Integrated Delivery Network: Region 7

Region 7 IDN

IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 2 (CY2017) and Year 3 (CY2018)

Revised 9/25/2017

NORTH COUNTRY HEALTH CONSORTIUM

Introduction

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

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

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

Attachment_B1.2A

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

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

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DSRIP IDN Project Plan Implementation (PPI)

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

Project Plan Requirement	Activity			
	6/30/17	12/31/17	6/30/18	12/31/18
Soliciting Community Input	See below			
Network Development	See below			
Addressing the Opioid Crisis	See below			
Governance	See below			
Budget	See below			
(Additional as needed)				

Soliciting Community Input:

Region 7 has made community engagement a priority with the formation of a Community Engagement Committee that has worked to represent the diversity of the communities this project aims to serve. The work of the committee has included the identification of the subgroups of the population in the region and how to best educate, inform and engage them in the work to come. The committee has created a user-friendly elevator speech and helped shape the monthly newsletter and Region 7 IDN webpages that provide updates and descriptions of the project. The webpages include a specific community and FAQ page that translates the complexities of the project into relatable and understandable information. This has met the first priority of education of our partners, knowing that through their comprehensive understanding of the project they in turn will build education of the communities they serve.

Active committee partners represent medical and behavioral health providers, social service organizations, and prevention and advocacy organizations across the region. As part of the community engagement plan, the Region 7 IDN Administrative Lead has met face-to-face with individual partners at their locations to discuss their specific roles in the IDN, answer questions, and provide them with appropriate messaging for the consumer base they work with. This investment in the IDN partners will provide them with the knowledge and confidence to engage and educate the populations they serve. We are already seeing the positive return on this approach as partners are sharing and incorporating the project into community and regional meetings and educational events they participate in.

The Community engagement plan relies on development of a strong foundation of education and understanding based on the premise that we must first help all citizens understand the project and how it relates to them and their community. From that point we can build consumer, family and community

engagement and incorporate that into evaluation and monitoring plans. Future plans include: using real-time consumer storytelling in print to translate the project deliverables into relatable goals in order to encourage consumer participation, these articles will be published in regional newspapers and on partner's websites and within their newsletters; establishing consumer feedback groups in regions through a Listening Session model with discussion guide; developing a contact list to disseminate updates and project status to consumers, families, community members and other interested parties; and having partners continue to include and promote the IDN work in community and professional meetings.

In addition, Carroll County has been actively engaging the community in relationship to the IDN project. In May of 2017 they held a community forum titled **"*Pathway from Silence to Solutions".*** The 2017 forum brought together individuals and organizations making a positive impact on the health and well-being of our communities, while addressing the complex issues related to substance misuse. The program included presentations by panelists from several community sectors, including law enforcement, healthcare, government, education, and community supports. Presenters highlighted the progress made in addressing gaps in available services and the barriers that have challenged our neighbors trying to get the help they need. April Allin, Region 7 IDN Program Manager for the North Country Health Consortium, took part in the Government sector panel and shared efforts underway through NH's Delivery System Reform Incentive Payment (DSRIP) 1115 Waiver Program. Following the panel presentations, participants in the forum had the opportunity to share their ideas for moving forward to provide additional prevention initiatives, intervention, treatment resources, and recovery supports in the county. This was an opportunity for others to become involved and to work to mitigate the substance misuse challenges facing our communities. Some key themes that were identified at the forum include importance of trauma-informed education/social-emotional development, the need to increase developmental/SBIRT screenings, and transportation challenges. In addition to the community forum**,** Carroll County Coalition for Public Health (C3PH) has shared information regarding NH's DSRIP 1115 Waiver Program in IDN Region 7 and has been attending numerous provider meetings in the region to discuss the IDN and the deliverables.

Network Development:

Region 7 is building a robust Network that is inclusive of primary care and behavioral health providers, as well as substance use disorder providers and social service agencies. With the intention of "following the patient" and threading together organizations that had not necessarily worked together in the past, the North Country Integrated Delivery Network (IDN) has made significant progress during the project planning phase. Although many North Country organizations have a long history of collaborative initiatives, the IDN project is enabling design of innovative models to work together in new ways and to address patient/client needs in a comprehensive, integrated manner. In order to prepare for implementation, North Country Health Consortium (Administrative Lead) staff met with twenty-six member organizations to better understand their programs and services, assess their level of understanding related to the IDN, and build relationships. These meetings have proven to be extremely valuable to bring partners together with similar goals and have even resulted in joint project proposals (the process use by Region 7 to distribute DSRIP funds to partners). Region 7, as will be discussed throughout the Implementation Plan, is comprised of three sub-regions, including Coos, Carroll, and

Northern Grafton Counties. Within Region 7, there are two Public Health Networks that both have strong connections between and among community partners. The IDN is building these relationships and strengthening the integration of services. Region 7 has already begun to see progress toward integration and coordination between service providers, including bi-directional integrated delivery of physical, behavioral health services, substance use disorder services, transitional care and alignment of care. Specifically, the region has a community mental health center, and a federally qualified health center collaborating to co-locate services. Additionally, Carroll County partners are developing a proposal for coordinated and integrate services among two hospitals, a health center, a family resource center, and a home health agency. Each Public Health Network employs a Continuum of Care (CoC) Facilitator who is instrumental in development of the IDN. The Facilitators have a keen sense of the community needs related to substance use disorder prevention, intervention, treatment and recovery services. For example, one important focus of the Region 7 Implementation Plan is the development of a cadre of Peer Recovery Supports, which is a direct reflection of the gap in services identified by the CoCs. Region 7 will build its Network taking into account the rurality and cultural diversity in its communities.

Addressing the Opioid Epidemic:

Integrated Delivery Network Region 7 contains Coos and Carroll counties, as well as a piece of north western Grafton county running from the Coos border down to North Haverhill. The two counties wholly contained within the region have been heavily affected by the opioid crisis. The New Hampshire Drug Monitoring Initiative (DMI) report for calendar year 2016 (released January 2017) marked Carroll and Coos as having the third and fourth highest overdose death rates per 10,000 population (2.98 and 2.63 respectively). The counties also ranked the same for opioid-related emergency department visits, with Coos ranking 3rd in the state, with 42.59 visits per 10,000 population and Carroll ranking 4th with 36.56 per 10,000 population.

In the face of these stark data points, some progress has been made. The Public Health Networks of the North County and Carroll county have begun to initiate their prevention strategic plans, working with local coalitions to improve conditions in schools, workplaces and communities that have up to this point exacerbated the problem. Paired with these grassroots movements, new outpatient treatment options and recovery resources have come online, both separate from and with IDN assistance. An example of an IDN-supported service added in the region would be Weeks Medical Center's new medication assisted treatment program, which is supported in part by capacity building funds from IDN Region 7. This new service will fill an MAT treatment gap in this part of the region, providing an option for those individuals who may otherwise have needed to travel far afield to access treatment.

With the initiation of IDN implementation in the region, these new resources will be supported and connected to one another as never before. This will provide for an environment in which a patient seeking help with an opioid use disorder finds support and appropriate care across the continuum and into sustained recovery.

Governance:

Region 7's Governance Structure includes a Steering Committee, and four workgroups: Financial, Data, Community Engagement, and Clinical. As the IDN has progressed toward accomplishment of early milestones, several of the workgroups have worked together. For example the Data and Clinical workgroups reviewed Shared Care Plan vendors together in order to ensure various perspectives were taken into account, and that the chosen vendor met the needs of Region 7 rural communities. The Steering Committee has representation from all of the required stakeholder groups, and all of the workgroups have participation from organizations that represent the large geographic area. The Steering Committee as well as the workgroups each has a charter that has been signed-off by members. Over the past several months, each of these groups has been extremely active – meeting regularly, and providing input and feedback to all IDN activities.

The Steering Committee oversees the proposal process implemented by the IDN, and makes the final decisions regarding funding, based on the Financial Workgroup recommendations. The Financial Workgroup and the Steering Committee have also approved all of the IDN budgets. The Steering Committee is responsible for the strategic vision, fund allocation, and the achievement of project metrics for the IDN. All of the workgroups have specific responsibilities, but all final decisions are made by the Steering Committee.

The role of the IDN Steering Committee is to take responsibility for the strategic vision, fund allocation, and the achievement of project metrics of the Integrated Delivery Network. It is intended that the Steering Committee leverage the experiences, expertise, and insight of key individuals at organizations committed to transforming the delivery of behavioral healthcare. Steering Committee members are not directly responsible for managing project activities, but provide support, oversight and guidance.

Steering Committee members have agreed to:

- Attend meetings and follow through on promises and commitments;
- Understand the strategic implications and outcomes of the Integrated Delivery Network;
- Be genuinely interested in the initiative and be an advocate for broad support of the outcomes being pursued;
- Foster positive communication regarding the project's progress and outcomes;
- Keep its organization's decision-makers informed of potential decisions and actions, and bring concerns up for discussion at the earliest point in the process;
- Follow North Country Health Consortium's conflict of interest and compliance policies

The Community Engagement Workgroup is responsible for decisions made regarding engagement of the public at large as well as communication between IDN members. The workgroup has provided input to the development of the Region 7 website and the Region 7 "elevator speech." The Community Engagement workgroup will also be instrumental in the development of patient satisfaction surveys that will be used at IDN participating agencies.

The Community Engagement Workgroup will advise the IDN Steering committee on ways to engage the entire Region 7 IDN community to gather input and feedback on improving patient outcomes in the region. These suggestions will reflect consideration of various community goals, issues, and concerns, and find the appropriate balance among competing interests.

The Community Engagement Workgroup has agreed to:

- Ensure the entire Region 7 IDN community is engaged in the development and implementation of the Integrated Delivery Network;
- Ensure the IDN's governance structure incorporates feedback from the entire IDN community throughout the demonstration period;
- Conduct public meetings necessary to inform and engage the community;
- Provide Steering Committee documentation to support recommendations;
- Send one representative to Sub-recipient review panel
- Adhere to NCHC conflict of interest policies and compliance plans

The Data Workgroup is responsible for recommending data sharing agreements, reporting and monitoring data sharing processes, assisting with project evaluation metrics. Members of the Data workgroup also participated on the Statewide HIT Taskforce. The Data Workgroup will advise the IDN Steering committee regarding data sharing processes, utilizing existing technology, and identifying what is needed to implement standardized reporting and monitoring for the Region 7 IDN. These suggestions will reflect consideration of various community goals, issues, and concerns, and find the appropriate balance among competing interests.

The Data workgroup has agreed to:

- Determine best data sharing processes among partners;
- Establish reporting and monitoring processes;
- Leverage existing technology to feed into the requirements of the IDN;
- Send one recipient to the sub-recipient review panel
- Adhere to the North Country Health Consortium's Compliance and Conflict of interest policies

The Clinical Workgroup will advise the IDN Steering committee regarding clinical pathway standards, and how to monitor fidelity, performance, and patient outcomes of the Region 7 IDN. These suggestions will reflect consideration of various community goals, issues, and concerns, and find the appropriate balance among competing interests.

The Clinical workgroup, under direction of the IDN 7 Medical Director, has agreed to:

- Develop standard clinical pathways;
- Provide guidance for monitoring implementation of clinical standards;
- Determine strategies for monitoring IDN and individual partner performance;
- Ensure fidelity to evidence-based standards;
- Implement process for monitoring and managing of patient outcomes
- Provide documentation to Steering Committee to support recommendations;
- Send a representative to the sub-recipient review panel;
- Follow North Country Health Consortium's conflict of interest and compliance plans

The Financial Work Group will advise the IDN Steering committee regarding decisions about the distribution of funds earned by the IDN over the course of the demonstration. These suggestions will reflect consideration of various community goals, issues, and concerns, and find the appropriate balance among competing interests.

The Finance workgroup has agreed to:

- Create metrics template for project evaluation. Consider applicability for context of surrounding communities and effective use of resources;
- Review and evaluate proposed project using evaluation metrics;
- Participate in the implementation process to ensure adequate steps are taken for financial checks and balances, and timeframe deadlines are outlined;
- Produce deliverables of the project within desired timeframes;
- Perform tasks and activities defined by the work plan;
- Develop reporting system for work plan deadline status
- Use discussion forum format for problem solving through collaboration;
- Provide consensus-based recommendations to the Steering Committee on key issues and concerns of the project;
- Represent a range of key stakeholders covering the entire service area;
- Provide professional and technical support by meeting at least quarterly to collaborate and provide partner updates;
- Develop a funding allocation plan that has separate metrics for evaluating data and social determinants of health, and allows for project review among partners;
- Develop budgeting template for standardized appearance;
- Review a process for development of a 5 year budget;
- Follow a procurement policy that addresses vendor risk assessment, conflict of interest policies, and prior year audits;
- Discuss additional cost control measures and provide suggestions to the Steering Committee;
- Provide documentation to Steering Committee to support recommendations;
- Assist in the development of year-to-date and budget forecasting processes;
- Develop a process to ensure that an organization or provider participating in multiple IDNs will not receive duplicative checks for the same service from multiple IDNs, including the consideration of developing a centralized reporting system to help with this task.
- Use memorandum of agreement template provided by lead agency;
- Use progress report template provided by lead agency;
- Establish funding criteria for 2 levels of sub-recipient proposals;
- Review sub-recipient submissions from partner agencies to make sure criteria is met before proposals go to sub-recipient review panel;
- Send delegate to sub-recipient review panel
- Provide specific local expertise, including identifying emerging local issues;
- Attend all meetings possible and prepare appropriately;
- Relay pertinent information to your constituents after each meeting and gather information/feedback from your constituents before each meeting;
- Assign a scribe for each meeting;
- Articulate and reflect the interests that advisory group members bring to the table;
- Maintain a focus on solutions that benefit the entire IDN Region 7 service area;
- Agree to North Country Health Consortium's conflict of interest and compliance policies.

Budget:

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Bidder/Program Name:	**North Country Health Consortium**
Budget Report for:	**Integrated Delivery Network: Region 7**
Budget Period:	**Quarter 1 and 2, 2017: January 1, 2017 - June 30, 2017**

	Total Program Cost			
Line Item	**Direct Incremental**	**Indirect Fixed**	**Total**	**NOTES**
1. Total Salary/Wages	$ 85,508.23	$ 12,689.63	$ 98,197.86	Approximately 3.5 FTE
2. Employee Benefits	$ 11,476.21	$ 1,658.71	$ 13,134.92	SS/Medicare/Health Insurance/Workers Comp./Unemployment
3. Consultants				
4. Equipment:				
Rental				
Repair and Maintenance				
Purchase/Depreciation				
5. Supplies:				
Educational	$ -	$ 0.00	$ 0.00	
Lab				
Pharmacy				
Medical				
Office	$ 2,706.96	$ 454.65	$ 3,161.61	2 Computers
6. Travel	$ 2,661.85	$ 380.68	$ 3,042.53	Regional Mileage & Conference
7. Occupancy				
8. Current Expenses				
Telephone				
Postage	$ 165.32	$ 25.59	$ 190.91	General Postage
Subscriptions	$ 872.51	$ 139.95	$ 1,012.46	Software Licenses
Audit and Legal	$ 2,309.10	$ 436.42	$	Federal requirement

			2,745.52	
Insurance	$ 331.35	$ 50.72	$ 382.07	Professional Liability
Board Expenses				
9. Software				
10. Marketing/Communications	$ 5,557.43	$ 752.11	$ 6,309.54	Meeting Expenses/Recruiting/Digital Communication
11. Staff Education and Training				
12. Subcontracts/Agreements	$ 472,349.50	$ -	$ 472,349.50	RFP payments to partners
13. Other (specific details mandatory):				
TOTAL	**$ 583,938.46**	**$ 16,588.44**	**$ 600,526.90**	

DSRIP IDN Process Milestones

DHHS will use the tool below to review and document each IDN's Implementation activity. 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
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet				

Project A1: Behavioral Health Workforce Capacity Development

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

A1-2. IDN-level Workforce: Gap Analysis

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;
- Licensed Mental Health Professionals;
- Peer Recovery Coaches; and
- Other Front Line Providers.

IDN-level Workforce: Gap Analysis

In mid-February 2017, workforce surveys were sent to 17 behavioral health and primary care agencies in Region 7 IDN, and 14 of those agencies completed the survey. The results of this survey were shared with the state behavioral health taskforce so the information could be compiled with the results from the other 6 regional IDNs, and the results were then incorporated into the statewide strategic plan. This survey serves as the foundation for the workforce gaps analysis of Region 7 IDN. The information gleaned from this survey, along with information obtained from regional community health needs assessment, and workforce needs for selected community-driven projects was collected and analyzed to create the Region 7 IDN gap analysis. The goal of this gap analysis is to identify workforce gaps in recruitment, hiring, training, and retention of specific behavioral health providers including but not limited to Master Licensed Alcohol and Drug Counselors; Licensed Mental Health Professionals; Peer Recovery Coaches; and Other Front-Line Providers.

Numerous challenges related to behavioral health workforce capacity shortages were identified in the region, but the challenges which rose to the top were related to recruitment and training. The main problem identified related to recruitment was a lack of available behavioral health workforce statewide. Region 7 IDN sees existing behavioral staff move from organization to organization, but there is not much expansion of the behavioral health workforce in Region 7 IDN. There is a significant shortage of psychiatrists both at the regional level and statewide, so Region 7 IDN will need to be innovative to get psychiatrists to be part of the multi-disciplinary core teams. NCHC will research the options for contracting psychiatric services for practices within the region and will share this information with IDN partners. The other challenge that rose to the top in the survey was related to training. Survey respondents felt the region needs to have trainings on integrated healthcare, and felt it was very important to cross train staff from partner agencies so all agencies understood the intersection of primary care, mental health, substance use disorders, and peer recovery support services.

Region 7 IDN identified recruitment and training as the top strategies to address the regional challenges. Survey respondents selected the pipeline program, expansion of the Statewide Loan Repayment Program (SLRP) to incentivize mental health and Substance Use Disorder (SUD) professionals, along with the need for coordinated recruitment efforts as the top strategies to address as a region. NNH AHEC was identified as a strategy to address the training needs of the region. The regional gap analysis needed to tie into the statewide strategic plan which was finalized at the end of June 2017, so in early July Region 7 IDN formed a regional workgroup to look at the goals and objectives of the statewide plan to prioritize how Region 7 wants to move forward to address the challenges related to behavioral health workforce capacity in the region. Region 7 IDN will be working on strategies for utilizing and connecting existing SUD and behavioral health resources, strategies to address gaps in educational preparation of SUD and behavioral health providers to ensure workforce readiness upon graduation, strategies to support training of non-clinical IDN staff in Mental Health First Aid, and strategies for strengthening the workforce in specific areas of expertise such as Master Licensed Alcohol and Drug Counselors (MLADCs), licensed mental health professionals, Peer Recovery Coaches, and other front line providers. The region will work to ensure the regional plan aligns with guidelines and targets established by the statewide plan, the IDN's community needs assessment, the IDN's workforce assessment survey and the community-driven projects selected by the IDN.

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 detailed narrative 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

NOTE: The STCs state that IDN completes the IDN Workforce Capacity Development Implementation Plan no later than 3/31/17. However, DHHS considers this to be a "soft" or recommended date. Therefore, all scoring for incentives require that the IDN Workforce Capacity Development Implementation Plan be complete by 6/30/17 and submitted by 7/30/17.

The Behavioral Health Workforce Capacity Project, referred to as project A1, is a statewide project designed to establish the workforce required to meet the objectives of the DSRIP demonstration. It will increase community-based behavioral health service capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use disorder and mental health services. Region 7 IDN has been actively involved in all phases of creating the statewide strategic plan to date, and the region's IDN Chief Executive Officer, Nancy Frank, serves as the vice-chair of the Behavioral Health Workforce Taskforce. The Taskforce has been meeting monthly over the last year to develop the Statewide Behavioral Health Workforce Capacity Strategic Plan. The Statewide strategic plan addresses common and shared needs for behavioral health workforce development, and Region 7 IDN has used this document as a road map to address regional workforce capacity needs.

Part of the statewide strategic planning process included collecting a workforce inventory list from each region which included number of current positions, number of open positions, and number of new positions anticipated. In addition, participating organizations were asked to list the top challenges associated with recruitment, hiring, training, and retention, as well as identify strategies to address these challenges. The information in the surveys was compiled and analyzed to complete the statewide strategic plan. Many of the challenges identified below mirror those of Region 7:

Recruitment/Hiring

- Compensation offerings below market levels
- Arcane license reciprocity agreements with other States
- Onerous licensing requirements
- Devalued profession/patients/clients

Education/Training

- Lack of marketing about career opportunities.
- Lack of pipeline from higher education
- Integrated care competencies needed
- Cultural differences across primary and behavioral health domains
- Costs

Retention/Sustainability

- High workloads
- Paperwork burden
- Billing for integration/supervision unclear

Federal and state policies related to licensing, reciprocity, and credentialing add to these challenges.

Behavioral health conditions are ubiquitous and debilitating; they lead to staggering burdens on individuals, families, and societies alike (Kessler et al. 2005; Kessler et al. 2009). Although effective treatments exist, most people with behavioral health conditions neither seek nor receive adequate treatment (Kessler et al., 2005). Of those that do, most seek help in primary care settings that consistently under-detect and under-treat behavioral health conditions (Coyne. Thompson. Klinkman. & Nease. 2002; Mertens. Lu, Parthasarathy. Moore. & Weisner. 2003; Schulberg, Block. & Madonia, 1996).

Experts have advocated for the integration of behavioral health (IBH) into primary care settings as the most effective way to close the behavioral health treatment gap (World Health Organization, 2008). Numerous randomized clinical trials indicate that IBH can enhance the detection, uptake, effectiveness, and cost-effectiveness of behavioral health care in primary care settings (Butler et al. 2008). The low-intensity behavioral health interventions offered in integrated care settings are best suited to mild to moderate levels of emotional distress, whereas more severe and chronic emotional distress responds best to specialty mental health care (Dickinson et al. 2005; Krahn et al. 2006). Nevertheless, widespread, effective, and financially sustainable implementation of IBH has proven elusive in settings of usual primary care (Alexander. Arnkoff. & Glass. 2010; Pincus, 2003).

Among the barriers to successful dissemination and translation of IBH has been a limited and poorly equipped workforce. National estimates indicate that the behavioral health workforce is insufficient to meet the need of patients in our safety net primary care settings (Burke et al.2013). The problem extends beyond the limited pool of behavioral health providers to inadequate preparation; the current behavioral health and primary care workforce lacks the training, acculturation, skills, attitudes, and leadership qualities necessary to successfully work as a team to enact IBH (Workforce I SAMHSA-HRSA. n.d.). Limited didactic and experiential training opportunities continue to hamper the dissemination and implementation of IBH (Hall et al. 2015).

New Hampshire is not an exception in this regard. A recent report commissioned by the Endowment for Health and conducted by Cherokee Health Systems highlighted the perception among key stakeholders that NH lacks an adequate IBH workforce (Cherokee Health Systems. 2014). Respondents highlighted a lack of qualified behaviorists, a confusing licensing environment, a shortage of psychiatry, and an overall aging workforce, as major impediments to IBH. Workforce shortages and inadequate preparation extended to the primary care/medical workforce as well. The aforementioned problems are further compounded by the lack of adequate specialty mental health care and the rural nature of many NH communities; the former places heavier behavioral health burdens on primary care practices, while the latter makes it difficult to recruit, train, and retain qualified professionals. The Cherokee (2014) report advocated for a multi-pronged workforce development strategy including but not limited to developing a statewide workforce plan that articulates the number and types of workforce needed, considering ways to expand the workforce pipeline, and advocating for policy changes to support workforce development. Region 7 IDN found many similarities when the IDN-level workforce gaps analysis was conducted within the region.

