29/21	
2	**Workforce Plan**	126d	07/03/17	12/29/17	
3	Recruit N4H Co-Occurring Disorders Clinical Director	126d	07/03/17	12/29/17	
4	Recruit N4H DDCAT/DDCMHT Assessors	45d	07/03/17	09/01/17	
5	**Training Plan**	891d	07/03/17	12/31/20	
6	**DDCAT/DDCMHT Assessment Capacity Development**	336d	09/04/17	12/31/18	
7	Deliver DDCAT/DDCMHT Assessor Training	80d	09/04/17	12/27/17	
8	Deliver Up To 30 Hours DDCAT/DDCMHT Consulting	335d	09/04/17	12/28/18	
9	Design DDCAT/DDCMHT "Train the Trainer" Assessor Training	256d	12/28/17	12/31/18	7
10	**Program Leader Development**	143d	09/07/17	03/30/18	
11	Schedule Co-Occurring Disorders Program Leader Training	79d	09/07/17	12/29/17	
12	Deliver Co-Occurring Disorders Program Leader Training	60d	01/08/18	03/30/18	
13	**Primary Care and Support Organization Development**	891d	07/03/17	12/31/20	
14	Define 2018 ITCOD Training Program for Primary Care and Support Organizations	126d	07/03/17	12/29/17	
15	Define 2019 ITCOD Training Program for Primary Care and Support Organizations	146d	06/04/18	12/31/18	
16	Define 2020 ITCOD Training Program for Primary Care and Support Organizations	148d	06/03/19	12/31/19	
17	Deliver 2018 ITCOD Training for Primary Care and Support Organizations	254d	01/02/18	12/31/18	14
18	Deliver 2019 ITCOD Training for Primary Care and Support Organizations	255d	01/02/19	12/31/19	15
19	Deliver 2020 ITCOD Training for Primary Care and Support Organizations	256d	01/02/20	12/31/20	16
20	**DDCAT/DDCMHT Organizational Assessments**	847d	09/04/17	12/31/20	
21	**July - December 2017**	82d	09/04/17	12/29/17	
22	Deliver Up to 4 Organizational Assessments with DDC Consultants and N4H Trainees	64d	09/04/17	12/04/17	
23	Create Up to 4 Organizational Assessment Reports	40d	10/10/17	12/06/17	22FS -38d
24	Deliver Up to 4 Organizational Assessment Report Presentations	20d	11/07/17	12/06/17	23FS -20d
25	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	36d	11/07/17	12/29/17	24FS -20d
26	**Progress Assessment Checkpoint**	14d	11/03/17	11/22/17	
27	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	11/03/17	11/16/17	22FS -20d
28	Document feedback and any areas of improvement for future DDC reviews	2d	11/17/17	11/20/17	27
29	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/21/17	11/22/17	28
30	Gather Feedback from Assessor Trainees from Dual Diagnosis Capability Review Training and Shadowing	1d	11/03/17	11/03/17	22FS -20d
31	Document feedback and incorporate any areas of need for additional training in project schedule	5d	11/06/17	11/10/17	30
32	**January - June 2018**	128d	01/02/18	06/29/18	
33	Deliver Up to 5 New Organizational Assessments (N4H Assessors)	105d	01/02/18	05/29/18	
34	Create Up to 5 Organizational Assessment Reports	90d	01/23/18	05/29/18	33FS -90d
35	Deliver Up to 5 Organizational Assessment Report Presentations	90d	01/23/18	05/29/18	34FS -90d
36	Create Up to 5 Dual Diagnosis Capability Quality Improvement Plans	70d	03/06/18	06/12/18	35FS -60d
37	N4H ITCOD Team Approves Funding for up to 5 Organization Dual Diagnosis Capability Quality Improvement Plans	72d	03/21/18	06/29/18	36FS -59d
38	**Progress Assessment Checkpoint**	55d	04/02/18	06/18/18	
39	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	15d	04/02/18	04/20/18	
40	Modify in-progress Quality Improvement Plans (if required)	5d	04/23/18	04/27/18	39
41	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	04/30/18	05/04/18	40
42	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	05/30/18	06/12/18	33
43	Document feedback and any areas of improvement for future DDC reviews	2d	06/13/18	06/14/18	42
44	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	06/15/18	06/18/18	43