Region 7 IDN's workforce planning group realizes that all of the goals and objectives of the strategic plan are important, and will contribute towards meetings those goals, and objectives, but will be focusing efforts on goal 4 and 5 of the strategic plan: NH has a pool of qualified behavioral health workforce

applicants adequate to the integrated primary and behavioral health care need and NH's behavioral health workforce positions are filled and there is less frequent turnover in staffing, respectively. Both goals tie directly to the results of the workforce survey completed by partner agencies - the biggest challenge to the behavioral health workforce in Region 7 is the need for recruitment and training.

Region 7 IDN intends to use a significant portion of the region's DSRIP funds to recruit, hire, train and retain the workforce required to meet the DSRIP objectives of more capacity to serve New Hampshire residents with mental health and substance use disorders, including opioid addiction; better integration of physical and behavioral health care; and smoother transitions across care settings. To ensure Region 7 has a workforce who is adequately prepared to work in an integrated healthcare environment, the Region will use SAMHSA's 9 Core Competencies for Integrated Healthcare as a framework for the Core Competency project, as well as the region's 3 community-driven projects. The nine core competencies are: Interpersonal Communication; Collaboration & Teamwork; Screening & Assessment; Care Planning & Care Coordination; Intervention; Cultural Competence & Adaption; Systems Practice; Practice Based Learning & Quality Improvement; and Informatics. The nine core competencies are skill based, and will be the foundation for the development of the regions' multiple toolkits and serve as a premise for the regions' evaluation model. The competencies will be used as a guide to develop job descriptions, employee performance reviews, and orientation programs for the workforce involved with delivery of integrated healthcare. They will also be used as a resource for the creation of curricula related to integrated health care. References to the 9 Core Competencies will be made throughout the implementation plan.

Practice-Based Learning and Quality Improvement involves having the ability to asses and continually improve services provided, including use of evidenced-based practices, fidelity assessments, and review of practice guidelines. Practices will utilize data, patient input and other healthcare organizations' quality improvement protocols and then collaborate as a team on the best way to implement processes which will lead to improvements. Multi-disciplinary core teams will work together to create a vision and define team goals. The team will use the PDSA Cycle and Model for Improvement to tie the team goals to a quality improvement initiative incorporating the PDSA cycle.

Care Planning & Care Coordination refers to the team's ability to create and implement integrated care plans that include information sharing and linkages between providers, patients, families and social service organizations. The Care Plans will be inclusive of whole health, wellness recovery, disease management and transitions, and the type and intensity of services will align with the needs of the Medicaid beneficiary.

Collaboration & Teamwork skills will provide the foundation for patient care. All levels of provider care need to function together as a team, working collaboratively for the best patient care plan. It is imperative that team members understand and respect each other's roles and responsibilities and how to resolve difference, express concerns, and follow a shared decision-making process. The multi-disciplinary core team will ensure they use warm handoffs as the patient moves among and between practice sites to improve the healthcare experience of the patient and lead to better health outcomes.

Interpersonal Communication is a crucial component of how multi-disciplinary team members engage with patients. Provider and social services staff across all departments such as front line, providers and transition workers will have the opportunity to learn skills that benefit both the provider organization and the patient and family members. These skills include learning to interact with a diverse population, active listening, reflective response and the ability to converse in a clear, non-judgmental way in common language that can be understood. Interactions with patients should include explanations of the roles and responsibilities of all parties and printed materials that the patient and family can review. The team will follow a flexible decision-making process.

Screening & Assessment is the ability to conduct brief screenings and assessments when indicated. To ensure a consistent process in the region, screening and assessment protocols that reveal family and social supports, common health problems, comorbidity, risk of substance use and other defined behavioral health indicators will be learned and utilized.

Intervention is the ability to provide a wide range of brief and/or long term, focused prevention, treatment and recovery service options that can supplement a patient's medical or behavioral health treatment. Examples of Interventions include education of the patient and family, linkages to peer support, specialty healthcare, and social services, and follow up to ensure connections. Treatment for mental health and substance use problems, crisis intervention, and prescribing and management of Medication Assisted Treatment services are additional examples of interventions.

Cultural Competence & Adaption is the ability to adapt service delivery to the culture of the patient and family that are in need of healthcare services. This involves identification of areas that can be adapted to meet the needs of these patients around language, faith and cultural norms. Team members need to be educated on cultural competence and the communication skills that will enable them to successfully engage the patient in care. It is also important to identify and address disparities in healthcare access and quality.

Systems Oriented Practice refers to the ability of workers to function effectively within the organizational and financial structures of the local system of healthcare, in consideration of health care coverage, limits to benefits, reimbursement and cost effectiveness, while still striving for innovation in the delivery of care. To remain sustainable practices must position themselves to make changes in the way care is delivered as it relates to emerging healthcare reforms.

Informatics is the ability to use healthcare technology like computer and web-based assessment, and intervention tools, direct secure messaging, telehealth applications and a shared care plan to improve patient outcomes. All technology will protect patient privacy.

To meet workforce goals and address the challenges identified the region will be primarily addressing four workforce projects: 1) grow our own mental health providers, 2) petition mental health licensing boards regarding supervision rules, 3) shared use of existing mental health professionals, and 4) create a central coordinating agency for recovery support services.

The primary focus of the grow-your-own model will be to support existing staff as they work to advance from one level of certification to another. To assist with this process, in the fall of 2017 NCHC is going to poll existing LADCs in the area to identify the unmet training needs related to obtaining MLADC licensure. The results of these polls will be analyzed by December 31, 2017, and a plan will be created to address the unmet need of the LADCs. In addition to this, the region needs to identify local mental health subject matter experts in the region who would be willing to utilize these skills for training purposes. NCHC will reach out to partner agencies in the fall of 2017 to see who they have for staff that may be interested in both professional development and sharing their knowledge with other colleagues in the region. NCHC will have a list of local training experts by December 31, 2017. The region's workforce budget will have funds set aside to pay to participating organizations should they have an employee who would like to be a local trainer for the IDN. These funds can be used to offset the loss of revenue when an employee is training others in the region instead of seeing patients. Having mental health trainers within the region will be a key to sustaining a qualified mental health workforce. Region 7 IDN will be using local trainers whenever possible for trainings by December 31, 2018. The region is also in position to work with these local subject matter experts to connect them to training programs at Plymouth State University, Springfield College, White Mountains Community College, and Granite State College. This connection will serve multiple purposes. The local subject matter experts in Region 7 IDN will work with the academic institutions to become adjunct faculty. The subject matter experts will develop learning objectives and curriculum content which will be approved by the academic institution. The organizations where the subject matter experts are employed would agree to serve as a mentor for students from these academic institutions in exchange for a reduced cost in tuition for professionals in Region 7 IDN looking to enter the mental health field, or advance their current level of certification. Region 7 IDN will be willing to use funds from the workforce budget to give to the academic institutions to help offset the reduced tuition rate if it is necessary. In addition, IDN funds can be used as scholarships for behavioral health trainings and for organizations to help support staff as they advance their level of certification. This use of funds is supported through the region's IDN sub-recipient proposal process. If an organization has a staff person interested in advancing their education they can go through the region's proposal process to apply for funds to help offset the costs associated with this training, including the loss of revenue due to non-billable hours. Region 7 IDN already has agencies using IDN funds to support this, including White Mountain Community Health Center in Conway, NH. This agency currently has 2 nurse practitioners, and they have asked for some IDN funds to help support these 2 professionals obtain their psychiatric nurse certification. This is very exciting for the region because these 2 nurse practitioners are a husband and wife team. Recruitment and retention is difficult at best, and when you add the rurality of Region 7 IDN into the mix it is often difficult to retain professionals, often because a spouse in unhappy in the region. Since both partners are working in the region, and enjoy the rural culture, using IDN funds to support their continued studies is a great investment for the region as it tries to build behavioral health workforce capacity. NCHC will actively encourage partner agencies to look at their existing staff to see who has both the interest and potential to seek out professional development and work towards advancing their current certification. NCHC will make this clear in all future funding cycles, and will include this language on the Region 7 IDN website.

The grow-your-own model ties in directly with the Northern New Hampshire Area Health Education Center (NNH AHEC), a program of the North Country Health Consortium. The role of NNH AHEC is to

connect students to careers, professionals to communities, and communities to better health. NNH AHEC has been involved with grow-your-own models related to health care professionals for many years, and will use this expertise to position the region for success regarding this grow-your-own model. Through "Live, Learn, Play in Northern NH", a program of the Northern NH AHEC/North Country Health Consortium, health professional students receive quality training experiences in rural medically underserved areas throughout northern New Hampshire. In addition, students will experience New Hampshire's most awe-inspiring scenery, outdoor recreation and complete a community service project. This is an important part of introducing health professional students to the rural nature of the region, and works into recruitment and retention strategies. NCHC will continue to support students from the University of New England College of Osteopathic Medicine and other institutions through LLP-NNH to enhance experiences in integrated health care delivery. This model will be used to bring mental health professional students to the area as the region explores collaborating with academic institutions offering education in the mental health field. NCHC will work with academic institutions offering mental health professions programs to help establish agreements between the institutions to 2 new clinical sites which will accept students into practice settings so they may gain clinical experience. Two formalized preceptor agreements will in place with these academic institutions by October 31, 2017. Region 7 IDN is working to have a system in place for 3 mental health professional students to be part of the Live, Learn, Play in Northern New Hampshire program by December 2017. Moving forward, the plan is to add an additional 3 students each year to the program, so by the end of 2020 there will be a total of 12 students that participated in the program.

The Northern NH Area Health Education Center aims to ensure rural challenges and solutions are included in workforce development policy both in New Hampshire and nationally. The Executive Director of Region 7 IDN is also the Director of the NNH AHEC and actively participates in statewide and national meetings related to workforce development, making sure to bring a rural voice to the table during key discussions. This relationship puts the region in a good position to be involved with both federal and state policy changes related to licensing, reciprocity, and credentialing, and advocating for the state to increase their state loan repayment funds, which was identified as an important strategy needed to build behavioral health workforce capacity. NNH AHEC ensures an adequately trained workforce exists in rural New Hampshire by providing continuing medical education and other training programs for all levels of North Country health care providers and to expand opportunities for North Country young people to learn about pursue careers in the health professions. NNH AHEC will look for opportunities to coordinate and share trainings across other regional IDNs. Region 7's IDN Executive Director also serves as the chair for the IDN Training and Education Workgroup. This workgroup is charged with addressing strategies from the statewide strategic plan which relate to the training and education needs of mental health professionals. This relationship will help ensure that Region 7 stays abreast of training opportunities happening within the state.

In the fall of 2017 Region 7 IDN will start to bring together mental health professionals from across to region to create a petition which will be sent to the NH Board of Mental Health Practice regarding supervision rules. A draft petition will be created by February 2018, which will then be shared with the region for feedback from partners. Region 7 will also explore opportunities to partner with other regions if possible. Partner feedback will be incorporated by April 2018, and then reviewed again by the

region's mental health professionals, before the petition is submitted to the NH Board of Mental Health Practice by June 30, 2018. Current rules state supervision of staff needs to be in a face-to-face format, which is difficult given the large distances between practice sites in Region 7. The petition is going to ask the Board to consider using Region 7 as a pilot to roll supervision using an electronic platform. There have been significant changes and advancements in the practice in behavioral health field over the past 10 years. The laws in NH and the Federal government have expanded as the use of telemedicine and electronic medical records have become more prevalent in practice settings. Insurance companies now pay for services delivered by tele-video equipment. The Centers for Medicare and Medicaid rules allow for billing of psychotherapy while using tele-video equipment by physician and other health care providers. Region 7 IDN is going to ask the Board for a waiver to pilot a model of long-distance supervision on a limited basis. The premise of this waiver will be based on the fact that patients can receive care virtually, so mental health practitioners should be able to use the same platform to receive supervision. Improvements in technology have made it so video connections are very high quality and electronic medical records can be accessed simultaneous by the supervisor and the supervisee in real time, as well as encrypted communications by email and by Jabber can allow instant communications between formal supervision sessions. The petition is also going to request that very experienced staff be grandfathered in as supervisors, and Region 7 IDN will ask the Board to consider shared group supervision as a potential option. All of these strategies would allow mental health professionals to advance to the next level of certification and help Region 7 IDN expand behavioral health workforce capacity.

Region 7 IDN is also going to share behavioral health resources. The DSRIP program requires a psychiatrist to be part of the multi-disciplinary core team. Region 7 IDN does not have enough psychiatrists in the region to meet this requirement, so agencies will need to be creative to meet this need. Agencies could consider a shared approach for this, or could use tele-psychiatry so a multi-disciplinary core team has a psychiatrist available for a consult. Often times an agency may not need a full-time position behavioral health position, and it would make more sense to have two agencies collaborate together to share the position. Region 7 IDN plans to set up process to share MLADCs to supervise LADCs across agencies within the region. To coordinate sharing of this behavioral health staff the region is going to spend the next year exploring the creation of a regional clearinghouse which would be used to collect requests for shared staff and help deploy the shared resources to the most appropriate place. The clearinghouse would also serve as a mechanism to help with some cost sharing of staff. An example of this is retirement plans. The clearinghouse would help negotiate expenses related to retirement plans, which could potentially yield a cost savings throughout Region 7 IDN, and this cost savings could be either divided up among IDN partners or reinvested into future behavioral health workforce expansion opportunities. The clearinghouse would also be a great way to publicize peer learning meetings. Sharing of staff may be risky due to issues around credentialing of agencies, and Region 7 IDN plans to strategize how to work with insurance agencies to help mitigate this risk.

Another example of shared staff resources includes the region's plan to use mobile LADCs. The region is positioned to work with Friendship House, the only residential treatment facility in region 7 IDN service area, to support the growth of LADCs in the organization. Friendship House will have a process in place to deploy mobile LADCs to the hospitals in the region on an as needed basis. This approach will be a

phased approach, based on the three counties, or sub-regions in Region 7 IDN. There will be an agreement in place with to have mobile LADC services in place for Grafton County by 12/31/18; Coos County 12/31/19; and Carroll County by 12/31/2020.

Region 7 IDN would benefit from the creation of a central coordinating agency for recovery support services. Currently, there is some forward movement to get people trained as peer recovery coaches, but there is not an infrastructure in place to coordinate and support this process. For example, although there are trainings happening in the area, many in the region do not know where these trainings are happening, and then how to access peer recovery coaches. If the region had one central agency coordinating the trainings, and helping to deploy recovery coaches, it will lead to more coordinated approach to getting recovery services to patients in a timely manner which will lead to better health outcomes. NCHC will promote the idea of a centralized peer support recovery organization for the region during the fall of 2017, and encourage IDN partners interested in becoming the central coordinating agency to submit a concept paper in November 2017. The concept papers will be reviewed, and the organizations best suited to be the central coordinating agency for recovery support services will be asked to submit a full proposal in March of 2018. Full proposals will undergo a multi-level review, and one agency will be selected to be the region's central coordinating agency for recovery support services by April 30, 2018. In addition, NCHC will create a survey to identify existing care coordinators in the region, and create a training plan to enhance their skills related to peer recovery support services by March of 2018.

Evaluation metrics:

MLADCs training needs identified	By December 31, 2017
Local mental health training experts identified	By December 31, 2017
Local mental health experts conducting trainings in Region 7 IDN	By December 31, 2018
3 mental health professions students immersed in Live, Learn, Play program by December 2017. Add an additional 3 students each year to program, so by the end of 2020 there will be a total of 12 students that participated in the program.	By December 31, 2017 December 2018-December 2020
Agreement in place with 2 academic institutions and Region 7 partners to provide LLP-NNH experience for behavioral health students	By December 31, 2017
Draft petition created to send to NH Board of Mental Health Practice	By February 28, 2018

Petition delivered to NH Board of Mental Health Practice	By June 30, 2018
Mobile LADC services in place for Grafton County Coos County Carroll County	By December 31, 2018 By December 31, 2019 By December 31, 2020
Plan developed showing how to use care coordinators to enhance peer recovery support services	By March 31, 2018
Centralized Peer Recovery Support services	June 2018
# of Care Advocates trained	15 by September 2018
# of Care Advocate supervisors trained	3 by September 2018
# of CTI workers trained	15 by December 31, 2018
# of CTI supervisors trained	3 by December 31, 2018
# of Peer Recovery Coaches trained	4 by December 31, 2018
# of Community Health Workers trained	4 by December 31, 2018
# of MLADCs trained	5 by December 31, 2108
# of other front line provider recruited	1 by December 31, 2018
# of Licensed Mental Health Professionals Trained	9 by December 31, 2018
HIT Integration Coach hired	By October 31, 2017
IDN Quality Improvement Coach hired	By October 31, 2017
Data Specialist hired	By December 31, 2017

Based on the workforce survey, along with information obtained from regional community health needs assessment, and workforce needs for selected community-driven projects, Region 7 IDN will be recruiting for 5 additional MLADCs, 9 additional Licensed Mental Health Professionals, 4 Peer Recovery Coaches, and 4 Community Health Workers who could potentially be Peer Recovery Coaches as well. The region is going to assess current staffing levels of care navigator positions as well as other front line providers, and based on these assessments determine who would like to have additional training, and if

there is a need to recruit for additional new positions. Recruitment for these positions will be done in a phased approach to meet the needs of the DSRIP program.

Progress Assessment Checkpoints

Position	**Recruitment plan**	**Activities**
CTI Workers: All Team members will have completed the Critical Time Intervention (CTI) training provided by a certified Trainer.	Recruit for 5 CTI workers by 12/31/2017 Recruit for 5 additional CTI workers by June 2018 Recruit for 5 additional CTI workers by December 2018 Recruit for 10 additional CTI workers 1/1/2019-12/31/2020	CTI Worker Training #1- November 2017 CTI Worker Training #2 – February 2018 Train-the-Trainer – August 2018 CTI Worker Training #3 – November 2018 CTI Worker Training #4 – November 2019 CTI Worker Training #5 – November 2020
CTI Supervisors: Those who have completed both the Critical Time Intervention Training and a CTI Supervisor training, and will provide supervision, clinical guidance, feedback and training to team members. Supervisors will assure all team members are maintaining the fidelity to the evidence-based program;	Recruit for 1 CTI supervisor by 12/31/2017 Recruit for 2 CTI supervisors 1/1/2018-12/31/2018 Recruit for 2 additional CTI supervisors 1/1/2019-12/31/2020	CTI Supervisor Training #1 - December 2017 CTI Supervisor Training #2 - December 2018 CTI Supervisor Training #3 – December 2019 CTI Supervisor Training #4 – December 2020
Community Health Workers	Recruit for 2 community health worker 8/1/2017-12/31/2018 Recruit for 2 additional community health workers 1/1/2019-12/31/2020	Offer 2 community health worker trainings per year – one of which will be completed by 12/31/2017 Offer 2 community health worker trainings per year

Psychiatric Nurse Practitioners	Recruit for 2 – 8/1/2017-12/31/2018	Ongoing partner proposal submissions looking to recruit new staff
Peer Recovery Coaches	Recruit for 2 peer recovery coaches 8/1/2017-12/31/2018 Recruit for 2 additional peer recovery coaches 1/1/2019-12/31/2020	Offer 2 Peer Recovery Coach Academy trainings per year - one of which will be completed by 12/31/2017 Offer 2 Peer Recovery Coach Academy trainings per year
MLADCs: Masters Licensed Drug and Alcohol Counselor	Recruit for 3 between 7/1/2017-12/31/2017 Recruit for 2 additional MLADCs between 1/1/2018-6/30/2018 Continue recruitment efforts in none hired 7/1/2018-12/31/2018	Ongoing partner proposal submissions looking to recruit new staff
Licensed Mental Health Professionals	Recruit for 3 licensed mental health professionals 8/1/2017-12/31/2017 Recruit for additional 3 licensed mental health professionals 1/1/2018-6/30/2018 Recruit for additional 3 licensed mental health professionals 7/1/2018-12/31/2018 Continued recruitment efforts for a total of 9 licensed mental health professionals 1/1/2019-12/31/2020	Ongoing partner proposal submissions looking to recruit new staff
Care Advocates – care coordinators trained to follow Region 7 care coordination	5 Care Advocates trained in Carroll County by 3/1/2018	2 day regional training in Carroll County by 3/1/2018

approach	5 Care Advocates trained in Coos County by Coos County by 6/1/2018 5 Care Advocates trained in northern Grafton County by 9/1/2018 15 Care Advocates trained by March 31, 2019 15 Care Advocates trained by March 31, 2020	2 day regional training in Coos County by 6/1/2018 2 day regional training in northern Grafton County by 9/1/2018 2 day regional training in Region 7 IDN 2 day regional training in Region 7 IDN
Care Advocate Supervisors – will monitor fidelity of Region 7 Care Advocate toolkit and help with reporting	Recruit for 1 Care Advocate supervisor by 12/31/2018 Recruit for 1 Care Advocate supervisor in 1/1/2019-12/31/2019 Recruit for 1 additional Care Advocate supervisor 1/1/2020-12/31/2020	Ongoing partner proposal submissions looking to recruit new staff
HIT Integration Coach	Recruit for 1 HIT Integration Coach 8/1/2017 -10/31/2017	NCHC place ad 8/2017
Data Specialist - regional	Recruit for 1 Data Specialist 8/1/2017-10/31/2017	NCHC place ad 8/2017
Data Specialist at partner sites	Recruit for up to 3 data specialists at IDN partner sites	Ongoing partner proposal submissions looking to recruit new staff
IDN Quality Improvement Coach	Recruit for 1 IDN Quality Improvement Coach 8/1/2017-10/31/2017	NCHC place ad 8/2017

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

From the IDN Workforce Capacity Development Implementation Plan, use the format below to identify the measureable 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
# of mental health professional students completing Live, Learn Play program in northern NH	6 by 2018			
# of new preceptor sites (practice site accepting students into practice settings for students to work with providers to gain clinical experience) receiving mental health professional students	2 by 2018			
# of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018			
Expanded supervision for masters level clinicians	1 by 2018			
# contracts in place in Region 7 for consultation with psychiatrists as member of multidisciplinary teams	1 by 2018			

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
Master Licensed Alcohol and Drug Counselors	16 by 2018	11			
Licensed Mental Health Professionals	23 by 2018	14			
Peer Recovery Coaches	6 by 2018	2			
CTI Workers	15 by 2018	0			

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
CTI Supervisors	3 by 2018	0			
Community Health Workers	4 by 2018	0			
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1			
Care Advocates	15 by 2018	0			
Other Front Line Provider	1 by 2018	0			
Care Advocate Supervisors	1 by 2018	0			
Community based clinician (round 1 funds for baseline 6/30/17)	1	1			
Physician assistant (round 1 funds for baseline 6/30/17)	1	1			
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1			
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1			
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2			
LICSW (round 1 funds for baseline 6/30/17)	3	1			
IDN QI Coach	1	0			
HIT Integration Coach	1	0			
IDN Data Specialist (NCHC)	1	0			
Data Specialists for IDN partners	Up to 3	0			

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.