	Task Name	Duration	Start	Finish	Predecessors
45	**July - December 2018**	126d	07/02/18	12/31/18	
46	**New Organization Assessments**	126d	07/02/18	12/31/18	
47	Deliver Up to 3 New Organizational Assessments (N4H Assessors)	109d	07/02/18	12/05/18	37
48	Create Up to 3 Organizational Assessment Reports	90d	07/30/18	12/05/18	47FS -90d
49	Deliver Up to 3 Organizational Assessment Report Presentations	90d	07/30/18	12/05/18	48FS -90d
50	Create Up to 3 Dual Diagnosis Capability Quality Improvement Plans	67d	09/11/18	12/14/18	49FS -60d
51	N4H ITCOD Team Approves Funding for up to 7 Organization Dual Diagnosis Capability Quality Improvement Plans	69d	09/21/18	12/31/18	50FS -59d
52	**12 month Organization Re-assessments**	126d	07/02/18	12/31/18	
53	Deliver Up to 2 Organizational Re-assessments (N4H Assessors)	109d	07/02/18	12/05/18	37
54	Create Up to 2 Organizational Re-assessment Reports	90d	07/30/18	12/05/18	53FS -90d
55	Deliver Up to 2 Organizational Re-assessment Report Presentations	60d	09/11/18	12/05/18	54FS -60d
56	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plan UPDATES	52d	10/02/18	12/14/18	55FS -45d
57	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plan Updates	50d	10/18/18	12/31/18	56FS -40d
58	**Progress Assessment Checkpoint**	60d	09/03/18	11/27/18	
59	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	09/03/18	09/28/18	
60	Modify in-progress Quality Improvement Plans (if required)	5d	10/01/18	10/05/18	59
61	Present to Project Advisory and Steering Committee (if funding changes needed)	1d	10/08/18	10/08/18	60
62	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	11/06/18	11/19/18	47FS -20d, 53FS -
63	Document feedback and any areas of improvement for future DDC reviews	2d	11/20/18	11/21/18	62
64	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/26/18	11/27/18	63
65	**January - December 2019**	255d	01/02/19	12/31/19	
66	**New Organization Assessments**	255d	01/02/19	12/31/19	
67	Deliver Up to 2 New Organizational Assessments (N4H Assessors)	225d	01/02/19	11/14/19	
68	Create Up to 2 Organizational Assessment Reports	190d	03/13/19	12/09/19	67FS -175d
69	Deliver Up to 2 Organizational Assessment Report Presentations	175d	04/03/19	12/09/19	68FS -175d
70	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	165d	04/17/19	12/09/19	69FS -165d
71	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plans	170d	05/01/19	12/31/19	70FS -155d
72	**12 month Organization Re-assessments**	255d	01/02/19	12/31/19	
73	Deliver Up to 12 Organizational Re-assessments (N4H Assessors)	230d	01/02/19	11/21/19	
74	Create Up to 12 Organizational Re-assessment Reports	190d	03/20/19	12/16/19	73FS -175d
75	Deliver Up to 12 Organizational Re-assessment Report Presentations	175d	04/10/19	12/16/19	74FS -175d
76	Create Up to 12 Dual Diagnosis Capability Quality Improvement Plan UPDATES	165d	04/24/19	12/16/19	75FS -165d
77	N4H ITCOD Team Approves Funding for up to 12 Organization Dual Diagnosis Capability QIP Updates	170d	05/01/19	12/31/19	70FS -155d
78	**Progress Assessment Checkpoint**	126d	05/20/19	11/13/19	
79	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	05/20/19	06/17/19	
80	Modify in-progress Quality Improvement Plans (if required)	20d	06/18/19	07/15/19	79
81	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	07/16/19	07/22/19	80
82	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	10/25/19	11/07/19	67FS -20d, 73FS -
83	Document feedback and any areas of improvement for future DDC reviews	2d	11/08/19	11/11/19	82
84	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/12/19	11/13/19	83
85	**January - December 2020**	254d	01/06/20	12/31/20	
86	**New Organization Assessments**	254d	01/06/20	12/31/20	
87	Deliver Up to 2 New Organizational Assessments (N4H Assessors)	225d	01/06/20	11/17/20	
88	Create Up to 2 Organizational Assessment Reports	190d	03/16/20	12/10/20	87FS -175d
89	Deliver Up to 2 Organizational Assessment Report Presentations	175d	04/06/20	12/10/20	88FS -175d
90	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	165d	04/20/20	12/10/20	89FS -165d

	Task Name	Duration	Start	Finish	Predecessors
91	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plans	179d	04/20/20	12/31/20	90FS -165d
92	**12 month Organization Re-assessments**	254d	01/06/20	12/31/20	
93	Deliver Up to 14 Organizational Re-assessments (N4H Assessors)	225d	01/06/20	11/17/20	
94	Create Up to 14 Organizational Re-assessment Reports	190d	03/16/20	12/10/20	93FS -175d
95	Deliver Up to 14 Organizational Re-assessment Report Presentations	175d	04/06/20	12/10/20	94FS -175d
96	Create Up to 14 Dual Diagnosis Capability Quality Improvement Plan UPDATES	165d	04/20/20	12/10/20	95FS -165d
97	N4H ITCOD Team Approves Funding for up to 14 Organization Dual Diagnosis Capability QIP Updates	179d	04/20/20	12/31/20	96FS -165d
98	**Progress Assessment Checkpoint**	134d	05/04/20	11/09/20	
99	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	05/04/20	06/01/20	
100	Modify in-progress Quality Improvement Plans (if required)	20d	06/02/20	06/29/20	99
101	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	06/30/20	07/06/20	100
102	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	10/21/20	11/03/20	87FS -20d, 99FS -
103	Document feedback and any areas of improvement for future DDC reviews	2d	11/04/20	11/05/20	102
104	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/06/20	11/09/20	103
105	**ITCOD Practice Improvement Community Meetings (Bi-Yearly)**	766d	01/01/18	12/31/20	
106	Jan - June 2018 ITCOD Practice Improvement Community Meeting	128d	01/01/18	06/28/18	
107	July - Dec 2018 ITCOD Practice Improvement Community Meeting	126d	07/02/18	12/31/18	
108	Jan - June 2019 ITCOD Practice Improvement Community Meeting	128d	01/01/19	06/28/19	
109	July - Dec 2019 ITCOD Practice Improvement Community Meeting	128d	07/01/19	12/31/19	
110	Jan - June 2020 ITCOD Practice Improvement Community Meeting	129d	01/01/20	06/30/20	
111	July - Dec 2020 ITCOD Practice Improvement Community Meeting	128d	07/01/20	12/31/20	
112	**ITCOD E-Newsletters (Bi-Yearly)**	846d	09/01/17	12/30/20	
113	Create July - December 2017 ITCOD E-Newsletter to Network 4 Health Participants	82d	09/01/17	12/29/17	
114	Create Jan - June 2018 ITCOD E-Newsletter to Network 4 Health Participants	85d	03/01/18	06/28/18	
115	Create July - December 2018 ITCOD E-Newsletter to Network 4 Health Participants	83d	09/03/18	12/31/18	
116	Create Jan - June 2019 ITCOD E-Newsletter to Network 4 Health Participants	84d	03/04/19	06/28/19	
117	Create July - December 2019 ITCOD E-Newsletter to Network 4 Health Participants	84d	09/02/19	12/31/19	
118	Create Jan - June 2020 ITCOD E-Newsletter to Network 4 Health Participants	85d	03/02/20	06/29/20	
119	Create July - December 2020 ITCOD E-Newsletter to Network 4 Health Participants	83d	09/01/20	12/30/20	
120	**Evaluation Metrics Reporting (Data)**	912d	07/03/17	01/29/21	
121	**July - December 2017**	147d	07/03/17	01/30/18	
122	Select data collection tool(s)	64d	07/03/17	09/29/17	
123	Implement data collection tool for July - December 2017 Assessment Organizations (post assessment)	62d	10/02/17	12/29/17	122
124	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	22d	01/01/18	01/30/18	
125	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	22d	01/01/18	01/30/18	
126	Report # of organizations assessed by DDCAT or DDCMHT index	22d	01/01/18	01/30/18	
127	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	22d	01/01/18	01/30/18	
128	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools, patient assessment, treatment and referral	22d	01/01/18	01/30/18	
129	**January - June 2018**	127d	02/01/18	07/31/18	
130	Implement data collection tool for Jan - June 2018 Assessment Organizations (post assessment)	106d	02/01/18	06/29/18	
131	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement Plans)	21d	07/02/18	07/31/18	
132	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	07/02/18	07/31/18	
133	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	21d	07/02/18	07/31/18	
134	Report # of organizations assessed by DDCAT or CCMHT index	21d	07/02/18	07/31/18	
135	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	07/02/18	07/31/18	
136	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools, patient assessment, treatment and referral	21d	07/02/18	07/31/18	