Budget Period: 01/01/2017-12/31/2020
Workforce Budget

Line Item	Direct Incremental	Indirect Fixed	Total	NOTES:
1. Total Salary/Wages	$ 221,265	$ 30,313	$ 251,578	**YR2-YR5**: Portion of Program Manager, HIT Lead, Data Specialist, YR4-YR5 F/T Practice Facilitator
2. Employee Benefits	$ 44,253	$ 6,063	$ 50,316	Benefits calculated at 20% of Salary
3. Consultants				
5. Supplies:				
Educational				
Office	$ 88,498	$ 12,124	$ 100,622	**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups
6. Travel	$ 60,000	$ 8,220	$ 68,220	**YR2-YR5:** Travel expenses for regional & conference/training expenses
7. Occupancy				
8. Current Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	$ 3,333	$ 457	$ 3,790	**YR2-YR5:** Proposal Software
10. Marketing/Communications	$ 84,007	$ 11,509	$ 95,516	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$ 118,000	$ 16,166	$ 134,166	**YR2-YR5:** Training $20,000, Three LLP students $1,500 each & Preceptor Support $500 each
12. Subcontracts/Agreements				
13. Other (specific details mandatory):				
Current Expenses: Administrative Lead Organizational Support	$ 15,747	$ 2,157	$ 17,904	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$ 1,983,499	$ -	$ 1,983,499	**YR2-YR5**: Budget line item to cover workforce related requests submitted by Region 7 IDN partners in future funding cycles
TOTAL	**$ 2,618,602**	**$ 87,009**	**$ 2,705,611**	

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.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services	A1, A2, B1, C1, D3, E5
White Mountain Community Health Center	Non-FQHC Community Health Partner	A1, A2, B1, D3, E5
Memorial Hospital	Hospital Facility	A1, A2, B1, C1, D3, E5
Huggins Hospital	Primary Care Practice; Hospital Facility	A1, A2, B1, C1, D3, E5
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services	A1, E5
Life Coping, Inc.	Community-based	A1, E5
Saco River Medical Group	Rural Health Clinic	A1, B1,
White Horse Addiction Center	Addiction & Recovery	A1, A2, B1, D3
Carroll County Department of Corrections	County Corrections Facility	A1, A2, C1
Androscoggin Valley Hospital	Hospital Facility	A1, A2, B1, E5
Coos County Family Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	A1, A2, B1, D3, E5
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-	A1, A2, B1, D3, E5

	based Organization providing social and support services	
Upper Connecticut Valley Hospital	Hospital Facility	A1, A2, B1, C1, D3, E5
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, C1, D3, E5
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	A1, A2, B1, C1, E5
Cottage Hospital	Hospital Facility	A1, A2, B1, C1, E5
Rowe Health Center	Rural Health Clinic	A1, A2, B1, C1, D3, E5
North Country Health Consortium/Friendship House	Substance Use Disorder Treatment (After 10/01/2017)	A1, D3
Mount Washington Valley Supports Recovery	Peer Recover, Transitional Housing	D3
Tri-County Community Action Program	Community-Based Organization	A1, C1, E5

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.

Integrated Delivery Network Administrative Lead Contract

Attestation Form

I, Nancy Frank, a representative of Region # 7, attest that I have reviewed and am in acceptance on behalf of Region 7 of the Statewide Workforce Capacity Development Strategic Plan as outlined in the New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver, IDN Process Measures Semi-Annual Reporting Guide for year 2 (CY2017) and Year 3 (CY2018), 2017-03-22 v.23

(Signature)

STATE OF NEW HAMPSHIRE

County of Grafton

The forgoing instrument was acknowledged before me this 31st day of July, 2017.

Tracy A Page

(Notary Public/Justice of the Peace)

TRACY A PAGE
Notary Public - New Hampshire
My Commission Expires September 18, 2018

(NOTARY SEAL)

Commission Expires: 09/18/2018

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

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

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 7 is participating in two statewide projects as defined in the Special Terms and Conditions (STC).[i] 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.[ii]

A2-1. IDN Participation in Statewide HIT Taskforce

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[iii]:

- 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 7 participated in these sessions.

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

Minimum, Desired, and Optional HIT Standards Definitions

IDN Region 7 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 and will be referenced throughout the rest of this document.

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[iv], 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.

HIT Standards Tables

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

Table 1. Minimum HIT Standards

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

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

Table 2. Desired HIT Standards

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

Table 3. Optional HIT Standards

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

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

Provide a narrative summarizing the results of the IDN's analysis of the current HIT infrastructure gaps obtained through the Statewide HIT Taskforce's current state assessment efforts, current HIT capacity, and community needs assessment. At a minimum, include in the narrative how HIT will support meeting the following objectives:

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

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

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

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

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

A final comprehensive statewide assessment report was completed in December 2016 based on the HIT Assessments submitted by member organizations. Individual HIT Data Supplements based on the HIT Assessments were provided to each IDN with the final version being received by Region 7 in March 2017.

Statewide Key Findings

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

Key findings from the New Hampshire health IT assessment include:

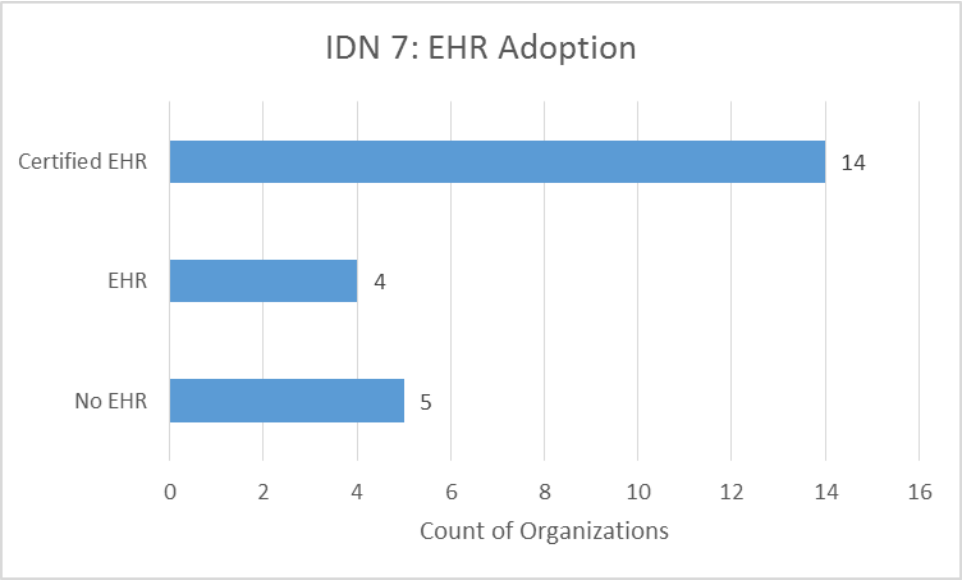
1. **Electronic health data capture capabilities are not widespread among IDN members.** While New Hampshire benefits from a high number of providers having adopted electronic health records (EHRs) at 74% of IDN members, there are a several key provider types that have less than 60% adoption rate including SUD treatment organizations at 57%, community-based organizations at 48%, and public health organizations at only 33%.
2. **Limited capabilities for electronic health data sharing throughout the state, but IDN members use available option.** Despite the limitations in electronic health data sharing among New Hampshire's providers, due in part to legislative restrictions, 48% of IDN member organizations are using or have

plans to use Direct Secure Messaging (DSM) through New Hampshire Health Information Organization (NHHIO).

3. **Low rate of patient consents are captured electronically.** The ability to electronically capture patient consents still appears to be in its infancy among IDN members with only 21% of all responding organizations doing so. High adopters of health IT such as hospitals, community mental health centers, and federally qualified health centers (FQHCs) are all below 50% for collecting and storing patient consents by electronic means.
4. **Patient referrals are mostly manual processes.** Sixty-one percent of IDN members responding to the assessment stated that patient referrals are performed manually by either fax, U.S. mail, or telephone. Only a small percentage of organizations, just 15%, are using DSM for referrals.
5. **Patients have limited options to access their health information electronically.** Currently, only 28% of all IDN members responding to the Assessment Tool have a patient portal.
6. **A higher than expected number of IDN members capture at least one social determinant of health data element.** While collection of social determinants of health data is fragmented and inconsistent across the health care continuum[vii], 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.

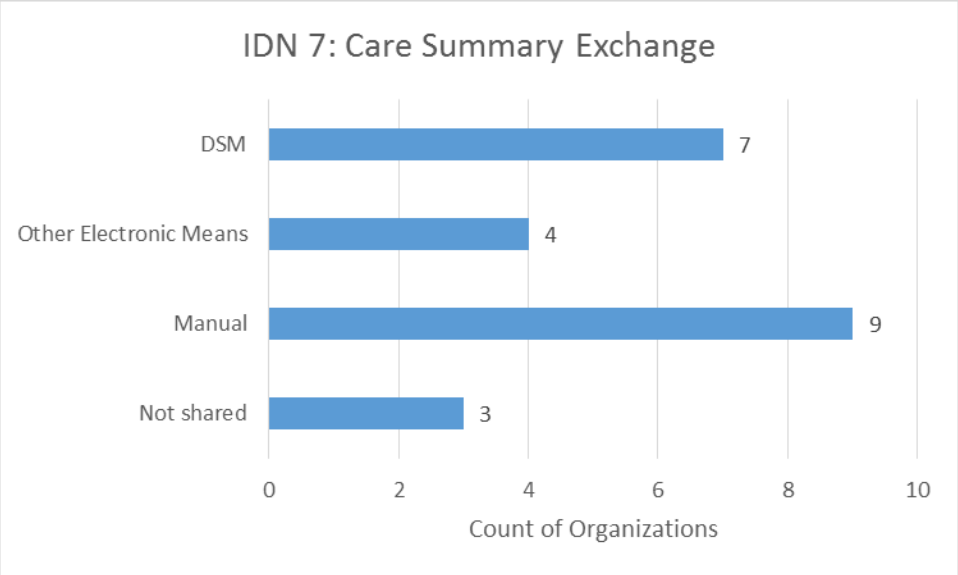
2.2 IDN-7 Specific Findings

Figure 1. EHR Adoption



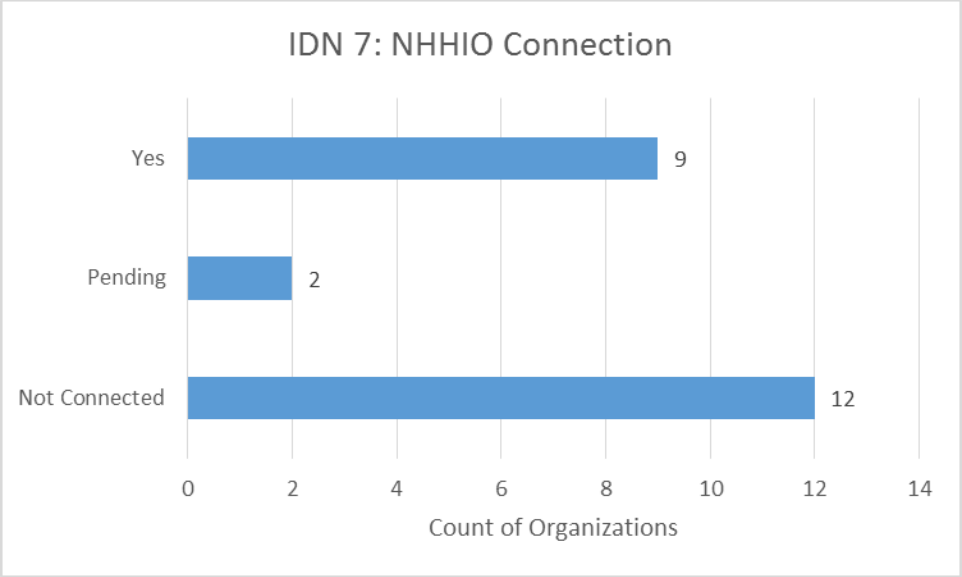
Based on the final version of the HIT Data Supplement for our region there was a total of eighteen (n=18) organizations that completed the HIT Assessment tool. From the results, fourteen (n=14) organizations attested to having a certified EHR system and four (n=4) organizations attested to having a non-certified EHR system. To be noted, five (n=5) organizations stated that they had no EHR system at all. Organizations with no EHR systems are important to identify in order to determine what further assistance they need to meet the State's DSRIP initiative objectives and Region 7 goals.

Figure 2. Direct Secure Messaging



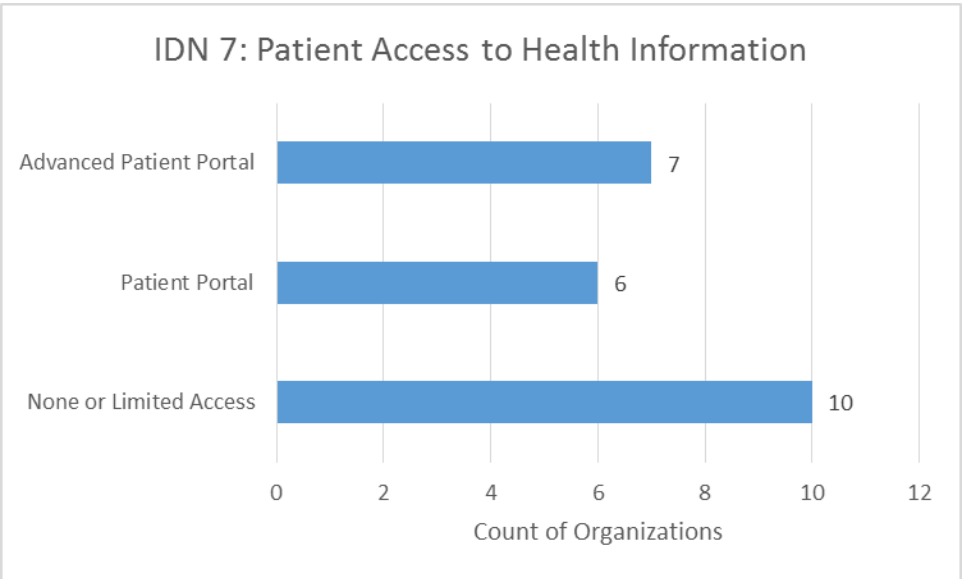
Limitations in electronic health data sharing among New Hampshire's providers exists, due in part to legislative restrictions. Because of these limitations, Direct Secure Messaging (DSM) is used through the New Hampshire Health Information Organization (NHHIO). NHHIO serves as a Health Information Service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

Figure 3. Electronic Health Data Sharing



All organizations that completed the HIT Assessment tool were cross referenced with the NHHIO's official list of organizations that are connected. In summary, for Region 7, nine (n=9) organizations are connected to NHHIO with an additional two (n=2) organizations that are in the process of connecting. Twelve (n=12) organizations are not connected or are not planning on connecting to NHHIO. While progressing through the DSRIP initiative, it will be important to ensure organizations that are not connected to NHHIO adopt a basic sharing protocol like direct secure messaging.

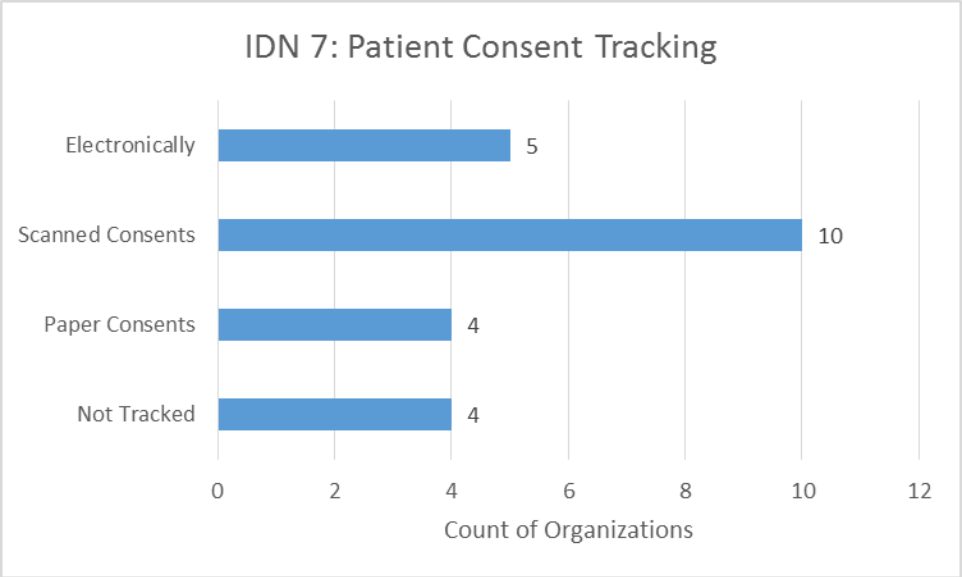
Figure 4. Patient Access to Health Information



From the HIT Assessment results, a question was asked about patient access to health information. In general, most organizations do not provide easy access to their patient's information. For Region 7, only seven (n=7) organizations provide an advanced patient portal with at least three of the following

features: lab results, appointment scheduling, billing, links to health information websites, prescription refills, referrals, or secure messaging. This compares to ten (n=10) organizations that do not provide a patient portal at all and provide limited access to their patient's information. It will be important to create infrastructure to allow substance use disorder patients access to their health information.

Figure 5. Patient Consent Tracking



Another critical area for the waiver program is how patient consents are tracked and processed. With patients being shared across multiple regions, it is imperative to define a standardized process. In Region 7, five (n=5) organizations capture patient consent information entirely electronically in an EHR system. Ten (n=10) organizations scan paper consents into an electronic system while another four (n=4) organizations only capture consents on paper. Four (n=4) organizations do not track patient consents at all. The HIT Taskforce determined that defining a statewide consent form and process should be a priority but it will require additional work outside the scope of HIT. If a statewide standard is defined it will be up to the HIT leads within each region to implement the infrastructure to make sharing easier.

The Challenge of Geography and Diverse Providers

IDN region 7 encompasses a large geographic area and a sparse population concentrated in approximately seven "sub regions", mostly centered around the hub towns of Berlin, Colebrook, Conway, Lancaster, Littleton, North Haverhill and Wolfeboro. These sub-regions each have their own provider set, including a hospital, primary care, behavioral health, and social determinant providers. Service utilization between these sub regions does happen but most care happens in a patient's sub-region or with region-wide providers such as Northern Human Services (the community mental health center for the region) or Tri-County Community Action Program (a provider of both behavioral health services and social determinant services). This vast geography and smaller pockets of care presents a unique challenge from a care coordination standpoint and reduces overall resources for projects such as IT infrastructure, since individual smaller providers have smaller IT budgets.

Addressing Gaps/Needs

In Fall 2016, IDN Region 7 selected the following three community driven projects:

- C1: Care Transition Teams
- D3: Expansion in Intensive Substance Use Disorder Treatment Options, including Partial Hospital and Residential Care
- E5: Enhanced Care Coordination for High-need Populations

The intent of all of the projects is to address the following goals:

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

IDN 7's regional Health Information Technology/Data Workgroup quickly recognized that that health information technology is a means to an end rather than a goal unto itself and that the well-defined goals outlined above would be accomplished through the HIT-enabled success of the other projects. They committed to the core concept that the HIT project needed to act in support of these three community driven and one mandatory competencies in order to achieve success in its overall goal. The directive for this group, like that of the statewide work group, became focused on finding solutions that would support an effective implementation of the core competency and community driven projects region-wide.

Priorities will include:

- Institute a secure, EHR-compatible electronic shared care plan tool for all direct service providers (both physical and behavioral health, region-wide, to better enable cross-site care coordination).

- Enable event notification triggered by specific patient actions to better enable care coordination and appropriate use of services across a wide region.

- Assist all agencies who could be involved in a patient's care in acquiring a direct secure messaging service allowing for secure transmission of appropriate information, when enabled by patient consent.

- Use data warehouse/data aggregation technologies to satisfy all internally-derived and state-directed reporting requirements of the project.

- Use data aggregation tools to enable population health management and improve outcomes through better direction of resources, in preparation for alternative payment models.

For specifics on how A2 project components interface with the core competency and community driven projects, please see below:

- **C1: Care Transition Teams**
    - **Project Description:** This project will follow the evidence-based ‘‘Critical Time Intervention’’ (CTI) approach to providing care at staged levels of intensity to patients with serious mental illness during transitions from the hospital setting or corrections facility to the community.
    - **HIT Support of C1**: Utilization of the region-wide electronic shared care plan tool PreManage ED will allow for portability of patient data from the hospital setting to their primary care provider for ongoing support, allowing a care manager or community health worker to better manage the care of the patient and make sure that patient care is taking place at the correct provider, preventing unnecessary use of the emergency department. Event notification services will assist similarly in care management of the patient as they transition. Utilization of direct secure messaging will allow secure and timely methods for appropriate involvement of community-based providers when necessary for the ongoing support of the patient. Population health tools enabled through a data aggregator will help care teams identify patients for involvement with the program, better allowing providers to predict which patients would benefit most from a CTI-style care plan.
- **D3: Expansion in Intensive Substance Use Disorder Treatment Options, including Partial Hospital and Residential Care**
    - **Project Description:** 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.
    - **HIT Support for D3:** Electronic shared care plans will allow better patient flow both in and out of the expanded services, helping to assure proper utilization of services based on the patient’s level of need and support their ongoing recovery in a secure manner compliant with privacy regulations. Direct secure messaging between service providers will allow involvement of recovery organizations and social determinant providers such as housing agencies, employment programs and other agencies central to a patient’s recovery.
- **E5: Enhanced Care Coordination for High-need Populations**
    - **Project Description:** 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.
    - **HIT Support for E5:** Population health analytics will help in identifying the patients who would fall into a high-risk category and help track outcomes. An electronic shared care plan and event notification system will assist care coordinators and community health workers in bringing their skills to bear in support of this population.

All three of these projects are in addition to the core competency project:

- **B1: Integrated Health Care**
    - **Project Description**: 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.
    - **HIT Support for B1:** A shared care plan and electronic sharing of data will be a key component in the formation of multi-disciplinary core teams across agencies in sub-regions and event notification will allow all members of the core team to stay up to date in real time. Direct secure messaging will allow these teams to effectively communicate with social determinant providers necessary to their patient care. A data aggregator will help assure that a comprehensive core standardized assessment is being delivered to all patients.

By tying HIT components as tightly as possible to the all IDN projects, the IDN can realize a great deal of efficiency in making sure that its other deliverables are spread throughout the region and that HIT does not become, from a provider perspective, a project unto itself – but rather something that will assist in overcoming the challenges of implementation.

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

Each IDN is required to complete a single IDN-level HIT Implementation Plan and timeline that defines a strategy for closing key HIT infrastructure gaps among medical providers, behavioral health providers, and community-based service organizations, and to demonstrate the use of interoperability best practices.

Using Microsoft Project or similar platform, provide a project plan that includes required activities, timelines, milestones, progress assessment checkpoints, and evaluation metrics for implementing the IDN's HIT implementation plan.

The plan will allow for regional differences in HIT capacity, prior investment, and future plans. The implementation plan will build upon the Assessment and Consensus phases and work to reduce the HIT gaps identified. There is expected to be a "floor requirement" and a "stretch goal" for each IDN plan so that each IDN shows progress over the five-year period, based on identified process milestones. These plans will be reviewed and approved prior to the state authorizing use of DSRIP funds for implementation.

a. At a minimum, the HIE integration plan component of the IDN's HIT implementation plan will include the following IDN providers: hospital, CMHC, community mental health providers, primary care, SUD, and DRF participants. The HIE integration plan will also include NH Hospital and state the level of anticipated HIE integration with other IDN participants such as county nursing home, county correction facility, DD agency, etc.

b. The IDN's HIT implementation plan will show, at a minimum, how and when all of an IDN's HIE participants will be utilizing ONC Certified Technologies and functions, and adhering to the ONC's 2016 Interoperability Standards Advisory.

c. The IDN's HIT implementation plan will describe how certain key population health management capabilities will be supported, such as individual and community risk assessments, care coordination and care management, health care transitions support, and quality measurement.

d. The IDN's HIT implementation plan will describe the clinical and financial analytic systems' required inputs and outputs, using the State-approved, interoperable standard.

e. The IDN's HIT implementation plan may include concepts and components that go beyond the HIT gaps identified in the Project Objective section of this document if they can demonstrate overall value to the DSRIP Demonstration implementation.

Indicate whether the IDN's HIT project targets are 1) minimally required, 2) desired, or 3) optional, as determined by the statewide IT Taskforce.

Include a detailed narrative to complement the project plan or provide further explanation, please include it.

The project plan must include milestones for the following timeframes:

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

NOTE: The IDN must submit its IDN HIT Implementation Plan no later than 7/30/17.

To support the successful implementation of the DSRIP Project, IDN Region 7 has agreed on the following HIT plan, with two large project areas with numerous associated subtasks under each.

Project Component 1: Support Care Coordination

HIT Capabilities and Standards Addressed	Minimum/Desired/Optional	For Whom	By When
Electronic Shared Care Plan	Minimum	All Direct Care Participants (both behavioral health and physical health)	Phased Rollout, with all providers adopting by 12/31/2018
Event Notification System (Transmit)	Minimum	Androscoggin Valley Hospital, Cottage Hospital, Huggins Hospital, Littleton Regional Hospital, Memorial Hospital, Upper Connecticut Valley Hospital, Weeks Hospital	Enable Feed from Hospitals by 12/31/2017
Event Notification System (Transmit)	Minimum	All Direct Care Participants (both behavioral health and physical health)	Enable Reception By All Direct Care Providers by 12/31/2018

Direct Secure Messaging	Minimum	All IDN Participants	Phased rollout with all providers enabled by 12/31/2018

In order to achieve the DSRIP goals of achieving coordinated care in all practices by 12/31/2018 and integrated care by 12/31/2019, IDN Region 7 has identified the above HIT components as areas of concentration for the project period.

A Note on Vendor Selection:

Working with the Statewide HIT Taskforce, IDN Region 7 has selected Collective Medical Technologies as a regional vendor to fulfill the shared care plan, event notification (send) and event notification (receive), components through their PreManage Community and PreManage ED products.

CMT is a national company with numerous large-scale implementations similar to the New Hampshire DSRIP project in its portfolio. Their software was selected out of a field of 3 separate vendors who were reviewed as being the best fit for the state. The statewide HIT taskforce has selected CMT as the vendor of choice and 5 other regions have also indicated that CMT will provide service moving forward. This is a positive development which will enable an event notification to be passed inter-region, a step important to the success of the program given the flow of patients between regions.

A vendor of choice has not been selected for direct secure messaging, since this capability exists within many certified EHRs already in place. In addition, where on site EHRs do not exist or do not possess such capabilities, New Hampshire Health Information Organization (NHHIO) has been working with providers to successfully deploy direct secure messaging standalone solutions to these. NHHIO's vendor of choice Kno-2 may be the correct vendor to deploy out to community based providers who do not currently have such capabilities, however given the growth in this field, IDN Region 7's HIT Workgroup will continue to work with its participant organizations to select a vendor of choice for this solution.

Project Component 1/1: Support Event Notification Feeds From Hospital Facilities

Given the demonstrated needs of providers involved in the B1, C1, D3 and E5 projects (see the assessment and gaps section) to receive real time notifications of patient interactions at hospitals, IDN Region 7 will work with its 7 hospital facilities and vendor Collective Medical Technologies to set up Health Level 7 (HL7) Admit, Discharge and Transfer (ADT) linkages with their software solution, PreManage ED. This tool, in turn, interfaces with the shared care plan tool PreManage Community (the rollout of which is covered in the next component section).

This project component will begin with each hospital signing the necessary agreements with CMT and then working with the vendor to put the required technologies in place. Where necessary, Region 7 will provide resources necessary to create the linkages between hospital and the vendor. By 12/31/2017 all hospitals will have made the necessary system changes in order to accommodate such transmissions.

IDN Region 7 Hospitals Include the following:

Androscoggin Valley Hospital (Berlin)
Cottage Hospital (Woodsville)
Huggins Hospital (Wolfeboro)
Littleton Regional Hospital (Littleton)
Memorial Hospital (Conway)
Upper Connecticut Valley Hospital (Colebrook)
Weeks Medical Center (Lancaster)

Synchronously with this setup, the IDN Clinical Workgroup, with advice from the vendor and selected members of the HIT workgroup, will also examine the core competency and community driven projects to determine what data elements should trigger an event notification for a patient's core team. By 12/31/2017, members of the clinical workgroup will submit recommendations for event notification triggers to the IDN steering committee for approval. Once approved these recommendations will be passed to the vendor for implementation.

Goals	
Minimum	3 Hospitals ADT Active With CMT By 12/31/2017 Clinical Committee Recommendations for Event Notification Implemented By CMT by 03/01/2018
Stretch	7 Hospital ADT Active with CMT by 12/31/2017 Clinical Committee Recommendations for Event Notification Implemented By CMT by 12/31/2017

Project Component 1/2 Support Electronic Shared Care Plan/Event Notification (receive) Adoption By Direct Care Providers

Recognizing the physical geography of Region 7 and the existence of no less than 7 distinct hospital service areas involving no less than 18 direct care providers, IDN region 7 has selected a phased rollout into three distinct sub regions for CMT's PreManage Community and ED Products. This product will enable not only the shared care plan technologies but also for users to receive event notifications. This product has been successfully used by other large scale healthcare implementations to integrate providers and reduce avoidable emergency department visits. The three sub regions (and associated providers) are as follows (note that providers whose service area spans all sub regions are included in the first sub-region but may participate with different staff in all sub-regional rollouts):

Sub Region 1 (Carroll County)	
Trained By: 03/01/2018	
Provider	**Provider Type**
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services
White Mountain Community Health Center	Non-FQHC Community Health Partner
Memorial Hospital	Hospital Facility
Huggins Hospital	Primary Care Practice; Hospital Facility
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services
Life Coping, Inc.	Community-based
Saco River Medical Group	Rural Health Clinic
White Horse Addiction Center	Addiction & Recovery
Carroll County Department of Corrections	County Corrections Facility

Sub Region 2 (Coos County)
Trained By 06/01/2018

Provider	Provider Type
Androscoggin Valley Hospital	Hospital Facility
Coos County Family Health Services	Federally Qualified Health Center (FQHC)
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services
Upper Connecticut Valley Hospital	Hospital Facility

Sub Region 3 (Northern Grafton County)	
Training Schedule: 09/03/2018	
Provider	**Provider Type**
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic
Cottage Hospital	Hospital Facility
Rowe Health Center	Rural Health Clinic
North Country Health Consortium	Substance Use Disorder Treatment (After 10/01/2017

Rollout will initiate with these providers signing a vendor agreement with CMT. Following this, the clinical workgroup will form recommendations for which fields are necessary in the regional shared care plan tool. These recommendations will then be passed to CMT to be added to the interface.

From there, the training on utilization of PreManage Primary will occur synchronously with other integration trainings acting in support of B1 and other projects over a three month period. The region will target each sub region in turn for these trainings, starting in January of 2018 and culminating in September of the same year. By presenting PreManage Primary alongside the protocol modifications will reinforce the utility of the solution for and help to incorporate it into new and existing workflows. On-site trainings will be offered as needed to providers who need additional staff trained in the use of the tool.

Though the initial rollout will be confined to agencies which have a member on a multi-disciplinary core team, in 2018, the Statewide HIT Taskforce will reconvene to examine the feasibility of including

community based providers into PreManage Primary, potentially giving them a more limited view of patient information.

Goals	
Minimum	Adoption of CMT PreManage Primary by 50% (9) of direct care providers by 12/31/2018
Stretch	Adoption of CMT PreManage Primary by 83% (15) of direct care providers by 12/31/2018

Project Component 1/3: Support Adoption of Direct Secure Messaging By IDN Participants

In order to allow for the passing of consent-enabled information between disparate sites, IDN Region 7 will be promoting the use and deployment of direct secure messaging to all IDN participants. The HIT Assessment conducted between November of 2016 and February 2017, found that only 7 of 23 responding organizations utilized direct secure messaging for some element of data exchanged- the remainder used a manual process instead or simply did not exchange information. By making direct secure messaging a priority goal for HIT in Region 7, the IDN will ensure that a secure line of communication for all IDN participants enabling integration opportunities for all participants – including those social determinant providers that may lack the HIT infrastructure to accommodate a more robust solution.

The IDN 7 Work Group will spend fall 2017 investigating accessible and best fit direct solutions in order to provide a recommendation to IDN participants. This recommendation will be presented to the steering committee by 12/31/2017.

This project will be accomplished by phased rollout enabled through a request for proposal process. Support of use cases will be supported by the Region 7 Integration team. The sub regional implementation schedule will mirror that of the Shared Care Plan/Event Notification System (receive) Rollout, but targeting all providers who did not report utilization of direct secure messaging on the HIT Assessment. These providers, by sub region, are as follows (note that region-wide providers are included in the first rollout even though they technically service all sub-regions).

Region 1 (Carroll)	
Provider	Provider Type
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services
Tri-County Community Action Program, Inc.	Substance Use Disorder Provider (until 10/01/2017); Community-Based Organization Providing Social and Support Services; Home and Community-Based Care Provider
Affordable Housing Education and Development (AHEAD)	Community-Based Organization providing social and support services; Other- Affordable Housing Organization
National Alliance on Mental Illness	Community-based organization providing social and support services
Hope for NH Recovery	Community-based organization - recovery center
Carroll County Coalition for Public Health	Community-Based Organization providing social

	and support services
Visiting Nurse Home Care and Hospice of Carroll County	Home and Community- Based Care Provider
White Mountain Community Health Center	Non-FQHC Community Health Partner
Huggins Hospital	Primary Care Practice; Hospital Facility
Children Unlimited	Community-Based Organization providing social and support services
Carroll County Department of Corrections	Country Corrections Facility
Saco River Medical Group	Rural Health Clinic
Central New Hampshire Visiting Nurse Association & Hospice	Home and Community- Based Care Provider
White Horse Addiction Center	Addiction & Recovery
MWV Supports Recovery	Peer Support Agency

Sub Region 2 (Coos)	
Provider	Provider Type
Androscoggin Valley Home Care Services	Home and Community- Based Care Provider
Granite State Independent Living	Home and Community- Based Care Provider

Sub Region 3 (Northern Grafton)	
Provider	Provider Type
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)
Cottage Hospital	Hospital Facility
Rowe Health Center	Rural Health Clinic
Grafton County Nursing Home	County Nursing Facility
Grafton County Department of Corrections	County Corrections Facility
North Country Health Consortium	Substance Use Disorder Treatment (After 10/01/2017

Goals	
Minimum	50% (18) adoption of direct secure messaging by IDN participants by 12/31/2018.
Stretch	83% (30) adoption of direct secure messaging by IDN Participants 12/31/2018.

Project Component 1/4 Ongoing Assessment Follow Up and Support of Adopted Sub Regions

Recognizing the complexity of the systems involved and the need for ongoing support in the face of a changing healthcare landscape and other challenges, IDN Region 7 commits to the ongoing support of its network as it moves towards meeting the criteria for integrated care and begins the transition into an advanced payment model. To accomplish this on the HIT side, ongoing assessment and follow up will be necessary.

Upon graduation of a sub-region from the initial integration trainings (which include utilization of HIT tools), the team will begin the process of a six month monitoring and assessment period, using the following methods to assess performance

Individual Interview-Style Follow Up With Sites
Vendor utilization data
HIT Utilization Survey (developed by the HIT working group and conducted at the end of the assessment period)

Following this six month assessment period, the regional team will convene the original trainees from IDN direct care participants as well as community based providers from the area in a learning collaborative environment to present the results of their assessment. The group will emerge from this learning collaborative with recommendations for follow-up. The regional team will take these recommendations to form a 6 month follow up plan and work to close the gaps identified through the assessment.

Based on the training deadlines identified in the "Support Electronic Shared Care Plan/Event Notification (receive) Adoption by Direct Care Providers" project component, the deadlines for the sub regions will be as follows:

Sub-region	Monitoring/Assessment Period	Learning Collaborative	Follow Up Period
Carroll	03/01/2018-09/03/2018	September 2018	09/03/0218-03/01/2019
Coos	06/01/2018-01/02/2019	January 2019	01/02/2019-06/01/2019
Grafton	09/03/2018-03/01/2019	March 2019	03/01/2019-09/01/2019

Goals:	
Minimum	83% of IDN Region 7 direct care providers utilizing shared care plans and receiving event notifications on a daily basis by 12/31/2019 83% of IDN Region 7 participants utilizing direct secure messaging to transmit data securely on a weekly basis by 12/31/2019
Stretch	100% of IDN Region 7 direct care providers utilizing shared care plans and receiving event notifications on a daily basis by 12/31/2019 100% of IDN Region 7 participants utilizing direct secure messaging to transmit data securely on a weekly basis by 12/31/2019

Project Component #2: Data Management

HIT Capabilities and Standards Addressed	Minimum/Desired Optional	For Whom	By When
Data Extraction / Validation	Minimum	All Participants	By 03/01/2018
Data Analysis / Validation	Optional	Regional Lead	By 03/01/2018
Population Health Tool	Optional	Regional Lead, Selected Participants	By 08/01/2018

A project with the scope and complexity of the DSRIP requires extensive data management for the purposes of reporting to funders and internal evaluation for process improvement. In addition, many of the projects, such as E5 and C1 would benefit from a comprehensive population health analytics solution, which could be enabled through the same infrastructure. Therefore IDN Region 7 is proposing pursuit of a regional data management infrastructure as an HIT project component.

Project Component 2/1: Regional Data Infrastructure Buildout

The most pressing need for data management is to create a regional structure that will accommodate reporting on outcome measures for all 6 DSRIP projects in a regional manner. Though the nature of phased project rollouts means that the 12/31/2017 reporting period will involve numerous process measures that can be handled through existing methods of communication, the 04/01/2018 deadline for reporting on statewide outcome measures means that a more robust and integrated solution is required, at least for the Medicaid-billing participants.

The first step is to secure data agreements from all 36 IDN participants to enable the flow of data for reporting. IDN Region 7 has a draft data sharing agreement that can be presented to the steering committee along with all measures that will need to be reported from their sites. In order to facilitate the flow of reporting data, Region 7 is targeting having all agreements signed and on file by 09/29/2017.

During the same period, the Region 7 HIT/Data Workgroup will review the recommendations of the statewide HIT Taskforce on data aggregation solutions (vendors currently being reviewed are the Massachusetts E-Health Collaborative, Cerner, and Reporting MD) and reach conclusions about which vendor will be the best fit for Region 7. Region 7 may engage an outside evaluation/analysis specialist to assist with this process. The final recommendation of the HIT/Data Workgroup will be presented to the steering committee, with final selection of a vendor projected to be no later than 10/02/2017.

Once a vendor has been selected, Region 7 will work with the vendor to assess integration capabilities of participant EHRs, where present. Any vendor selected will also be able to support alternative data extraction methods, such as a provider entry portal or acceptance of provider flat files. A successful

vendor will also have built-in reports to enable easy reporting of statewide and regional outcome measures during each period.

Once the entry methods for each provider has been determined, regional webinar-based trainings will be held by lead agency staff on the methods of data extraction to be utilized and the specific measures that will need to be tracked. Attendance at these webinars would be expected from whoever has the reporting or data extraction responsibilities in a given organization. The first training will need to happen no later than 03/01/2018 in order to facilitate successful reporting of the Statewide Outcome measures due 04/01/2018. Given the ongoing nature of reporting requirements, this training will be repeated a no later than a month out from each IDN and Statewide Reporting deadline in a manner customized for the upcoming reporting deadline. A table showing the deadlines and training schedules can be found below.

Training Held No Later Than	**For Reporting Deadline**	**Measure Types**
03/01/2018	04/01/2018	Statewide
05/30/2018	06/30/2018	Region
09/01/2018	10/01/2018	Statewide
11/30/2018	12/31/2018	Regional
03/01/2019	04/01/2019	Statewide
05/30/2019	06/30/2019	Regional
07/01/2019	08/01/2019	Statewide
09/01/2019	10/01/2019	Statewide
11/30/2019	12/31/2019	Regional
03/01/2020	04/01/2020	Statewide
05/30/2020	06/30/2020	Regional
07/01/2020	08/01/2020	Statewide
09/01/2020	10/01/2020	Statewide
11/30/2020	12/31/2020	Regional
03/01/2021	04/01/2021	Statewide
05/30/2021	06/30/2021	Regional
07/01/2021	08/01/2021	Statewide
09/01/2021	10/01/2021	Statewide
11/30/2021	12/31/2021	Regional

It is anticipated that the need for these trainings will be frontloaded, with trainings in 2018 requiring more time and more depth about use of tools and/or measure flow and with later trainings being more of a check-in and an orientation for new staff at participant sites. It will also serve as an opportunity to inform the data extraction specialists at each site should a measure change or a new measure be added.

Project Component 2/2: Population Health Analytics

Though the primary purpose for the selection of a data aggregator is to ease the burden of reporting on both the participant organizations and the administrative lead, all vendors reviewed to date have demonstrated elements of population health analytics within their solutions. The Office of the National Coordinator (ONC) of Health Information Technology defines “Population health management (PHM) tools help providers aggregate and analyze data to create a comprehensive, actionable clinical picture of each patient. Using the information generated by these tools, providers can track and improve clinical outcomes — and lower health care costs." Because the focus of all three community driven projects and the core competency are focused on improving outcomes and lowering healthcare costs for the attributed Medicaid population, it is believed that utilizing the aggregator for this purpose would be a good fit.

This will be accomplished first through an exploration of the selected tools capabilities in this area, a process targeted for completion by 06/30/2018 and enabled as a joint effort of the administrative lead, the clinical workgroup, and HIT/data workgroups. Once this has been determined, IDN Region 7 will work to create a trial population health protocol, enabled through the aggregator, that will support project E5 (Enhanced Care Coordination for High Needs Populations). Though this exploration has yet to be done, possible areas to address would be the identification of high needs populations that may be unseen and determining shared characteristics of successful patients already in the population.

Once these protocols have been outlined, Region 7 will seek a volunteer organization already involved in the E5 project that would be willing to trial them in late 2018. A joint presentation will be made to the Region 7 Steering Committee before the end of the year, highlighting the successes and lessons from this process. From here, the Steering Committee will determine whether to expand this tool to other practices. If such a determination is made, a second wave of 3 providers involved in E5 will be selected for participation in this second wave, taking place in calendar year 2019.

Goals	
Minimum	24 members with any data aggregator connection 20 Reporting Periods Successfully Completed Population Health Tool Protocol developed and piloted at 1 site
Stretch	24 members with automated data aggregator connection Population Health Tool developed and integrated with 5 region participants

Project Component 3: Support HIT Improvement Throughout the Region Through Sub Recipient Proposal Process

Potential HIT Capabilities and Standards Addressed	Minimum/Desired Optional	For Whom
Secured Data Storage	Minimum	All Participants
Electronic Data Capture	Minimum	All Participants
Internet connectivity	Minimum	All Participants
Discrete Electronic Data Capture	Desired	All Participants
Integrated Direct Messaging	Desired	All Participants
Patient Engagement Technology	Optional	All Participants
Capacity Management Tools	Optional	All Participants

Throughout the capacity building period, IDN Region 7 has sought to allow for local innovation on the part of providers, trusting in the natural resourcefulness of Northern New Hampshire providers who have historically operated in this challenging environment to bring forward solutions best suited to their local conditions. Region 7 plans to continue this in the implementation period, giving participants a chance to seek funding for their own innovative project components above and beyond the region-wide projects outlined above. This will be handled through a request for proposal process offered on a semi-annual basis.

For HIT Project funding, preference will be given to participant organizations seeking funding to do the following (from highest priority to lowest)

Create, improve or expand current health information exchange (HIE) infrastructure
Create or improve their ability to store or transmit patient data in a secure manner
Assure stable and secure internet connectivity
Create or enhance ability to capture and transmit patient consents electronically
Offer innovative technology-enabled patient engagement solutions
Other HIT capabilities supportive of DSRIP integration of care goals

REGION 7 IDN FUNDING CYCLE

Reporting period	Jan. -June 2017	July-Dec. 2017	Jan. -June 2018	July-Dec. 2018	Jan. -June 2019	July-Dec. 2019	Jan-June 2020	July-Dec. 2020
Anticipated release of funds from NH DHHS	Sept-Oct 2017	March-April 2018	Sept-Oct 2018	March-April 2019	Sept-Oct 2019	March-April 2020	Sept-Oct 2020	March-April 2021
Concept Paper Due Date	5/15/2017	11/15/2017	5/15/2018	11/15/2018	5/15/2019	11/15/2019	5/15/2020	11/15/2020
Invitation to Write Proposal	6/30/2017	12/30/17	6/30/2018	12/30/2018	6/30/2019	12/30/2019	6/30/2020	12/30/2020
Full Proposals Due	9/6/2017	3/6/2018	9/6/2018	3/6/2019	9/6/2019	3/6/2020	9/6/2020	3/6/2021
Funding Notification	10/30/2017	4/30/2018	10/30/2018	04/30/2019	10/30/2019	04/30/2020	10/30/2020	04/30/2020
Fund Disbursement #1, 50% of Funds distributed	11/15/2017	05/15/2018	11/15/2018	05/15/2019	11/15/2019	05/15/2019	11/15/2019	5/15/2020
Interim Progress Report Due	2/15/2018	8/15/2018	2/15/2019	8/15/2019	2/15/2020	8/15/2020	2/15/2021	8/15/2021

Fund Disbursement #2, 25% of Funds Distributed	2/28/2018	8/29/2018	2/29/2019	8/29/2019	2/29/2020	8/29/2020	2/29/2021	8/29/2021
Final Report & Expenditure Report Due	5/15/2018	11/15/2018	5/15/2019	11/15/2019	5/15/2020	11/15/2020	5/15/2021	11/15/2021
Final Fund Disbursement Final 25% of Funds Distributed	5/30/2018	11/30/2018	by 5/30/2019	11/30/2019	5/30/2020	11/30/2020	5/30/2021	11/30/2021

Proposals will be reviewed and scored by the HIT/Data Work Group before being passed onto the Steering Committee for final approval.

Once selected, projects will be funded for 6 month periods. Successful applicants will be required to sign a memorandum of agreement with the IDN Region agreeing to deliverables contingent upon the approved project. Upon receipt of this document, 50% of funds will be provided to the partner. At the halfway point, 3 months into each funding period, funded participants will need to submit an interim progress report. Upon receipt of this interim report, 25% of funds will be distributed to the participants. At the end of the project period, participants will submit a final report with specific measures agreed to on the MOA. Upon receipt of this report, the remainder of the funding will be released to the participant.

Goals	
Minimum	1 HIT participant project funded and completed that achieves at least one of the minimum/desired/optional capabilities
Stretch	5 HIT participant project funded and completed that each achieves at least one of the minimum/desired/optional capabilities

A2-4. IDN HIT: Evaluation Project Targets

From the IDN HIT Implementation Plan, use the format below to identify the measurable targets, or goals, that the plan 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
Participant sites with at least one staff member trained in use of PreManage Primary	18			
Number of Participants Exchanging Information Via Shared Care Plan Tool	18			
Hospitals Sending Event Notifications To PreManage ED	7			
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35			
Reporting Periods Successfully Completed (By 2020)	20			
Pilot Participants Using Population Health Tool (By 2020)	5			
Region 7 Patient Lives In PreManage Primary (By 2020)	19601			
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5			

A2-5. IDN HIT: 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.