	Task Name	Duration	Start	Finish	Predecessors
137	**July - December 2018**	127d	08/01/18	01/31/19	
138	Implement data collection tool for July - December 2018 Assessment Organizations (post assessment)	105d	08/01/18	12/31/18	
139	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement Plans)	23d	01/01/19	01/31/19	
140	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	23d	01/01/19	01/31/19	
141	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/19	01/31/19	
142	Report # of organizations assessed by DDCAT or CCMHT index	23d	01/01/19	01/31/19	
143	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	23d	01/01/19	01/31/19	
144	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools, patient assessment, treatment and referral	23d	01/01/19	01/31/19	
145	**January - December 2019**	23d	01/01/20	01/31/20	
146	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement Plans)	23d	01/01/20	01/31/20	
147	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	23d	01/01/20	01/31/20	
148	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/20	01/31/20	
149	Report # of organizations assessed by DDCAT or CCMHT index	23d	01/01/20	01/31/20	
150	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	23d	01/01/20	01/31/20	
151	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools, patient assessment, treatment and referral	23d	01/01/20	01/31/20	
152	**January - December 2020**	278d	01/01/20	01/29/21	
153	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement Plans)	21d	01/01/21	01/29/21	
154	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	01/01/21	01/29/21	
155	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/20	01/31/20	
156	Report # of organizations assessed by DDCAT or CCMHT index	21d	01/01/21	01/29/21	
157	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	01/01/21	01/29/21	
158	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools, patient assessment, treatment and referral	21d	01/01/21	01/29/21	
159	**Process Milestones by Reporting Period**	892d	06/30/17	12/31/20	
160	**Period ending June 30, 2017**	0	06/30/17	06/30/17	
161	Develop Implementation Plan	0	06/30/17	06/30/17	
162	Create Implementation Schedule/Timeline	0	06/30/17	06/30/17	
163	Create Budget	0	06/30/17	06/30/17	
164	Create Workforce Plan	0	06/30/17	06/30/17	
165	Create Training Plan	0	06/30/17	06/30/17	
166	Vendor Selection for Dual Diagnosis Capability Assessments	0	06/30/17	06/30/17	
167	Participant Selection through 12/31/17	0	06/30/17	06/30/17	
168	Organizational Leadership Sign-off	0	06/30/17	06/30/17	
169	**July - December 2017**	81d	09/01/17	12/29/17	
170	Recruit N4H DDCAT/DDCMHT Assessors (Workforce Plan)	0	09/01/17	09/01/17	4
171	Complete Schedule for July - December 2017 Dual Diagnosis Capability Organizational Assessments	0	09/15/17	09/15/17	
172	Complete up to 4 Dual Diagnosis Capability Organizational Assessments	0	12/04/17	12/04/17	22
173	Deliver DDCAT/DDCMHT Assessor Training (Training Plan)	0	12/27/17	12/27/17	7
174	Recruit N4H Co-Occurring Disorders Clinical Director (Workforce Plan)	0	12/29/17	12/29/17	3
175	Schedule Co-occurring Disorders Program Leaders Training (Training Plan)	0	12/29/17	12/29/17	11
176	Complete up to 1 Dual Diagnosis Capability Quality Improvement Plan	0	12/29/17	12/29/17	25
177	Define 2018 ITCOD Training Program for Primary Care and Support Organizations	0	12/29/17	12/29/17	14
178	Deliver ITCOD e-Newsletter	0	12/29/17	12/29/17	113
179	**January - June 2018**	73d	03/19/18	06/28/18	
180	Complete Schedule for January - June 2018 Dual Diagnosis Capability Organizational Assessments	0	03/19/18	03/19/18	
181	Deliver Co-Occurring Disorders Program Leader Training	0	03/30/18	03/30/18	12
182	Complete up to 5 Dual Diagnosis Capability Organizational Assessments	0	05/29/18	05/29/18	35