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
HIT Lead	1	1			
HIT Integration Coach	1	0			
Data Specialist (at NCHC)	1	0			
Data Aggregator Specialists in community (through proposal process)	Up to 3	0			

A2-6. IDN HIT: Budget

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

Budget Period: **01/01/2017-12/31/2020**

HIT Budget

Line Item	Direct Incremental	Indirect Fixed	Total	NOTES:
1. Total Salary/Wages	$ 285,830	$ 39,159	$ 324,989	**YR2-YR5**: Portion of Program Manager, HIT Lead, Data Specialist, YR2-YR5 F/T Integration Coach
2. Employee Benefits	$ 57,166	$ 7,832	$ 64,998	Benefits calculated at 20% of Salary
3. Consultants				
5. Supplies:				
Educational				
Office	$ 48,498	$ 6,644	$ 55,142	**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups
6. Travel	$ 80,000	$ 10,960	$ 90,960	**YR2-YR5:** Travel expenses for regional & conference/training expenses
7. Occupancy				
8. Current Expenses				
Telephone				
Postage				
Subscriptions	$ 593,600	$ 81,323	$ 674,923	**YR2-YR5** Annual Subscriptions, 1X Set Ups $53,000, SCP tool
Audit and Legal				
Insurance				

Board Expenses				
9. Software	$ 3,333	$ 457	$ 3,790	**YR2-YR5:** Proposal Software
10. Marketing/Communications	$ 4,007	$ 549	$ 4,556	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$ 100,000	$ 13,700	$ 113,700	**YR2-YR5**: anticipated trainings/conferences
12. Subcontracts/Agreements				
13. Other (specific details mandatory):				
Current Expenses: Administrative Lead Organizational Support	$ 15,747	$ 2,157	$ 17,904	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$ 145,000		$ 145,000	**YR2-YR5**: Supplies/Travel/Shared Care Plan
TOTAL	**$ 1,333,181**	**$ 162,781**	**$ 1,495,962**	

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

Use the format below to provide a list of key organizations and providers participating in the IDN HIT project.

Organization Name	Organization Type
Affordable Housing Education and Development (AHEAD)	Community-Based Organization providing social and support services; Other- Affordable Housing Organization
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)
Androscoggin Valley Home Care Services	Home and Community- Based Care Provider
Androscoggin Valley Hospital	Hospital Facility
Carroll County Coalition for Public Health	Community-Based Organization providing social and support services
Carroll County Department of Corrections	Country Corrections Facility
Central New Hampshire Visiting Nurse Association & Hospice	Home and Community- Based Care Provider
Children Unlimited	Community-Based Organization providing social and support services
Coos County Family Health Services	Federally Qualified Health Center (FQHC)
Cottage Hospital	Hospital Facility

Organization Name	Organization Type
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services
Grafton County Department of Corrections	County Corrections Facility
Grafton County Nursing Home	County Nursing Facility
Granite State Independent Living	Home and Community- Based Care Provider
Hope for NH Recovery	Community-based organization - recovery center
Huggins Hospital	Primary Care Practice; Hospital Facility
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services
Life Coping, Inc.	Community-based
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic
Memorial Hospital	Hospital Facility
MWV Supports Recovery	Peer Support Agency
National Alliance on Mental Illness	Community-based organization providing social and support services
North Country Health Consortium	Substance Use Disorder Treatment (After 10/01/2017)
North Country Healthcare	North Country Hospital Affiliation
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services
Rowe Health Center	Rural Health Clinic
Saco River Medical Group	Rural Health Clinic
ServiceLink Resource Center of Carroll County and Grafton County	Community-Based Organization providing social and support services
T. Murray Wellness Center, Inc.	Other: Specialist Practice

Organization Name	Organization Type
Tri-County Community Action Program, Inc.	Substance Use Disorder Provider (until 10/01/2017); Community-Based Organization Providing Social and Support Services; Home and Community-Based Care Provider
Upper Connecticut Valley Hospital	Hospital Facility
Visiting Nurse Home Care and Hospice of Carroll County	Home and Community- Based Care Provider
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic
White Horse Addiction Center	Addiction & Recovery
White Mountain Community Health Center	Non-FQHC Community Health Partner

A2-8. IDN HIT. Data Agreement

Use the format below to document the requirement of the data sharing agreement pursuant to STC 22.

Organization Name	Data Sharing Agreement Signed Y/N
Affordable Housing Education and Development (AHEAD)	N
Ammonoosuc Community Health Services	N
Androscoggin Valley Home Care Services	N
Androscoggin Valley Hospital	N
Carroll County Coalition for Public Health	N
Carroll County Department of Corrections	N
Central New Hampshire Visiting Nurse Association & Hospice	N
Children Unlimited	N
Coos County Family Health Services	N
Cottage Hospital	N
Crotched Mountain Foundation	N
Grafton County Department of Corrections	N
Grafton County Nursing Home	N

Organization Name	Data Sharing Agreement Signed Y/N
Granite State Independent Living	N
Hope for NH Recovery	N
Huggins Hospital	N
Indian Stream Health Center	N
Life Coping, Inc.	N
Littleton Regional Healthcare	N
Memorial Hospital	N
MWV Supports Recovery	N
National Alliance on Mental Illness	N
North Country Healthcare	N
Northern Human Services	N
Rowe Health Center	N
Saco River Medical Group	N
ServiceLink Resource Center of Carroll County and Grafton County	N
T. Murray Wellness Center, Inc.	N
Tri-County Community Action Program, Inc.	N
Upper Connecticut Valley Hospital	N
Visiting Nurse Home Care and Hospice of Carroll County	N
Weeks Medical Center	N
White Horse Addiction Center	N
White Mountain Community Health Center	N

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

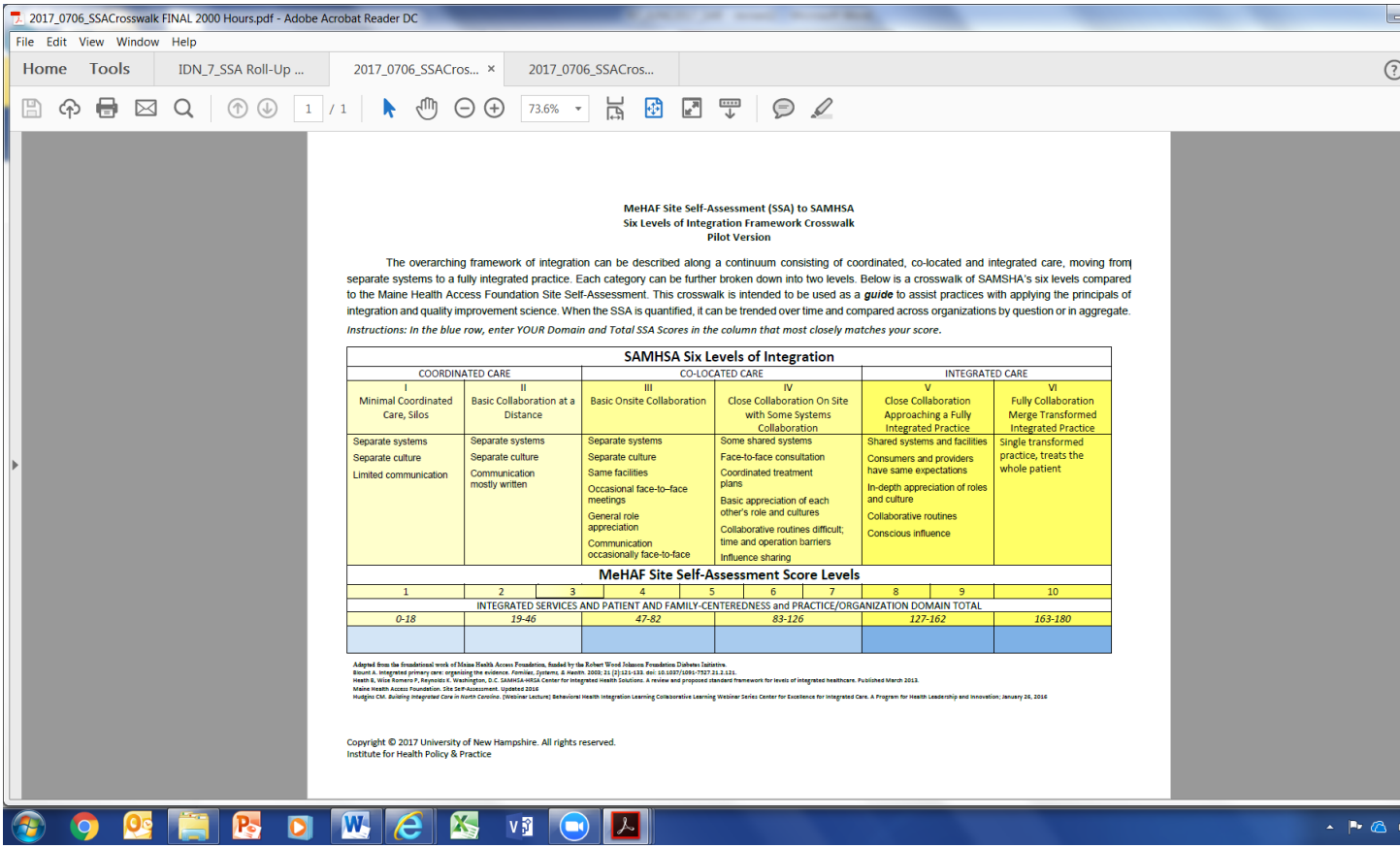
Provide a narrative summarizing the results of the IDN's assessment and gap analysis of the primary care and behavioral health providers' current state of practice against the SAMHSA designation requirements and the Special Terms and Conditions. At a minimum, include the following:

- 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.

To assess the current level of behavioral health integration existing in participating behavioral health and primary care practices, and to demonstrate progress over time, NCHC contracted with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to administer a Site Self-Assessment (SSA) Survey to the practices in June 2017. The SSA is based on the Maine Health Access Foundation Site Self-Assessment (MeHAF SSA), and asks respondents to answer 9 questions related to characteristics about integrated services and patient and family services, and 9 questions related to characteristics about their respective practice or organization. Those completing the survey were asked to watch a tutorial which included instructions for practices completing the SSA. The practice teams were encouraged to print the SSA form and complete it individually and with their team, and then come up with the best response that reflects the current status at the practice. The answers were based on a score of 1-10 for each question, with 1 representing a low score for a characteristic, and 10 representing a high score for a characteristic. CHI used a SAMHSA/SSA Crosswalk Guide to analyze the results, and then share these results with NCHC on July 10th. NCHC learned where the practices landed along the continuum of integration, which sites were high and low performers, and areas for improvement. CHI explained that since the surveys are a self-assessment some of the results may be a bit skewed because many practices may rate themselves higher than they really are. They said scores often go down when sites take the 6-month follow up survey, and then start to climb again when the 12-month post survey is completed. The same survey will be given again in December 2017 and in June 2018, and then on a yearly basis as a way to quantitatively and qualitatively measure the progress of these practices as they move along the continuum of integrated healthcare.

The image below depicts a crosswalk of SAMSHA's six levels compared of integration as compared to the Maine Health Access Foundation Site Self-Assessment. The crosswalk is intended to be used as a guide to assist practices with applying the principals of integration and quality improvement science. When the SSA is quantified, it can be trended over time and compared across organizations by question or in aggregate.



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MeHAF Site Self-Assessment (SSA) to SAMHSA
Six Levels of Integration Framework Crosswalk
Pilot Version

The overarching framework of integration can be described along a continuum consisting of coordinated, co-located and integrated care, moving from separate systems to a fully integrated practice. Each category can be further broken down into two levels. Below is a crosswalk of SAMSHA's six levels compared to the Maine Health Access Foundation Site Self-Assessment. This crosswalk is intended to be used as a ***guide*** to assist practices with applying the principals of integration and quality improvement science. When the SSA is quantified, it can be trended over time and compared across organizations by question or in aggregate.

Instructions: In the blue row, enter YOUR Domain and Total SSA Scores in the column that most closely matches your score.

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

Adapted from the foundational work of Maine Health Access Foundation, funded by the Robert Wood Johnson Foundation Diabetes Initiative.
Blount A. Integrated primary care: organizing the evidence. *Families, Systems, & Health.* 2003; 21 (2):121-133. doi: 10.1037/1091-7527.21.2.121.
Heath B, Wise Romero P, Reynolds K. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. A review and proposed standard framework for levels of integrated healthcare. Published March 2013.
Maine Health Access Foundation. Site Self-Assessment. Updated 2016
Hudgins CM. *Building Integrated Care in North Carolina.* [Webinar Lecture] Behavioral Health Integration Learning Collaborative Learning Webinar Series Center for Excellence for Integrated Care. A Program for Health Leadership and Innovation; January 26, 2016

Sixteen practices completed the survey in Region 7 IDN, with an average combined score of 121 points out of a total of 180 points. The following sections of the survey scored lower than 6 out of 10 points, and will become a focus for improvements in the region: level of integration - primary care and mental/behavioral health care; patient care team for implementing integrated care; patient/family to integration management; and physician, team and staff education and training for integrated care. IDN staff will work with provider agencies to implement workflows and protocols to address these weaknesses and position practice sites to improve these scores when taking the same survey over the course of the DSRIP demonstration.

Composite scores by Practice	
Practice Site	**6/30/17 Baseline results**
7-101	153
7-102	124
7-103	103

7-105	91
7-106	145
7-107	109
7-108	132
7-109	154
7-111	86
7-115	116
7-118	118
7-119	121
7-120	121
7-121	117
7-122	117
7-123	124

MeHAF Site Self Assessment (SSA) to SAMHSA Six Levels of Integration Framework Crosswalk

NCHC plans to use the results of the SSA Survey as a gaps analysis framework for the Regions' IDN Quality Improvement Team. The IDN Quality Improvement Team will consist of a full-time Integration Coach and a full-time Quality Improvement Coach both of whom will be NCHC employees. NCHC will begin to recruit for this team in August 2017 with the expectation that the team will be ready to be deployed to practice sites in November/December 2017. The team will work with any practice within the IDN, but will start by outreaching to sites that scored low on the SSA Survey. The Integration Coach will work with practice sites to ensure sites are using health information technology, which includes, but is not limited to, a shared care plan, event notification system, direct secure messaging, and patient registries, to move along the continuum of integrated healthcare in an efficient and effective manner. In addition, the Integration Coach will help practices collect and use measurement data to assess the effectiveness of changes made. The Quality Improvement Coach will work with the multidisciplinary core team to help the team members better understand how their practice compares to the ideal and where there is room for improvement by observing and delineating practice operations, assessing needs, and gathering baseline data, as well as guiding discussions of the current practice and opportunities for change, and if necessary prepare the organizational infrastructure for quality improvement implementation through such activities as advising on team-building, improving communication, and helping to develop leadership skills. The Quality Improvement (QI) Coach will share best practices and assist practices in customizing processes to fit their own situation, and incorporating the changes into their day-to-day routines, to increase the likelihood that the changes will be sustained. The QI Coach will help practices advance along the continuum by utilizing a toolkit and using the Plan-Do-Study-Act (PDSA) rapid cycle evaluation model.

Region 7 IDN will build a delivery system that prevents, treats, and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service to meet DSRIIP

goals: reduce avoidable acute care admissions and ED utilization, and measurably improve the health status for Medicaid beneficiaries and other state residents. The center of the DSRIP program is the required Core Competency Project which focuses on the integration of care across primary care, behavioral health (mental health and substance misuse/substance use disorder(SUD)) and social support service providers. This project, in conjunction with working to improve care transitions, enhance care coordination for the high needs population, and expand SUD treatment options, will lead to an integrated behavioral health delivery system. The region will address behavioral health workforce shortages and develop an HIT infrastructure to support integrated healthcare.

According to SAMHSA's Standard Framework for Levels of Integrated Healthcare there are two tiers of integration, coordinated care and integrated care. Region 7 IDN will provide training, support and financial incentives for the primary care and behavioral health providers in the region to progress along a path from their current state of practice toward the highest feasible level of integrated care. All behavioral health and primary care practices participating in the Core Competency Project need to achieve a Coordinated Care Practice designation by December 31, 2018.

The Quality Improvement Coach will schedule a meeting with members from the multi-disciplinary core team at each practice site to assess the needs of the practice and use this information along with the baseline integration survey results to form a coaching plan for each site. The coaching plan will outline who will participate on the QI team, how often the team will meet, and what are the team goals. In addition, the plan will lay out the process to be used to drive improvement in the practice, how these are to be documented, and the way current and ongoing status is going to be monitored using data. The plan will be shared with the practice site to get feedback, and once the plan is agreed upon the coaching sessions will start.

NCHC has assessed Region 7 IDN partners, and currently has no partners which capture all the required domains of the comprehensive core standardized assessments. The region will work together to finalize a comprehensive core standardized assessment tool which can be used by organizations if they wish to have a standardized tool in place. The tool will be adaptable to meet the needs of the organization, since some organizations already have robust assessments in place, and only need to add a question or two to their existing tool.

Region 7 IDN will be challenged by the DSRIP requirement of having to have psychiatrists as part of the multi-disciplinary core team. Due to the shortage of psychiatrists both within the region, and at the statewide level, the region will need to be innovative in addressing this requirement. Advances in technology make tele-psychiatry a viable option for many providers. NCHC has reached out to the Department of Psychiatry at the Geisel School of Medicine to begin conversations related to providing psychiatric consults for Region 7 IDN partners.

NCHC has been researching best practices for integrating behavioral health and primary care, and has been collecting tools used in this process. SAMHSA-HRSA Center for Integrated Health Solutions, Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care Integration Playbook, Institute for Health Improvement, Advancing Integrated Mental Health Solutions (AIMS) Center, and Partners in Health Interagency Toolkit will serve as the main resources for the development of the Region 7 Core Competency Integration Toolkit. Region 7 IDN plans to use a consistent approach for improving the integration of behavioral health and primary care in the region, and therefore has decided to develop similar toolkits for each of the community-driven projects as well. These toolkits, which will include sample forms, policies, and procedures, will be reviewed by various

work groups in the region and finalized in late summer/early fall of 2017, and then they will be introduced at the September 2017 quarterly regional meeting, and then rolled out to partner agencies starting in October 2017 during various training opportunities. The toolkits will be measured for effectiveness using the PDSA approach, and partner feedback will be used to edit the tools to fit the needs of partners in the region.

The Region 7 Core Competency Integration Toolkit will contain:

- Multi-agency consent form packet;
- Sample job descriptions for members of the multi-disciplinary core team;
- NH Board of Medicine Guidelines on opioid prescribing;
- Comprehensive Core Standardized Assessment form;
- Sample screening tools for adults, adolescents and children;
- Sample protocols for patient assessment, treatment, and management;
- Sample referral protocols including those to/from PCPs, BH providers, social service support providers, Hospitals, and EDs;
- Sample communication plans, relevant workflows and case conference templates to be used by the multi-disciplinary core team and Community Care Teams;
- Samples of contracts or MOUs that can be used between participating providers and organizations including social support providers to outline the roles and responsibilities for both of the organizations, including, but not limited to compliance, liability, insurance, coverage schedules, consultant report turnaround time, referral processes; and
- Tools related to SAMHSA 9 Core Competencies: quality improvement resource guide, guide to shared care plan, guide to data aggregation, Integration 101 guide, team building activities, templates to define roles & responsibilities of core team members, information on co-occurring disorders, information regarding shared decision making, guide to Systems Oriented Practice, tool to develop patient & family education brochure, information on cultural competency, information on Active Listening, Reflective Response, protocols for patient interaction, protocols for internal communication, communication protocols to share the information learned with treatment, transitional care and social service providers will be defined.

The IDN QI coach will work with participating practices to help them ensure care coordination at their practice site is supported by documented work flows, joint service protocols and communication channels with community based social support service providers.

As previously mentioned, participating behavioral health and primary care practices must reach a level of coordinated care by December 31, 2018. To do this the practice must demonstrate at least the following five components which will be discussed in detail in within the implementation plan section.

1. A Comprehensive Core Standardized Assessment
2. Shared Care Plan

3. A Multi-Disciplinary Core Team

4. Standardized Workflows and Protocols

5. Information Sharing: Care Plans, Treatment Plans, Case Conferences

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.

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

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

Region 7 IDN will build a delivery system that prevents, treats, and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service to meet DSRIIP goals: reduce avoidable acute care admissions and ED utilization, and measurably improve the health status for Medicaid beneficiaries and other state residents. The center of the DSRIP program is the required Core Competency Project which focuses on the integration of care across primary care, behavioral health (mental health and substance misuse/substance use disorder (SUD)) and social

support service providers. This project, in conjunction with working to improve care transitions, enhance care coordination for the high needs population, and expand SUD treatment options, will lead to an integrated behavioral health delivery system. The region will address behavioral health workforce shortages and develop an HIT infrastructure to support integrated healthcare.

According to SAMHSA's Standard Framework for Levels of Integrated Healthcare there are two tiers of integration, coordinated care and integrated care. Region 7 IDN will provide training, support and financial incentives for the primary care and behavioral health providers in the region to progress along a path from their current state of practice toward the highest feasible level of integrated care. All behavioral health and primary care practices participating in the Core Competency Project need to achieve a Coordinated Care Practice designation by December 31, 2018.

I. *Comprehensive Core Standardized Assessment*

Screening for unmet social needs is not currently a standardized practice, so the DSRIP program is requiring participating practice sites to have a Comprehensive Core Standardized Assessment *process* in place to capture information about the following domains at least on an annual basis: demographic, medical, substance use, housing, family & support services, education, employment and entitlement, legal, risk assessment including suicide risk, and functional status (activities of daily living, instrumental activities of daily living, cognitive functioning). The Comprehensive Core Standardized Assessment *process* must include evidence based universal screenings like PHQ2 and PHQ9 which are used to screen for depression, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) which is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. In addition, pediatric providers will ensure that all children receive standardized, validated developmental screening, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30-month pediatric visits; and use Bright Futures or other American Academy of Pediatrics recognized developmental and behavioral screening system.

Results from this assessment tool will be used to inform a patient's treatment plan, and make referrals to community services, and ultimately lower their health care costs and improve health outcomes. NCHC participated in the Dartmouth Knowledge Exchange, which was a type of learning collaborative among the IDN Regions, led by professionals working in the Dartmouth health system. The group worked through the list of these domains to find questions which patients could be asked to address the domains. These questions will be used to develop a comprehensive core standardized assessment tool to be used by agencies that do not already have a tool to collect this information. In addition, a discussion paper titled Standardized Screening for Health-Related Social Needs in Clinical Settings; The Accountable Health Communities Screening Tool was released by Centers for Medicare & Medicaid Services (CMS) in May 2017. The discussion paper focuses on the development a 10-item screening tool to identify patient needs in 5 different domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety). Since this tool was released by CMS there is a high probability that it will get incorporated at many sites to assess some of the domains within the DSRIP program. NCHC has been actively querying participating practices to see which sites can capture the required domain information, and will use this as a guide to see which sites may need additional help from the IDN Quality Improvement Team.

The DSRIP program highlights the need to address social determinants of health for the Medicaid beneficiary to improve health outcomes and lead to cost savings. Addressing these social determinants of health by piloting an incentivized process to help pay for changes in the system should feed into an alternative payment model. One of the big social determinants of health impacting the Medicaid beneficiary is housing insecurity. Region 7 IDN will work together to improve supportive housing in the region through the core competency project, and the 3 community-driven projects. Supportive housing is an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities. Multiple studies have been conducted on supportive housing across the country and show overall system cost savings of providing supportive housing to homeless and disabled individuals. SAMHSA literature provides the best overview:

When people are unable to afford safe and decent housing, food, and other necessities of life, day-to-day existence is extremely stressful. When people with psychiatric disabilities experience high levels of stress, they can experience an increase in the severity of their symptoms or may begin having symptoms again after being symptom free (in remission) for some time. Permanent Supportive Housing is also an effective response to unnecessary institutionalization of people with psychiatric disabilities and their segregation from the community at large. People are often forced to stay in institutions or live in custodial settings because they lack access to residential options that provide less restrictive alternatives or service options.

The IDN projects provide opportunities to identify and connect with those individuals who are of the greatest need, those whose lives revolve around illness, psychiatric disability, substance use disorder and a struggle to get through the most basic of daily functions. Caring for those with illness is not only the right thing to do; it is also proven to be the most cost effective. These are also the individuals that cycle in and out of hospitals, jails and shelters creating the largest cost burden to our communities and state.

The Care Transition project, C1 will provide the Critical Time Intervention Model to be utilized by participating Region 7 partners. Tri-County Community Action Program (TCCAP) has a Homeless Outreach program that serves people in the entire Region 7 IDN Service area. The Homeless Outreach program identifies persons who are unsheltered through direct outreach activities and through reports/referrals from shelters, police, churches, town welfare officers, human service providers, other agencies, and community members. Once a potentially homeless person is identified, the Outreach Worker initiates contact with the unsheltered homeless for the purpose of providing assistance with attaining adequate shelter and access to needed services. Each individual and family referred for services are assessed for the immediacy of need and type of intervention appropriate to ameliorate the threat of homelessness and act to respond to the homeless emergency. TCCAP has applied for funds under project C1 to utilize CTI to engage individuals in finding a home. CTI has been used very successfully in other states to engage this population. In most cases being homeless is only one factor an individual may be dealing with. Having a mental illness or substance use disorder and/or medical issues prevents people from attaining a home. With the CTI intervention, individuals will have a nine-month period to reach goals in wellness, stability and housing. In looking at the high utilizing Medicaid population, those individuals with complex needs, income becomes an additional barrier to securing housing. In E5 Care Advocates will be working one-on –one with families and individuals to obtain multiple services including the essentials of the social determinants of health. This provides a unique opportunity to access, support and follow these individuals and help guide them through obtaining

health, housing, possible employment and the stability that has eluded them. Under the regional project of D3 we will be working with Mount Washington Valley(MWV) Recovery, a sober housing establishment for woman. The establishment of this resource has been greatly supported by the Conway area community and again provides a unique opportunity to fill the gap between residential treatment and secure housing. The sober housing will allow women to have a place to transition successfully into employment, schooling and eventually their own housing by providing them a safe place to live and access on-going recovery support services. MWV Recovery will be expanding to include a sober living house for men.

Housing is a right of all families and individuals and the IDN project provides an opportunity to find and support individuals in health and other needs and lay the foundation for securing a home. Region 7 has additional partners who offer services and expertise that can help reach the goal of housing for Medicaid recipients. Affordable Housing, Education, and Development (AHEAD) is a partner in Region 7. AHEAD develops and provides quality affordable rental housing, financial education, and home ownership opportunities that strengthen the families and communities of Northern New Hampshire. Currently, AHEAD owns and operates 399 units of affordable multifamily rental housing in nine northern New Hampshire communities. Northern Human Services (NHS), the community mental health center that provides services to all three counties in Region 7 has staff trained in evidence based supportive housing.

The plan for Region 7 IDN moving forward is to bring these partners and others together, to connect, share resources and determine next steps to fulfilling this need. There is a wide range of community based services, new initiatives and resources in Region 7, but because of our region's geographic expanse there is not necessarily a centralized knowledge of them all. The Administrative Lead will facilitate partners coming together with the goal of developing a pilot around supportive housing for Region 7. Together partners will be able to create a list of assets and their potential, determine the scope of need for housing services, and then compile and prioritize a list of needs. An action plan will be created and reviewed with our governance structure to explore possible funding. Collaboration and building community are among the strengths of the Region 7 partners and NCHC is confident in their ability to pull together and address this pressing need.

Region 7 IDN realizes integrated care involves more than just physical and behavioral health, it also involves oral health. There is well documented information that vulnerable groups have less access to dental services, worse oral health, and bear a disproportionate burden of oral diseases. Oral health is often taken for granted, but it is an essential part of overall health. Good oral health enhances the ability to speak, smile, smell, taste, touch, chew, swallow and convey our feelings and emotions through facial expressions. However, oral diseases, which range from cavities to oral cancer, cause pain and disability for millions of Americans each year. Oral health is essential to overall general health and well-being, but as Healthy People 2020 national oral health objectives are being finalized, there is a growing recognition that many challenges identified 20 years ago have not been adequately addressed. Dental caries (tooth decay) is the single most common chronic childhood disease; and there are striking disparities in oral diseases among various disadvantaged and underserved population subgroups. The oral health needs of the patient will be considered as Region 7 IDN is implementing programming to improve the delivery of integrated healthcare. Region 7 partners, including some of the Federally Qualified Health Centers and rural health clinics, have oral health integrated into their scope of services. Region 7 will continue to advocate for inclusion of oral health as an adult Medicaid benefit.

2. Shared Care Plan

Region 7 IDN will work with IDN partners to implement a shared care plan in the region. A shared care plan is a document that depicts a plan of care for a patient, which can be shared with other organizations involved in the patient's care with appropriate consent. Tied to the shared care plan is a process known as Event Notification Service (ENS). ENS is a means to alert a patient's care team at the time of an acute event such as a hospital admission, a transfer to another hospital, and discharge from a hospital. Region 7 IDN will be contracting with Collective Medical Technologies (CMT) to implement PreManage Primary and PreManage Ed in the region. PreManage Primary is the name of the shared care plan/event notification system that will be used by health centers and community organizations, and PreManage ED is the system that will be installed at hospitals to use hospital generated admission, discharge, and transfer (ADT) data elements to create alerts which will be sent to clinical, behavioral and community providers. Region 7 IDN will follow a phased approach to get all participating B1 providers using a shared care plan by December 31, 2018. For additional information on the rollout of the shared care plan refer to section A2 and the A2 Project Timeline.

3. Multi-disciplinary Core Team

Coordinated Care Practice sites must have a multi-disciplinary core team available to support individuals at risk for or with diagnosed behavioral health conditions or chronic conditions that includes primary care providers, behavioral health providers (including a psychiatrist), assigned care coordinators or community health workers. The need to have a psychiatrist as part of the multi-disciplinary core team will pose challenges for the region, since there is such a shortage in the region. The region will need to consider sharing the time of a psychiatrist or contracting with an agency to provide psychiatric time for consulting, which includes participating in case conferences as needed. The team may also include peer specialists, pharmacists, social support service providers, and pediatric providers, dependent on the needs of the Medicaid beneficiary. Team members are not required to be physically co-located or to be part of the same organization, although co-location is strongly encouraged where feasible given the size and volume of a practice. The DSRIP requirements of needing to have a multi-disciplinary core team which works with social service providers to address patient needs lends itself well to a Community Care Team (CCT) model. Region 7 IDN will support CCTs, forming partnerships with primary care practice involved with the care of the Medicaid beneficiary. CCTs will be comprised of both clinical and non-traditional health providers such as community health workers, peers, and navigators. There is growing awareness that to achieve the best outcomes, patients and families must be actively engaged in decisions about their health care and must have enhanced access to information and support. Creating ongoing, sustainable partnerships with patients and families often requires changes in organizational culture. The idea of new multi-disciplinary teams, and engaging families in the creation of patient centered care plans may cause challenges for some practices as they try to advance along the continuum of integrated healthcare. The Region 7 IDN QI team will monitor this potential problem area and make sure trainings are available that will help with change management techniques. Changes in practices related to communication and coordination of care often require that staff acquire new skill sets. An organization must be willing to provide its staff members and team's time and support for training and to learn how to collaborate across and within disciplines before they can collaborate effectively with patients and families. The University of Massachusetts Medical School Center for Integrated Primary Care offers courses as well as a full certificate program that is a comprehensive training in Primary Care Behavioral Health. The e-learning modules provide a rigorous orientation to integrated primary care that can benefit physicians, integration team leaders and administrators. A

Region 7 team will participate in the on-line curriculum and share information and tools with other organizations.

Region 7 IDN will be use a three-pronged approach to help transform the delivery of behavioral health care in the region. SAMHSA's 9 Core Competencies, referenced in the A1 Workforce plan is the first prong. It is imperative that the region has an adequately trained workforce to meet the needs of the patient. The Continuum of Care concept (Coc) is the second prong the region will be using. Continuum of care is a concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care. The continuum of care framework addresses prevention, early intervention, treatment, and recovery support services. Although utilized primarily for Substance Use prevention programming, this framework is applicable to all deliverables within this demonstration project.

- **Prevention-** Promotion of health and prevention strategies are key elements in an overall approach to better health. Prevention strategies include education, awareness raising, engagement and community coalition building.
- **Early Intervention-** Key to reducing the demand on Behavioral and Primary care services, early intervention involves screening and brief intervention and assessment, education of providers and community of the value of identifying illness early in life or early in the development of illness. Early intervention has the potential to reduce the severity of illness and impact the sustainability of healthcare.
- **Treatment-** Treatment services must be integrated, accessible, coordinated and culturally competent and based on clinical expertise and the patient's values and preferences.
- **Recovery Support Services**- Critical to long term behavioral health recovery are services that are often peer based, accessible, and available within the community for long term sustainability of recovery.

Region 7 IDN will focus on transitional services as the third prong**.** There is growing recognition of the importance of facilitating transitions in health care services. Patients with chronic behavioral or health conditions often fall through the cracks as they transition from more intensive services to community based services**.** Transition services must include the coordination and continuity of behavioral and/or medical health care during a movement from one healthcare setting to either another or to home and community. An essential element of transition is addressing the Social Determinants of health for the patient, including but not limited to food, housing, education and employment and transportation. Transitional programming should include the creation of a transition policy, tracking and monitoring, transition readiness planning, transfer of care and completion of services.

Due to the large geographic coverage area, Region 7 IDN has been broken down into 3 sub-regions to assist in the implementation of integrated healthcare: Carroll, Coos, and Grafton. Although work will be broken down by sub-regions, NCHC will coordinate the implementation process to ensure an integrated approach is followed. Each of the 3 sub-regions in Region 7 will have at least one Community Care Team who will work directly with primary care practices to provide wrap-around services for the Medicaid beneficiary. Patients who have high hospital costs, emergency department use, and readmissions are identified through referrals, claims review, and screening and assessments. Region 7 IDN will reach out to Maine, Vermont, and North Carolina to learn about payment models for CCTs and use this information to assist in the development of alternative payment models.

Region 7 IDN realizes the importance of having a robust care coordination system in place to meet the DSRIP goals. The IDN care coordination system will support the core multi-disciplinary team to ensure the team is coordinating care, and communicating among team members to optimize patient care and help the patient meet their care plan goals, which includes connections to community supports. Region 7 IDN will make efforts to structure the care coordination system in such fashion that one care coordinator will assume the lead role in managing the patient's care plan, and the agency taking on the lead coordinating role will work closely with other care coordination programs that are following the same patient. Care coordinators or community health workers are the heart of the multi-disciplinary core team. As such, Region 7 IDN has decided to use a regional care coordination training plan designed to train existing care coordinators in a regional approach. Each participating organization will be required to attend a 1 or 2-day regional care coordination training depending on which projects they are part of. The purpose of this training is to learn how to think about care coordination from a regional approach, not just from the needs of one organization. The morning of the first day will be devoted to learning how to use PreManage, the shared care plan of the region, and the value of using the tool to deliver integrated health. Time will also be spent on how to use the multi-agency consent form, and how to explain the consent process to the patient. The morning session will end with an overview of the Community Care Team Model. The morning session is designed to bring together executive level staff, IT staff, clinicians, and care coordinators to learn about the shared care plan, the value of it, and have a team-based approach for moving forward with this new model. In addition, participating sites will have the ability to access on-line trainings for instructions on how to use PreManage, and the IDN HIT Integration Coach will be following up with sites to aid with the integration of PreMange into workflows. The afternoon session and the second day will be for training care coordinators in the regional approach using the Care Advocate training model curriculum: linkages to community, regional and state resources, health literacy, cultural competency, Integration 101, co-occurring mental health and substance use disorder, patient outreach strategies, patient advocacy, and using the Care Advocate Toolkit which is described in detail under E5 Enhanced Care Coordination section of this plan. These regional care coordination trainings will be repeated throughout the course of the DSRIP program to ensure enough care coordinators get trained in this regional approach, so the system will be sustainable after the DSRIP program ends. The care coordinators involved with these community projects need to understand community resources, the value of the shared care plan, the importance of the multi-agency consent forms, and how the overall system of behavioral health integration leads to better health outcomes. This includes the Care Advocates in project E5, the CTI workers in project C1 and care coordination and peer support roles in D3. As previously mentioned, Region 7 IDN realizes the value of community health workers and the role they can play in the delivery of integrated healthcare. Research has shown that properly trained community health workers can play a unique role in helping high-need patients navigate the health system, obtain necessary supportive resources, and build self-efficacy and health literacy; by doing so, they can improve patient experiences and outcomes and reduce hospital readmissions. As such, NCHC will offer two community health worker trainings per year throughout the DSRIP program, starting in 2018. The region will have additional trainings specifically related to the 3 community driven projects such as Critical Time Intervention training, and Peer Recovery Coach trainings which will be discussed in detail in the respective community-driven project sections of the implementation timeline.

It is also important that other members of the multi-disciplinary core team receive trainings on using the shared care plan, including the technical components of using it, along with the value of using the technology to improve the delivery of integrated healthcare. To cause the least amount of disruption in

a workday, these additional team members will be able to asynchronously learn about the shared care plan. NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff. The Region 7 HIT Integration Coach will then follow up with sites to support the work involved with integrating the use of the shared care plan into workflows. NCHC will survey practice sites 6 months after they are trained in Pre-Manage and use the results of these surveys to identify any gaps in training and address those gaps.

The DSRIP program requires core team members to have adequate training in management of chronic diseases including diabetes hyperglycemia, dyslipidemia, hypertension, and the nature of mental health disorders and substance use disorders to enable team members to recognize the disorders and as appropriate, to treat, manage or refer for specialty treatment as appropriate, and to know how to work in a care team. Practice staff who are not involved in direct care should also receive training in knowledge and beliefs about mental disorders that can aid in their recognition, and management in special situations. NCHC distributed a training needs survey to participating providers in June 2017 and will use the results of this survey as a way to determine what trainings need to happen at a facility, and how many staff need to be trained. This information will then feed into the creation of a training plan which will start with reaching out to the member agency to discuss program offerings and see what meets the needs best for the practice site. At this point, NCHC will create a training plan for the practice site. Some of the training may be available via an on-line platform, some may be in a lunch-and-learn format, and some may be available during one of many regional training opportunities held during quarterly meetings, and the yearly IDN conference. NCHC will work diligently with providers to make sure front-line staff get trained in mental health first aid, which the region will offer on a repeating cycle, using different venues and modalities for delivery.

Region 7 IDN will focus on bi-directional integration of care to improve quality in care, achieve better patient outcomes, and reduce treatment costs. Irrelevant on where care originates, and who is coordinating that care, to be effective the care model needs to be patient-centered, population-based, data-driven, and evidence-based. Patients need to share in the decision making of their care and learn self-management support strategies. Region 7 will encourage participation in Recovery Coach Academies currently offered in the region by trained Recovery Coaches, and explore opportunities for train-the-trainer programs for the Self-Management and Recovery Training (SMART) program, where participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors.

A solid training plan is a major key to Region 7 IDN achieving all the DSRIP goals. Region 7 IDN has developed a comprehensive training plan which encompasses the B1 project and all three community-driven projects, and places NCHC in the center of the plan serving as a regional training center. NCHC will assess the need for additional trainings to be added to this training menu, and will use evaluation feedback from the participants to gauge the effectiveness of the training programs. NCHC is home to the Northern New Hampshire Area Health Education Center (NNHAHEC), which is an approved provider of nursing and physician continuing education credit, and can apply to the mental health licensing agencies to obtain continuing education credits for mental health professionals. NCHC will ensure continuing education credits are offered for eligible trainings and participants.

Trainings will be delivered in a variety of modalities to meet the needs of the IDN membership. NCHC has both video conferencing capability, and a Moodle Platform which can be used to deliver on-line programming, either recorded, or live. In addition, NCHC is positioned to develop curriculum as needed

by convening planning committees to review curriculum, and develop materials, or the organization can contract with outside agencies to come to the region to deliver established trainings. NCHC also has experience with going to practices delivering trainings on-site, and often uses a lunch and learn format for this process. Several IDN member organizations filled out a training needs survey in June 2017 which included information on the types of trainings they need, the number of staff they have, including front line staff, and the delivery methods they prefer to use for these trainings. The results of these surveys will be utilized as the region works to roll out the full array of trainings associated with the DSRIP program.

The training plan will be deployed in a multi-prong approach. Quarterly meetings will be one opportunity to deliver trainings to Region 7 IDN members. In addition to these quarterly meetings, the region will hold an annual Region 7 IDN Conference in June of each year of the DSRIP program. This conference will be a full day event, with the morning session being the full membership together to hear highlights from the year and the overall progress along the continuum of integrated healthcare. The afternoon session will be set up with 4 tracks, so participants can take a variety of workshops related to each of the community-driven projects and the core competency project.

Required trainings related to the core competency project will be delivered in a way that meets the needs of the practice. NCHC is addressing the need to train front line staff and looking at options to do this in the most efficient and effective manner. The region will have an IDN QI Coach who will be working with the multi-disciplinary core teams to identify further training needs and arrange for those trainings. In addition, as the shared care plan is rolled out to the IDN members, NCHC staff will work to ensure that practice sites are receiving the necessary training to support that roll out. To begin this process, at the next quarterly meeting scheduled for fall of 2017 the draft agenda for the meeting will be:

- Review of the implementation plan
- Timeline of deliverables
- Overview of 42 CFR Part 2 & introduce draft multi-agency consent form
- Co-occurring mental health and SUD presentation
- Introduce toolkit concept
- Value of shared care plan
- Use of Community Care Team model to achieve integrated health care

Below is the master training table for Region 7 IDN. The table lists all the trainings, both required and optional that may be needed for projects associated with implementation of the DSRIP program.

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1

Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5
Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients	B1
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in	B1, E5

	health care. This interactive workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	
Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe "integrated care," and the SAMHSA levels of integration,	B1
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1
Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or	B1

	substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1
Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	B1
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination, organization, teaching, capacity building, motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	E5, B1

Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN	B1, C1, E5
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1
Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	D3

Health Equity	Providers Linking Patient With Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	B1
Self-Management and Recovery Training (SMART) program-	Participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	D3
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery	D3

	and enhance the treatment process.	
Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	D3, E5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly webinars, core training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	B1, D3, E5
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral	B1

	health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the	B1

	cost of care delivery in integrated care settings.	
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	B1
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the current evidence to support the transition.	B1
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for individuals who have a mental health issue (MHI) or substance use disorder (SUD), describe the return on	D3

	investment of helping patients quit smoking, discuss strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	D3
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction	E5

	on all the Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills and Tracking and Reporting required.	
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	B1
Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

4. Standardized Workflows and Protocols

Since the multi-disciplinary team approach requires professionals to work across practice settings, the success of the team is based on each member of the treatment team understanding their roles and responsibilities as the team works together to care for a common patient, it is important to have written roles and responsibilities for members of the team. There is a high likelihood that members of the multi-disciplinary core team or CCT have not worked together in the past, and the team members will come from a variety of organizations within the community. As a result, the Core Competency Project requires documented workflows for core team members so everyone understands the process for the flow of information. There needs to be protocols in place to ensure safe transitions from institutional settings back to primary care, behavioral health and social support service providers, and intake procedures in place to solicit patient consent to confidentially share information among providers. The Core Competency Integration Toolkit will contain samples of these documents, and the IDN QI Coach will work with practice sites to help staff incorporate these tools into their workflows.

To ensure there was an understanding of the amended 42 CFR Part 2, Region 7 IDN joined six of the other IDNs and contracted with The University of New Hampshire, Health Law and Policy Program at UNH School of Law, Institute for Health Policy and Practice and the NH Citizens Health Initiative to provide technical assistance as the IDNs worked to develop confidentiality tools related to substance use disorder projects. Region 7 IDN had a team of representatives who represented hospitals, federally qualified health centers, community health centers, addiction centers, and staff from NCHC participate in three Substance Use Disorder ("SUD") Treatment Confidentiality Boot Camps to learn about federal and state confidentiality requirements, focusing on 42 CFR Part 2. This multi-disciplinary Boot Camp team will assist NCHC staff with the development of a multi-agency consent form, and the adoption of compliant practices consistent with newly amended 42 CFR Part 2 utilizing the tools that were created during the Privacy Bootcamp sessions. The multi-agency consent form will be reviewed by the region's legal counsel, and the consent form will be incorporated into the development of all of the toolkits being used throughout the region. As the timeline shows, Region 7 IDN has been involved with this process since mid-May, and plans to have draft consent forms to share with the region by fall 2017.

5. Information Sharing: Care Plans, Treatment Plans, Case Conferences

To be considered a coordinated care practice site information must be shared regularly among team members. The foundation for this information sharing is the clinical-CCT partnership. The care coordinator at the center of this team will work to set up at least a monthly case conference between members of the multi-disciplinary core team and members of the CCT. The care coordinator can reference the Core Competency Integration Toolkit for a case conference template. Participating providers will develop a system so anyone in the clinical-CCT partnership can request a case conference regarding a patient.

All participating practices will have documented workflows which include a communication plan inclusive of protocols related to what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected. Templates of these protocols and plans will be available in the Core Competency Integration toolkit, and again the IDN QI Coach will be a resource for the practice sites to help get these workflows into place. The IDN QI Coach will work with practices to ensure they have a process in place which adheres to the New Hampshire Board of Medicine guidelines on opioid prescribing.

All participating practice sites must be working toward closed-loop referral capabilities (electronic or non-electronic). Although the ideal situation would be a fully-integrated electronic closed loop referral process, (e-referral) the closed-loop can be achieved in other ways as well by something as simple as picking up the phone to say the referral was received or using Direct Secure Messaging (DSM), a secure web-based email protocol that encrypts information to ensure that communication is private. The region will be working to have signed data sharing agreements between partners during the fall of 2017, and shortly thereafter a data aggregator will be selected for the region. The region will have webinars for staff to learn how to use the new data aggregator, which should be live before April 1, 2018.

The DSRIP program has additional *Integrated Practice* designation requirements for practices trying to advance past coordinated care designation. To achieve an Integrated Practice designation all the requirements for the Coordinated Care Practice designation referenced above must occur, plus the adoption of both MAT and evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting. In addition, participating practice sites will be required to use technology to identify at-risk patients, plan their care, monitor/manage patient progress toward goals, and ensure a

closed loop referral process. Practice sites will utilize a shared or interoperable electronic health record and/or an electronic care coordination system that incorporates the comprehensive core standardized assessment and shared care plan. Practice sites will be proficient in the use of documented work flows, joint service protocols and have solid communication channels and a closed loop referral in place which encompasses community based social support service providers. Region 7 IDN's QI Coach will work with practice sites who are interested in advancing along the continuum to become an integrated practice. To monitor fidelity to integration, and to show if the program is making a difference at the practice level, the practices will receive the CHI Integration Survey on an annual basis after the first 18 months of the program. Giving this survey repeatedly will allow for a consistent way to demonstrate progress over the demonstration period.