	Task Name	Duration	Start	Finish	Predecessors
183	Complete up to 5 Dual Diagnosis Capability Quality Improvement Plans	0	06/12/18	06/12/18	36
184	Complete Jan - June 2018 ITCOD Practice Improvement Community Meeting	0	06/28/18	06/28/18	106
185	Deliver ITCOD e-Newsletter	0	06/28/18	06/28/18	114
186	**July - December 2018**	336d	09/01/17	12/31/18	
187	Complete Schedule for Jul - Dec 2018 Dual Diagnosis Capability Organizational Assessments	0	09/01/17	09/01/17	
188	Complete up to 3 Dual Diagnosis Capability Organizational Assessments	0	12/05/18	12/05/18	49
189	Complete up to 2 Dual Diagnosis Capability Organizational Re-assessments	0	12/05/18	12/05/18	55
190	Complete up to 7 Quality Improvement Plans	0	12/14/18	12/14/18	50
191	Complete up to 2 Dual Diagnosis Capability QIP UPDATES	0	12/14/18	12/14/18	56
192	Deliver 2018 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/18	12/31/18	17
193	Define 2019 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/18	12/31/18	17
194	Complete July - Dec 2018 ITCOD Practice Improvement Community Meeting	0	12/31/18	12/31/18	107
195	Deliver ITCOD e-Newsletter	0	12/31/18	12/31/18	115
196	**January - December 2019**	148d	06/03/19	12/31/19	
197	Deliver 2019 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/19	12/31/19	18
198	Define 2020 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/19	12/31/19	16
199	Jan-Dec 2019 Dual Diagnosis Capability Organizational Assessments SCHEDULED	0	06/03/19	06/03/19	
200	Complete up to 2 NEW Dual Diagnosis Capability Organizational Assessments	0	12/09/19	12/09/19	69
201	Complete up to 2 NEW Quality Improvement Plans	0	12/09/19	12/09/19	70
202	Complete up to 12 Dual Diagnosis Capability Organizational Re-assessments	0	12/16/19	12/16/19	75
203	Complete up to 12 Dual Diagnosis Capability QIP UPDATES	0	12/16/19	12/16/19	76
204	Complete Jan - June 2019 ITCOD Practice Improvement Community Meeting	0	06/28/19	06/28/19	108
205	Complete July - Dec 2019 ITCOD Practice Improvement Community Meeting	0	12/31/19	12/31/19	109
206	Deliver ITCOD e-Newsletter (Jan - Jun 2019)	0	06/28/19	06/28/19	116
207	Deliver ITCOD e-Newsletter (July - Dec 2019)	0	12/31/19	12/31/19	117
208	**January - December 2020**	150d	06/01/20	12/31/20	
209	Complete Schedule for Jan-Dec 2020 Dual Diagnosis Capability Organizational Assessments	0	06/01/20	06/01/20	
210	Deliver ITCOD e-Newsletter (Jan - Jun 2020)	0	06/29/20	06/29/20	118
211	Complete Jan - June 2020 ITCOD Practice Improvement Community Meeting	0	06/30/20	06/30/20	110
212	Complete up to 2 NEW Dual Diagnosis Capability Organizational Assessments	0	12/10/20	12/10/20	89
213	Complete up to 2 NEW Quality Improvement Plans	0	12/10/20	12/10/20	90
214	Complete up to 14 Dual Diagnosis Capability Organizational Re-assessments	0	12/10/20	12/10/20	95
215	Complete up to 14 Dual Diagnosis Capability QIP UPDATES	0	12/10/20	12/10/20	96
216	Deliver ITCOD e-Newsletter (July - Dec 2020)	0	12/30/20	12/30/20	119
217	Complete July - Dec 2020 ITCOD Practice Improvement Community Meeting	0	12/31/20	12/31/20	111
218	Deliver 2020 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/20	12/31/20	19
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Transformation Waiver Section 1115
Integrated Treatment of Co-occurring Disorders Training Plan and Curriculum

The Center for Evidence Based Practice at Case Western Reserve University (CEBP) will provide initial training and technical assistance in support of Network4Health's planned use of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index to support our partner organizations understanding of their programs dual diagnosis and treatment capabilities. The planned CEBP services include:

Dual Diagnosis Capability Assessor Training and Evaluation Shadowing

- DDCAT and DDCMHT Training:
  - Conducting the evaluation
  - Item rating & consensus
  - Introduction to report writing
  - Introduction to report delivery & action planning
- Evaluations and Shadowing
  - The CEBP consultants will conduct the first 4 Network4Health DDCAT/DDCMHT assessments with members of the Network4Health DDC Assessment Team shadowing and learning from their work. SAMHSA's DDCAT and DDCMHT Toolkits recommend shadowing an experienced DDCAT/DDCMHT Assessor as "one of the best training methods". The CEBP team will be responsible for pre-evaluation data gathering, a 1-day on-site evaluation with each of the 4 organizations, rating consensus call facilitation and assessment report delivery.

Dual Diagnosis Capability Assessor Technical Assistance

- CEBP will provide 30 hours of telephone, web or video conference consultation to the N4H DDC Assessment Team to support the ongoing Network4Health DDCAT/DDCMHT assessments. Consultation may include:
  - Evaluation rating consensus meeting shadowing
  - Review of, and feedback on, written report narratives and recommendations
  - Report delivery: mock report delivery, report delivery shadowing, debriefing
  - Initial action planning session preparation

Dual Diagnosis Capability Program Leaders Training

- Our partners at CEBP will plan and deliver a 2 day in-person training to provide supervisors and program managers with the opportunity to familiarize themselves with the DDCAT/DDCMHT indices and the planning and implementation processes associated with each. Participants in this training will also learn about the implications of DDCAT/DDCMHT for supervising improved treatment strategies and models of care for

individuals with co-occurring mental illness and substance use disorders. Other key evidence based tools for the integrated treatment of co-occurring conditions, such as motivational interviewing, may also be introduced in this training. All organizations participating in the N4H ITCOD sponsored DDCAT/DDCMHT assessments will be asked to identify at least one Dual Diagnosis Capability Program Leader for their organization. The training can accommodate up to 60 participants.