Region 7 IDN has designed evaluation measures for the B1 project, and each of the community-driven projects as required, and is currently negotiating with the Institute for Health Policy and Practice to operationalize the evaluation plan, analyze the results, and create evaluation reports for the region. Outcome measures used to show impact of the DSRIP program will include 3 linkage mechanisms: 1) number of co-located sites; 2) number organizations with formal systems in place for psychiatric consults; and, 3) number of formalized referral arrangements that are in place. Region 7 will explore working with other IDN regions as the evaluation process moves forward to leverage using similar measures to show a bigger program impact. In addition, the region will work closely with NH DHHS and the managed care organizations to make sure data is being used in an effective manner. However, for the tracking of process data the Administrative Lead will create an online reporting system featuring web-based form (or forms) feeding into a spreadsheet that captures process measure data (such as number of staff trained). Thirty (30) days prior to the regional reporting deadline, participant organizations will be prompted to fill these forms out within 2 weeks. If entry into the forms is not possible, a fillable PDF will be provided on request. Once the data has been entered and received, Administrative Lead staff will combine data collected this way with data collected from workgroup meetings, event attendance lists and any sub-recipient interim or final reports that have been submitted in the last six months. These data will, together, form a master process measure data tracking sheet for the past 6 months. This master process measure data tracking sheet will be used, in conjunction with outcome data captured from EHRs through the data aggregator to support all regional data reporting

NCHC, the Region 7 Administrative Lead agency, will create Dashboard Reports for reporting on measures. This method will provide a quick overview of the current state of the data to make it easier to identify key trends. These Dashboard Reports will be shared with the entire IDN on a semi-annual basis, and will be placed on the IDN website that will be created.

Measurement Plan

	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Region 7 IDN partner organizations	# of partner organizations using	Core competency Assessment	Participating organizations complete	Quarterly	Program Manager

will use Comprehensive Care Standardized Assessment and Shared Care Plan	Comprehensive Standardized Assessments and screening tools	Template	tracking tool		
	# of partner organizations using shared care plans for treatment and follow-up	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
Region 7 IDN partner organizations use multi-disciplinary core teams	# of partner organizations that have training plans in place for core team members and extended team if needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of partner organizations that have training curricula in place for each member of the core team and extended team if needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of partner organizations having written roles and responsibilities for core team members and other members	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager

	as needed				
Region 7 IDN partner organizations use standardized workflows and protocols	# of partner organizations using protocols for patient assessment, treatment, and management # of partner organizations using referral protocols	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of partner organizations that have formal agreements in place around referral protocols, services to be provided by community-based organizations, coverage schedules, and consultant report turn arounds	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of registries utilized by partner organizations to track and monitor patients served by the IDN	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager

Region 7 IDN partner organizations use information sharing for care plans, and treatment plans	# of partner organizations having communication plans regarding documentation workflows between core team members and extended team if needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
Region 7 IDN partner organizations identify evidence-based programs to implement	# of evidence based programs implemented	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager

Example of a dashboard:

Objective	**Measures**	**Target**	**Frequency**	**Findings**	**Trending**
Goal 1: Increase the number of fully integrated practices sites in Region 7 IDN					
	Coordinated care designation	100% by 12/31/18	quarterly		
	Integrated care designation	100% of identified practices	quarterly		

		working towards this goal by 2020			
Goal 2: Increase behavioral health workforce capacity within Region 7 IDN					
	# of psychologists at each site # of psychiatrists at each site # of LADCS at each site #MSW at each site #LCMHC at each site # other at each site (psychiatric nurse practitioners, etc.)	20% increase in behavioral health staff by 2020		# new staff positions recruited and trained Staff vacancy and turnover rate	
Goal 3: Reduce gaps in care across care settings	# of closed-loop referrals # of pt referred to CTI program	50% of referrals result in closed loop referral by 2020 # of patients completed CTI			

Goal 4: Demonstrate cost-savings for selected programs	Annual 30-day behavioral health indicators patient hospital readmissions to hospitals (age 18+, not including maternity, rehabilitation or cancer treatment diagnoses) rate per 1,000 population	20% decrease in annual 30-day hospital readmissions rate for patients with behavioral health indicators rate per 1,000 population from 9.1 in 2015 to 7.2 by 2020	Annually		
	Annual emergency department visits for patients with behavioral health indicators rate per 1,000 population	20% decrease in annual emergency department visits for patients with behavioral health indicators rate per 1,000 from 1073 in 2015 to 858 by 2020.			

The B1 project requires a mechanism, such as registries, be in place to track and monitor individuals served by the program. A disease registry is a database of information about patients with specific types of diagnoses. Information gleaned from these registries can be used to prevent disease, create effective care transitions, manage gaps in care, reduce preventable admissions, prevent readmissions, and evaluate care processes and outcomes.

The uses of patient registries tie directly into population health management. As the region works to improve both population health management, and the social determinants of health, the region is positioning itself to have a system in place to measure these components which will tie into alternative payment models.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

From the IDN HIT Infrastructure Project Plan, use the format below to identify the measureable 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
# of partner organizations using comprehensive core standardized assessment	18 as of 2018			
# of partner agencies using shared care plan	18 as of 2018			
# of partner agencies using multi-disciplinary core team	18 as of 2018			
# of partner agencies using standardized workflow and protocols	18 as of 2018			
# of partner organizations which have implemented MAT services	5 as of 2018			
# of psychiatric nurse practitioners	3 as of 2018			
# of MLDACs	16 as of 2018			
# Licensed Mental Health Professionals	23 as of 2018			
# of Peer Recovery Coaches	6 as of 2018			
# of Community Health Workers	4 as of 2018			
# CTI Workers	15 as of 2018			
# CTI Supervisors	3 as of 2018			
# Care Advocates	15 as of 2018			

Performance Measure Name	Target	Progress Toward Target		
# Care Advocate Supervisors	1 as of 2018			
# Community based clinicians (staffing from first round of capacity)	1 as of 2018			
# Physician assistant clinicians (staffing from first round of capacity)	1 as of 2018			
Community nurse coordinator clinicians (staffing from first round of capacity)	1 as of 2018			
Behavioral health assistant clinicians (staffing from first round of capacity)	1 as of 2018			
Behavioral health case managers clinicians (staffing from first round of capacity)	5 as of 2018			
LICSW clinicians (staffing from first round of capacity)	3 as of 2018			
IDN QI Coach	1 as of 2018			
HIT Integration Coach	1 as of 2018			
IDN Data Specialist (NCHC)	1 as of 2018			
Data Specialists for IDN partners	Up to 3 as of 2018			

B1-4. IDN Integrated Healthcare: Workforce Staffing

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

Provider Type*	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Master Licensed Alcohol and Drug Counselors	16 by 2018	11			

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
Licensed Mental Health Professionals	23 by 2018	14			
Peer Recovery Coaches	6 by 2018	2			
CTI Workers	15 by 2018	0			
CTI Supervisors	3 by 2018	0			
Community Health Workers	4 by 2018	0			
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1			
Care Advocates	15 by 2018	0			
Other Front Line Provider	1 by 2018	0			
Care Advocate Supervisors	1 by 2018	0			
Community based clinician (round 1 funds for baseline 6/30/17)	1	1			
Physician assistant (round 1 funds)	1	1			
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1			
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1			
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2			
LICSW (round 1 funds for baseline 6/30/17)	3	1			
IDN QI Coach	1	0			
HIT Integration Coach	1	0			
IDN Data Specialist (NCHC)	1	0			
Data Specialists for IDN partners	Up to 3	0			

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.

Budget Period: **01/01/2017-12/31/2020**
Core Competency

Line Item	Direct Incremental	Indirect Fixed	Total	NOTES:
1. Total Salary/Wages	$ 84,151	$ 11,529	$ 95,680	**YR2-YR5**: Portion of Program Manager, HIT Lead, Data Specialist; YR2-YR5 F/T QI Coach
2. Employee Benefits	$ 16,830	$ 2,306	$ 19,136	Benefits calculated at 20% of Salary
3. Consultants				
5. Supplies:				
Educational				
Office	$ 48,498	$ 6,644	$ 55,142	**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups
6. Travel	$ 100,000	$ 13,700	$ 113,700	**YR2-YR5:** Travel expenses for regional & conference/training expenses
7. Occupancy				
8. Current Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	$ 3,333	$ 457	$ 3,790	**YR2-YR5:** Proposal Software
10. Marketing/Communications	$ 84,007	$ 11,509	$ 95,516	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$ 80,000	$ 10,960	$ 90,960	**YR2-YR5**: anticipated trainings/conferences
12. Subcontracts/Agreements				
13. Other				
Current Expenses: Administrative Lead Organizational Support	$ 15,747	$ 2,157	$ 17,904	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$ 3,509,565		$ 3,509,565	**YR2-YR5**: Personnel/Supplies/Software
TOTAL	**$ 3,942,131**	**$ 434,752**	**$ 4,001,393**	

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

(at the practice or independent practitioner level)

Organization/Provider	Agreement Executed (Y/N)
Coos County Family Health Services	Y
Cottage Hospital/Rowe Health Center	Y
Littleton Regional Healthcare	Y
Friendship House/North Country Health Consortium	Y
Northern Human Services	Y
Ammonoosuc Community Health Services	Y
Androscoggin Valley Hospital	Y
North Country Healthcare	Y
White Mountain Community Health Center	Y
Weeks Medical Center	Y
Memorial Hospital	Y
Huggins Hospital	Y
Indian Stream Health Center	N in process
Upper Connecticut Valley Hospital	N in process
Whitehorse Addiction Center	Y
Crotched Mountain Foundation	N in process
Life Coping	N in process
Saco River Medical Group	N in process
Carroll County Dept. of Corrections	N in process
North Country Health Consortium	N in process

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

Name	Title	Organization	Sign Off Received (Y/N)
Jebb Curelop		Life Coping	Y
Monika O'Clair	Vice President of Strategy & Community Relations	Huggins Hospital	Y
Emily Benson	C3PH PHAC Coordinator	Carroll County Coalition for Public Health	Y
Rona Glines	Director of Physician Services	Weeks Medical Center	Y
Ken Gordon	Chief Executive Officer	Coos County Family Health Services	Y
Suzanne Gaetjens-Oleson	Regional Mental Health Administrator	Northern Human Services	Y
Jeanne Robillard	Chief Operating Officer	Tri-County Community Action Program	Y
Bernie Seifert	Coordinator of Older Adult Programs	NAMI NH	Y
Russ Keene	President and Chief Executive Officer	North Country Healthcare	Y
Karen Woods	Administrative Director	Cottage Hospital	Y
Sue Ruka	Director of Population Health	Memorial Hospital	Y
Jason Henry	Superintendent	Carroll County Corrections	Y

Multi-disciplinary core team

NCHC will work with organizations which already have elements of a multi-disciplinary core team, and suggest expanding these teams to include providers from other agencies, with the purpose to come together and discuss mutual high needs patients. Region 7 IDN has not identified who will participate on each multi-disciplinary team, but the region will have 3 teams in place by the end of 2018. The teams will be established in waves, following the roll out of the shared care plan; Carroll County by March 2018, Coos County by June 2018, and northern Grafton County by September 2018. Rolling out the teams in a staggered approach will allow for rapid cycle evaluation to see what works the best, and share best practices with the other teams as they get established. NCHC will work with organizations within each core team region to find representation to make up these teams to meet the DSRIP requirements, and approach the Region 7 IDN Steering Committee about incentivizing these teams if it becomes necessary.

Additional members may be added to the team, based on the needs of the patient, following the Community Care team model discussed earlier in the plan. The core team will be comprised of primary care providers, behavioral health providers, care managers, or community health workers, and consulting psychiatrists. In addition, Region 7 IDN is following the Community Care Team model, so depending on patient needs, social service providers will often be added to the multi-disciplinary core team meetings. Tri-County Community Action Program (TCCAP), Affordable Housing, Education and Development (AHEAD), and ServiceLink cover all of Region 7 IDN and will have a standing seat on the MDCT as needed. Other social service agencies or organizations like corrections, home health, or schools will be included based on need.

IDN staff has reached out to the Department of Psychiatry at the Geisel School of Medicine at Dartmouth to begin the discussions related to purchasing psychiatric consulting services for Region 7 IDN. NCHC will discuss utilizing Dartmouth for psychiatric services at the September 28, 2017 Regional quarterly IDN meeting, and will then follow up with Dartmouth to discuss next steps. NCHC will propose purchasing up to 5 hours a month of psychiatric consulting services from Dartmouth over a phased approach to match the rollout of the MDCT. 3 of the hours will be used for monthly case conferences, and the other 2 will be available for emergency consults. NCHC will also explore the options of e-consults with Dartmouth, which is a process where a provider can pose a question about a specific patient, and a Dartmouth psychiatrist will offer a response in 72 hours.

Carroll County Multi-Disciplinary core team

Provider Type	**Organization**
Primary Care Provider	Huggins or Memorial Hospital
Behavioral Health Provider	Northern Human Services
Care Manager or Community Health Worker	Huggins Hospital
Care Manager or Community Health Worker	Memorial Hospital
Care Manager or Community Health Worker	White Mountain Community Health Center

Care Manager or Community Health Worker	Saco River Medical Group
Psychiatrist	Northern Human Services or consulting contract with Dartmouth Hitchcock or other entities

Coos County Multi-Disciplinary core team

Provider Type	**Organization**
Primary Care Provider	Weeks Medical Center or Indian Stream Health Center
Behavioral Health Provider	Northern Human Services and/or Indian Stream Health Center
Care Manager or Community Health Worker	Indian Stream Health Center
Care Manager or Community Health Worker	Weeks Medical Center
Care Manager or Community Health Worker	Coos County Family Health Services
Psychiatrist	Northern Human Services or consulting contract with Dartmouth Hitchcock or other entities

Northern Grafton County Multi-Disciplinary core team

Provider Type	**Organization**
Primary Care Provider	Ammonoosuc Community Health Services
Behavioral Health Provider	Ammonoosuc Community Health Services and/or Northern Human Services
Care Manager or Community Health Worker	Rowe Health Center
Care Manager or Community Health Worker	Littleton Regional Healthcare
Psychiatrist	Northern Human Services or consulting contract with Dartmouth Hitchcock or other entities

A solid training plan is a major key to Region 7 IDN achieving all of the DSRIP goals. Region 7 IDN has developed a comprehensive training plan which encompasses the B1 project and all three community-driven projects, and places NCHC in the center of the plan serving as a regional training center. NCHC will assess the need for additional trainings to be added to this training menu, and will use evaluation feedback from the participants to gauge the effectiveness of the training programs. NCHC is home to the Northern New Hampshire Area Health Education Center (NNHAHEC), which is an approved provider of nursing and physician continuing education credit, and has the ability to apply to the mental health licensing agencies to obtain continuing education credits for mental health professionals. NCHC will ensure continuing education credits are offered for eligible trainings and participants.

Trainings will be delivered in a variety of modalities to meet the needs of the IDN membership. NCHC has both video conferencing capability, and a Moodle Platform which can be used to deliver on-line programming, either recorded, or live. In addition, NCHC is positioned to develop curriculum as needed by convening planning committees to review curriculum, and develop materials, or the organization can contract with outside agencies to come to the region to deliver established trainings. NCHC also has experience with going to practices delivering trainings on-site, and often uses a lunch and learn format for this process. Several IDN member organizations filled out a training needs survey in June 2017 which included information on the types of trainings they need, the number of staff they have, including front line staff, and the delivery methods they prefer to use for these trainings. The results of these surveys will be utilized as the region works to roll out the full array of trainings associated with the DSRIP program.

The training plan will be deployed in a multi-prong approach. Quarterly meetings will be one opportunity to deliver trainings to Region 7 IDN members. In addition to these quarterly meetings, the region will hold an annual Region 7 IDN Conference in June of each year of the DSRIP program. This conference will be a full day event, with the morning session being the full membership together to hear highlights from the year and the overall progress along the continuum of integrated healthcare. The afternoon session will be set up with 4 tracks, so participants can take a variety of workshops related to each of the community-driven projects and the core competency project.

Required trainings related to the core competency project will be delivered in a way that meets the needs of the practice. NCHC is addressing the need to train front line staff and looking at options to do this in the most efficient and effective manner. The region will have an IDN QI Coach who will be working with the multi-disciplinary core teams to identify further training needs and arrange for those trainings. In addition, as the shared care plan is rolled out to the IDN members, NCHC staff will work to ensure that practice sites are receiving the necessary training to support that roll out. To begin this process, at the next quarterly meeting scheduled for fall of 2017 the draft agenda for the meeting will be:

- Review of the implementation plan
- Timeline of deliverables
- Overview of 42 CFR Part 2 & introduce draft multi-agency consent form
- Co-occurring mental health and SUD presentation
- Introduce toolkit concept
- Value of shared care plan
- Use of Community Care Team model to achieve integrated health care

NCHC plans to use the results of the SSA Survey as a gaps analysis framework for the Regions' IDN Quality Improvement Team. The IDN Quality Improvement Team will consist of a full-time Integration Coach and a full-time Quality Improvement Coach both of whom will be NCHC employees. NCHC will begin to recruit for this team in August 2017 with the expectation that the team will be ready to be deployed to practice sites in November/December 2017. The team will work with any practice within the IDN, but will start by outreaching to sites that scored low on the SSA Survey. The Integration Coach will work with practice sites to ensure sites are using health information technology, which includes, but is not limited to, a shared care plan, event notification system, direct secure messaging, and patient registries, to move along the continuum of integrated healthcare in an efficient and effective manner.

In addition, the Integration Coach will help practices collect and use measurement data to assess the effectiveness of changes made. The Quality Improvement Coach will work with the multidisciplinary core team to help the team members better understand how their practice compares to the ideal and where there is room for improvement by observing and delineating practice operations, assessing needs, and gathering baseline data, as well as guiding discussions of the current practice and opportunities for change, and if necessary prepare the organizational infrastructure for quality improvement implementation through such activities as advising on team-building, improving communication, and helping to develop leadership skills. The Quality Improvement (QI) Coach will share best practices and assist practices in customizing processes to fit their own situation, and incorporating the changes into their day-to-day routines, to increase the likelihood that the changes will be sustained. The QI Coach will help practices advance along the continuum by utilizing a toolkit and using the Plan-Do-Study-Act (PDSA) rapid cycle evaluation model.

The Quality Improvement Coach will schedule a meeting with members from the multi-disciplinary core team at each practice site to assess the needs of the practice and use this information along with the baseline integration survey results to form a coaching plan for each site. The coaching plan will outline who will participate on the QI team, how often the team will meet, and what are the team goals. In addition, the plan will lay out the process to be used to drive improvement in the practice, how these are to be documented, and the way current and ongoing status is going to be monitored using data. The plan will be shared with the practice site to get feedback, and once the plan is agreed upon the coaching sessions will start.

NCHC has been researching best practices for integrating behavioral health and primary care, and has been collecting tools used in this process. SAMHSA-HRSA Center for Integrated Health Solutions, Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care Integration Playbook, Institute for Health Improvement, Advancing Integrated Mental Health Solutions (AIMS) Center, and Partners in Health Interagency Toolkit will serve as the main resources for the development of the Region 7 Core Competency Integration Toolkit. Region 7 IDN plans to use a consistent approach for improving the integration of behavioral health and primary care in the region, and therefore has decided to develop similar toolkits for each of the community-driven projects as well. These toolkits, which will include sample forms, policies, and procedures, will be reviewed by various work groups in the region and finalized in late summer/early fall of 2017, and then they will be introduced at the September 2017 quarterly regional meeting, and then rolled out to partner agencies starting in October 2017 during various training opportunities. The toolkits will be measured for effectiveness using the PDSA approach, and partner feedback will be used to edit the tools to fit the needs of partners in the region. The Region 7 Core Competency Integration Toolkit will contain:

- Multi-agency consent form packet;
- Sample job descriptions for members of the multi-disciplinary core team;
- NH Board of Medicine Guidelines on opioid prescribing;
- Comprehensive Core Standardized Assessment form;
- Sample screening tools for adults, adolescents and children;
- Sample protocols for patient assessment, treatment, management;
- Sample referral protocols including those to/from PCPs, BH providers, social service support providers, Hospitals, and EDs;

- Sample communication plans, relevant workflows and case conference templates to be used by the multi-disciplinary core team and Community Care Teams;
- Samples of contracts or MOUs that can be used between participating providers and organizations including social support providers to outline the roles and responsibilities for both organizations, including, but not limited to compliance, liability, insurance, coverage schedules, consultant report turnaround time, referral processes; and
- Tools related to SAMHSA 9 Core Competencies: quality improvement resource guide, guide to shared care plan, guide to data aggregation, Integration 101 guide, team building activities, templates to define roles & responsibilities of core team members, information on co-occurring disorders, information regarding shared decision making, guide to Systems Oriented Practice, tool to develop patient & family education brochure, information on cultural competency, information on Active Listening, Reflective Response, protocols for patient interaction, protocols for internal communication, communication protocols to share the information learned with treatment, transitional care and social service providers will be defined.

The IDN QI coach will work with participating practices to help them ensure care coordination at their practice site is supported by documented work flows, joint service protocols and communication channels with community based social support service providers.

The QI Coach will ensure that multi-disciplinary core team members either receive training, or can show they have training related to diabetes, dyslipidemia, hypertension, and various mental health and substance use disorder topics. Trainings have been identified below, but the list can expand to address needs.

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1
Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5

Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients	B1
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in health care. This interactive workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	B1, E5
Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe “integrated care,” and	B1

	the SAMHSA levels of integration,	
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1
Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	B1
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1
Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	B1
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination,	E5, B1

	organization, teaching, capacity building, motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	
Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN	B1, C1, E5
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1
Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	D3
Health Equity	Providers Linking Patient With	B1

	Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	
Self-Management and Recovery Training (SMART) program-	Participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	D3
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery and enhance the treatment process.	D3
Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own	D3, E5

	health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly webinars, core training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	B1, D3, E5
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	B1
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with	B1

	organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and	B1

	identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the current evidence to support the transition.	B1
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for individuals who have a mental health issue (MHI) or substance use disorder (SUD), describe the return on investment of helping patients quit smoking, discuss strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	D3
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This	D3

	includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction on all the Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills and Tracking and Reporting required.	E5
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	B1
Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

Again, the IDN QI Coach will be reaching out to practices to discuss this training component, and reach out to agencies who have not provided this information to date to create a training plan with them. The IDN QI Coach will be working on this from December 2017-December 2018, pending recruitment of the position.

Mental Health First Aid (reflected in the master training table above), will be the main training given to staff not providing direct care to ensure they have an understanding about mental disorders that can aid in recognition and management of these disorders. The QI Coach will be working with practices to establish a time and modality to deliver these trainings.

NCHC asked Region 7 IDN partners to determine how many of their non-front-line staff should be trained in knowledge and beliefs about mental disorders that can aid in recognition and management. NCHC will use Mental Health First Aid training to provide this training and it will be rolled out on a regional level, with 2 trainings being offered in 2017, and 4 training being offered in each year 2018-2020, spread throughout the region.

Members of the Multi-Disciplinary Core Team will meet monthly on behalf of patients with significant behavioral health conditions or chronic conditions. Region 7 IDN will have a total of 3 teams which will start meeting in a phased approach. Meeting dates will be determined based on the best fit for team members. NCHC staff will assist with establishing meeting dates and times, and ensures the team has all the necessary resources in place to make the meetings as successful as possible.