In addition to our use of CEBP services, Network4Health will strive to promote and expand training services currently available within our partner organizations. When necessary, additional outside training organizations will be identified to support the following needs:

N4H Assessor Training Course Development and Delivery

- The Network4Health Dual Diagnosis Capability Assessment Team will develop a training curriculum and materials to support in-house training of additional Dual Diagnosis Capability Assessors to ensure continued staffing of the Network 4 Health Dual Diagnosis Capability (DDC) Assessment Team in later years of the project.

Co-Occurring Disorders Quality Improvement Plan (COD QIP) Training and Technical Assistance

- Upon receipt of a DDCAT or DDCMHT assessment report and dual diagnosis capability continuum designation (Addiction-only services, Mental-health only services, Dual-diagnosis capable, Dual-diagnosis enhanced), participating organizations will document a Co-occurring Disorders Quality Improvement Plan (COD QIP). The one-year COD QIP will target training, process improvement, procedure modifications or other consultative services to help increase the organizations competencies and program structure for the identification and integrated treatment of patients with co-occurring disorders. Where feasible, the Network4Health ITCOD Advisory Board will work to make trainings in support of a COD QIP available across participating organizations. Trainings and services may include:
    - DDCAT/DDCMHT Overview
    - ITCOD (formerly IDDT) Clinical
    - ITCOD (formerly IDDT) Implementation and Organizational Change
    - Motivational Interviewing
    - Stages of Change
    - Critical Time Intervention (CTI)

- Cognitive Behavior Therapy (CBT)
- LEAP (Listen, Empathize, Agree, Partner)
- Medication Assisted Treatment
- Suboxone Treatment Protocol

Co-Occurring Disorders Training for Primary Care and Community Support Organizations

- The Dual Diagnosis Capability (DDC) Primary Care and Community Support Team will provide evidence based training for relevant components of identification and treatment for patients with co-occurring severe mental health and substance use disorders. A subset of the ITCOD Project Advisory team, the Dual Diagnosis Capability Primary Care and Community Support Team will be responsible for the development of a yearly ITCOD Primary Care and Community Support Organization Training Program. The team will focus on education and training activities that meet the needs of organizations who frequently work with patients with co-occurring disorders, but are not the primary mental health or substance use disorder treatment providers. The group will likely focus initial work in the following areas:
  - Definition and distribution of Dual Diagnosis Capability Toolkits
  - Population Health Assessment (SBIRT, PHQ-9's, PHQ-2's) Implementation and Usage Training
  - Certified Recovery Support Worker (CRSW) Training
  - Motivational Interviewing Training - including technique usage for patients with co-occurring disorders as well as the application within other areas of care such as chronic disease management.

Training Plan

Training or Training Related Activity	***Participants***	***Completion By…***
DDCAT/DDCMHT Assessment Capacity Development		
Deliver DDCAT/DDCMHT Assessor Training	**Up to 5**	**12/27/2017**
Deliver Up To 30 Hours DDCAT/DDCMHT Consulting	**Up to 5**	**12/28/2018**
Design DDCAT/DDCMHT "Train the Trainer" Assessor Training	**Up to 5**	**12/31/2018**

Transformation Waiver Section 1115
Integrated Treatment of Co-occurring Disorders Training Plan and Curriculum

Program Leader Development		
Deliver Co-Occurring Disorders Program Leader Training	**Up to 50**	**3/30/18**
Primary Care and Support Organization Development		
Define 2018 ITCOD Training Program for Primary Care and Support Organizations	**See Deliver 2018**	**12/29/2017**
Define 2019 ITCOD Training Program for Primary Care and Support Organizations	**See Deliver 2019**	**12/31/2018**
Define 2020 ITCOD Training Program for Primary Care and Support Organizations	**See Deliver 2020**	**12/31/2019**
Deliver 2018 ITCOD Training for Primary Care and Support Organizations	**Up to 50**	**12/31/2018**
Deliver 2019 ITCOD Training for Primary Care and Support Organizations	**Up to 50**	**12/31/2019**
Deliver 2020 ITCOD Training for Primary Care and Support Organizations	**Up to 50**	**12/21/2020**