Carroll County Multi-disciplinary core team	Monthly starting March 2018
Coos County Multi-disciplinary core team	Monthly starting June 2018
Grafton County Multi-disciplinary core team	Monthly starting September 2018

Direct Secure Messaging:

To allow for the passing of consent-enabled information between disparate sites, IDN Region 7 will be promoting the use and deployment of direct secure messaging to all IDN participants. The HIT Assessment conducted between November of 2016 and February 2017, found that only 7 of 23 responding organizations utilized direct secure messaging for some element of data exchanged- the remainder used a manual process instead or simply did not exchange information. By making direct secure messaging a priority goal for HIT in Region 7, the IDN will ensure that a secure line of communication for all IDN participants enabling integration opportunities for all participants – including those social determinant providers that may lack the HIT infrastructure to accommodate a more robust solution. The IDN 7 Work Group will spend fall 2017 investigating accessible and best fit direct solutions to provide a recommendation to IDN participants. This recommendation will be presented to the steering committee by 12/31/2017.

This B1 project will be accomplished by phased rollout enabled through a request for proposal process. Support of use cases will be supported by the Region 7 Integration team. The sub regional implementation schedule will mirror that of the Shared Care Plan/Event Notification System (receive) Rollout, but targeting all providers who did not report utilization of direct secure messaging on the HIT

Assessment. NCHC will first focus efforts on Carroll County providers, followed by Coos County providers, and finish with providers in northern Grafton County.

Goals	
Minimum	50% (18) adoption of direct secure messaging by IDN participants by 12/31/2018.
Stretch	83% (30) adoption of direct secure messaging by IDN Participants 12/31/2018.

Closed Loop Referrals

NCHC will work with IDN partners to confirm that they have workflows in place which support a closed loop referral process, whether it be via electronic, or non-electronic means. These workflows will ensure that the referring provider has a way to track a referral, monitor the referral process, receive the consultant's report, and communicate with the patient. The IDN Quality Improvement Coach, and HIT Integration Coach will share best practices related to closed loop referrals, and assist provider practices with creating workflows to incorporate a closed loop referral process. Provider teams will decide how to measure their success by choosing from the following types of measures:

- % decrease in number of open referrals
- % increase in number of closed referrals
- % decrease in the number of days from referral created to referral sent
- % of complete summary of care records sent with referral to specialist
- % decrease # of total days from referral created to referral closed
- Provider satisfaction with the referral process
- Patient satisfaction with the referral process

The tracking of referral results can often be a barrier to the closed loop referral process, so the IDN QI coach will focus attention on this process when working with IDN partners. After the patient sees the specialist, results should be returned to the primary care office, typically in the form of a consult letter that is routed to the primary care physician. Unfortunately, if the patient fails to keep the appointment or the results of the visit are not sent to the primary care office, there is usually no obvious signal to the primary care staff that continuity of care has been broken. This failure is often not discovered until the patient returns to the primary care office for a follow-up visit or calls to find out his or her results. This inadvertently transfers the follow-up burden to the patient. In the worst case, a seriously ill patient might never contact either practice, assuming that “no news is good news.” Although there has been significant improvement in this area due to enhanced care coordination related to things like patient centered medical home models, meaningful use standards, and accountable care organizations, some patients are still falling through the cracks, and Region 7 IDN will work together to strengthen the safety net around these patients.

Most sites are using an electronic health record to assist with tracking, however, if the EHR does not have the ability to track the referral process, or a site does not have an EHR, a referral coordinator can enter pertinent data into a spreadsheet when he or she receives a patient referral form from the primary care physician. Each spreadsheet record should include at least the patient name, physician or

clinic referred to, diagnosis, and date of referral request. Once the date and time of the appointment are known, they should also be entered in the spreadsheet, along with the date and method of patient contact. Finally, there should be a column for the date the results from the specialist were received at the primary care office.

The DSRIP program stresses the importance of involving the patient in their care, and patient feedback about the referral process would be a good way to do so. NCHC will work with provider sites either implementing a new referral process, or streamlining an existing referral process, to garner patient feedback with following types of questions:

•Their ability to get an appointment when they wanted it

•Whether they were notified of the appointment in a timely manner

•How long they had to wait to see a specialist

•The suitability of the instructions they received

•Their overall experience with the specialist

Feedback from patients about their experiences with the referral process will help to identify areas where the process is still not adequately patient centered. Over time, the increased efficiency and accuracy of the referral process can lead to increased quality of care and patient satisfaction.

Documented work flows and/or protocols

Region 7 IDN Clinical workgroup is currently assessing workflows and protocols to assess best practices to include in the B1 Toolkit to ensure safe care transitions from institutional settings back to primary care, behavioral health and social support service providers. Examples of tools currently in use include Clinical Guidelines, Principles of Practice, Triage Guidelines, Standing Orders, Care Management Principles of Practice. Some agencies follow workflows associated with their EMRs and are disease specific. The Clinical Workgroup has identified SAMHSA-HRSA Center for Integrated Health Solutions, Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care Integration Playbook, Institute for Health Improvement, Advancing Integrated Mental Health Solutions (AIMS) Center, and Partners in Health Interagency Toolkit will serve as the main resources for the development of the Region 7 Core Competency Integration Toolkit. The B1 toolkit is scheduled to be completed by 10/17/2017, and the IDN QI Coach will start utilizing the toolkit at practice sites in November 2017, and continue throughout 2018 until all participating primary care and behavioral health sites have documented workflows and protocols in place. NCHC has started to collect examples of workflows and protocols in the region, and will utilize these forms as the basis for the regional toolkit which is currently being developed. The IDN QI Coach will continue reaching out to IDN partners to collect existing documents and protocols, and will work with other IDN partners to share tools from the integration toolkit.

Integrated Care Designation:

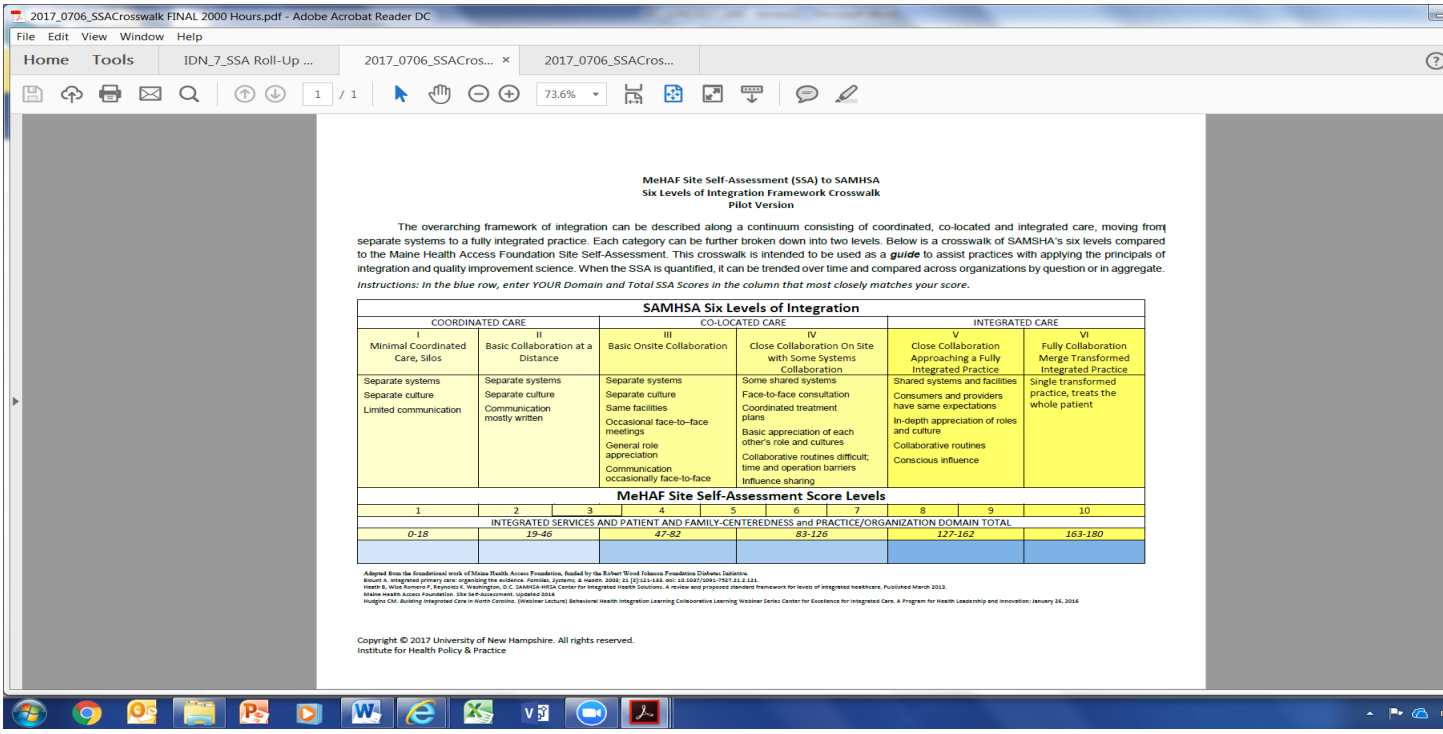
As mentioned under B1-1, Region 7 IDN contracted with Citizen Health Initiative in June 2017 to do a baseline survey of all practices to assess the level of integration at all participating practice sites and

create a plan to move sites forward along the continuum of integrated healthcare. When Region 7 IDN submitted the Project Plan in October 2016 the following organizations were identified in Table 12A:

Androscoggin Valley Hospital
White Horse Addiction Center
Ammonoosuc Community Health Services
Cottage Hospital
Rowe Community Health Center
White Mountain Community Health Center
Indian Stream Health Center
Huggins Hospital
Coos County Family Health Services
Weeks Medical Center

Since the region only chose to survey primary care and behavioral health organizations, Androscoggin Valley Hospital and Cottage Hospital were not included in the CHI level of integration survey. Additional organizations did complete the CHI survey including: Tri-County Community Action Program, Littleton Regional Hospital, and Memorial Hospital.

The image below depicts a crosswalk of SAMSHA's six levels compared of integration as compared to the Maine Health Access Foundation Site Self-Assessment. Sixteen practices completed the survey in Region 7 IDN, with an average combined score of 121 points out of a total of 180 points. The following sections of the survey scored lower than 6 out of 10 points, and will become a focus for improvements in the region: level of integration - primary care and mental/behavioral health care; patient care team for implementing integrated care; patient/family to integration management; and physician, team and staff education and training for integrated care. IDN staff will work with provider agencies to implement workflows and protocols to address these weaknesses and position practice sites to improve these scores when taking the same survey over the course of the DSRIP demonstration.



MeHAF Site Self-Assessment (SSA) to SAMHSA
Six Levels of Integration Framework Crosswalk
Pilot Version

The overarching framework of integration can be described along a continuum consisting of coordinated, co-located and integrated care, moving from separate systems to a fully integrated practice. Each category can be further broken down into two levels. Below is a crosswalk of SAMSHA's six levels compared to the Maine Health Access Foundation Site Self-Assessment. This crosswalk is intended to be used as a ***guide*** to assist practices with applying the principals of integration and quality improvement science. When the SSA is quantified, it can be trended over time and compared across organizations by question or in aggregate.

Instructions: In the blue row, enter YOUR Domain and Total SSA Scores in the column that most closely matches your score.

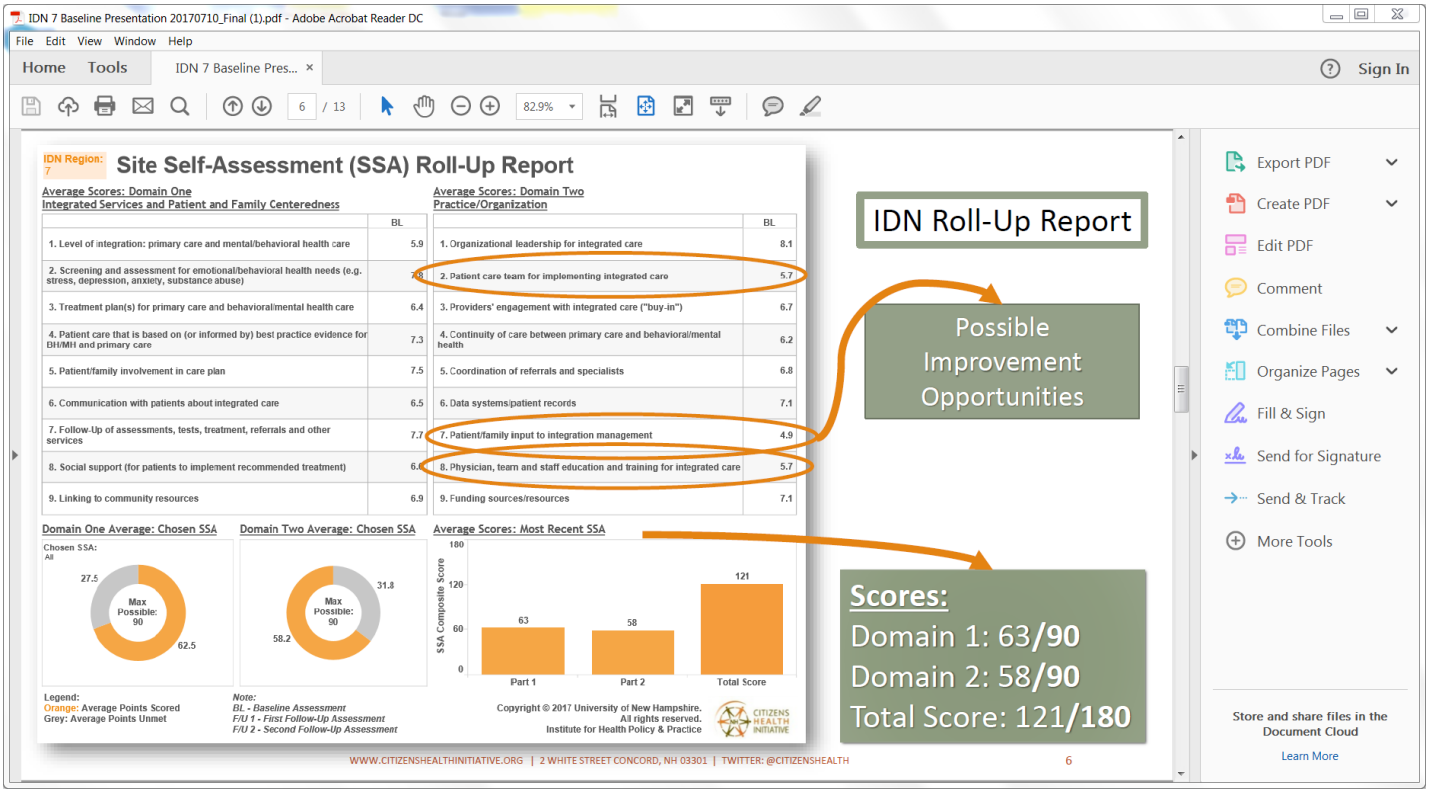
SAMHSA Six Levels of Integration					
COORDINATED CARE		CO-LOCATED CARE		INTEGRATED CARE	
I Minimal Coordinated Care, Silos	II Basic Collaboration at a Distance	III Basic Onsite Collaboration	IV Close Collaboration On Site with Some Systems Collaboration	V Close Collaboration Approaching a Fully Integrated Practice	VI Fully Collaboration Merge Transformed Integrated Practice
Separate systems Separate culture Limited communication	Separate systems Separate culture Communication mostly written	Separate systems Separate culture Same facilities Occasional face-to–face meetings General role appreciation Communication occasionally face-to-face	Some shared systems Face-to-face consultation Coordinated treatment plans Basic appreciation of each other's role and cultures Collaborative routines difficult; time and operation barriers Influence sharing	Shared systems and facilities Consumers and providers have same expectations In-depth appreciation of roles and culture Collaborative routines Conscious influence	Single transformed practice, treats the whole patient

MeHAF Site Self-Assessment Score Levels									
1	2	3	4	5	6	7	8	9	10
INTEGRATED SERVICES AND PATIENT AND FAMILY-CENTEREDNESS and PRACTICE/ORGANIZATION DOMAIN TOTAL									
0-18	*19-46*		*47-82*		*83-126*		*127-162*		*163-180*

Adapted from the foundational work of Maine Health Access Foundation, funded by the Robert Wood Johnson Foundation Diabetes Initiative.
Blount A. Integrated primary care: organizing the evidence. *Families, Systems, & Health*. 2003; 21 (2):121-133. doi: 10.1037/1091-7527.21.2.121.
Heath B, Wise Romero P, Reynolds K. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. A review and proposed standard framework for levels of integrated healthcare. Published March 2013.
Maine Health Access Foundation. Site Self-Assessment. Updated 2016
Hudgins CM. *Building Integrated Care in North Carolina*. (Webinar Lecture) Behavioral Health Integration Learning Collaborative Learning Webinar Series Center for Excellence for Integrated Care. A Program for Health Leadership and Innovation; January 26, 2016

MeHAF Site Self Assessment (SSA) to SAMHSA Six Levels of Integration Framework Crosswalk

Region 7 IDN had an average composite score of 121 points out of 180 points, which according to the crosswalk, is a level 4 on the Six Levels of Integration. Region 7 has many agencies that have either already achieved patient centered medical home status, or are in the process of working toward the designation, which positions these organizations to be in the process of moving along the continuum of integrated healthcare. Based on feedback from CHI, we anticipate that once the IDN QI Coach starts to work with some of these agencies it is anticipated that these scores may decrease at first, once staff fully identifies with the needs of the IDN. Each practice site has a report like the one below, and the IDN QI Coach will work with the practices to help them make a coaching plan on how to improve their scores and advance along the continuum of integrated healthcare.



Region 7 IDN CHI Integration Survey Roll-Up

The IDN Clinical workgroup is currently assessing workflows and protocols to assess best practices to include in B1 Toolkit. The toolkit will include MAT best practices and protocols related to evidence-based treatment of mild-to-moderate depression within an integrated practice setting. Region 7 IDN Staff has been working to get protocols from sites, but currently hasn't received examples to include in the implementation plan. Once the IDN QI Coach gets hired, their first role will be to reach out to individual sites to continue assessing protocols in place, and create a plan to get new ones incorporated as necessary. This work will start in late fall 2017 and continue into 2018. In addition, the Clinical workgroup is working in conjunction with Data workgroup to assess level of technology at participating provider sites, and the capabilities of this technology to identify patients at risk, plan care, monitor/manage patient progress towards goals, and have a closed loop referral process. The plan to do this is below:

Provider List		**Process Details**			
Provider	**Provider Type**	**Identify At Risk Patients**	**Plan Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018

White Mountain Community Health Center	Non-FQHC Community Health Partner	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Memorial Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Huggins Hospital	Primary Care Practice; Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Life Coping, Inc.	Community-based	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Saco River Medical Group	Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
White Horse Addiction Center	Addiction & Recovery	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Carroll County	County Corrections	Region will pilot	Targeted for	Targeted for rollout	Targeted for

Department of Corrections	Facility	use of data aggregator to perform population health tasks by 12/31/2018	rollout of CMT PreManage 03/01/2018	of CMT PreManage 03/01/2018	rollout of CMT PreManage 03/01/2018
Androscoggin Valley Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Coos County Family Health Services	Federally Qualified Health Center (FQHC)	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Upper Connecticut Valley Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	Region will pilot use of data aggregator to perform population health tasks by	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018

		12/31/2018			
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
Cottage Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
Rowe Health Center	Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
North Country Health Consortium	Substance Use Disorder Treatment (After 10/01/2017	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018

The IDN Clinical workgroup is currently assessing workflows and protocols to assess best practices to include in B1 Toolkit. Practices within Region 7 IDN have been asked if they have these protocols in place, and currently none of them have been able to identify any written protocols related to this. Again, the IDN QI Coach will be working with site starting in late fall of 2017, and continuing into 2018 to get these protocols in place, using tools from the B1 toolkit.

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

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

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated	12	0			

Care Practice					
Integrated Care Practice	8	0			

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	Saco River White Mountain Community Health Rowe LRH Whitehorse Huggins ISHC ACHS Memorial Weeks Northern Human Services Coos County Family Health Services Friendship House			

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	ISHC ACHS Memorial Weeks			

	CCFHS NHS Friendship House White Mountain Community Health Center			

In the original project plan submission, 12 agencies were represented in table 12A. Currently we have 12 sites in Region 7 working toward coordinated care, although some differ from the original plan. Originally, 4 agencies were identified as working toward integrated care; currently 8 are in this category since new sites have established MAT services.

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

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

Care Transitions

Workforce Plan including staffing, recruitment and retention strategies

Critical Time Intervention (CTI) will provide Region 7 with an evidence based practice that will address clients/patients whose needs are complex, who struggle with transition, and often end up cycling in and out of emergency, hospitalization and corrections systems. Addressing this population is a priority for Region 7 partners. The ability to utilize IDN funds to incentivize hiring for CTI workers is critical to implementing this program. The proposed workforce will include those case management staff already employed by partners and new hires. Partners will have a much broader base to hire from because this position does not require the credentialing and clinical experience needed for clinical staffing. Also the inclusion of peer CTI workers will not only broaden the services that are provided but again increase the number of people eligible to take on this role. Hiring from a regional perspective will enable the program as local candidates will have local experience with resources.

The common thread throughout Region 7's projects is preventing patients from "falling through the cracks" and revolving in and out of more intensive services. Transitioning patients through the maze of care services is a central theme to all of Region 7's plans. This provides us the opportunity for cross training of care management staff who may be providing services and care under any of the three regional projects. As outlined in the timeline and training plan, CTI trainings are scheduled out over time to build the workforce as the program develops. This will make the launch of the program more manageable and it allows for time to measure and respond to the implementation process before hiring/training of new CTI workers. It is believed that this will result in a more successful start-up of the program.

Retention of staff is dependent on multiple factors including adequate training, opportunities for advancement and professional development, personal satisfaction, workers feeling competent and valued, strong supervision and the opportunity to share experiences with peers.

A retention plan will be built into the roles and responsibilities of both workers and supervisors of this program and will include, but not limited to:

- A robust training program that equips workers with the necessary tools and soft skills to effectively serve a more complex patient;
- Ongoing complimentary training and professional development to learn new skills;
- Strong supervision that guides, receives input from CTI workers, provides problem solving expertise and processes experiences that could lead to worker burnout;

The implementation of a Learning Collaborative inclusive of all 5 IDN Regions participating in the CTI project, guided by an expert from The Center for Advancement for Critical Time Intervention (CACTI), that will meet monthly via technology and quarterly in person to provide guidance and direction and help CTI workers to hone skills and have access to the latest evidence based practices;

A technical assistance one-on-one mentoring program that connects supervisors and CTI workers to a CTI professional provided by CACTI;

A focused vision of the program that is clearly communicated to all intersecting providers and social service partners. Everyone on the same page and moving in the same direction, eliminating the delay in services and redundant services;

Sharing of accomplishments and milestones on both a micro and macro level.

Projected annual client volumes: Each CTI worker will be able to engage up to 5 patients at a time, and Region 7 IDN is proposing 2 CTI workers per team. Following this model, and using a phased approach, based on organization's participation, Region 7 IDN is anticipating engaging with 120 clients by the end of 2018, and as the program expands to other organizations, grow so the region will serve 500 patients by the end of 2020.

Key organizational, provider/participants

Region 7 partners who have made the initial commitment to the CTI program include Tri County Cap, and Carroll County Corrections. In addition, Northern Human Services (NHS), and Memorial Hospital, are working to build this program into their future plans and proposals. With the interest expressed we are confident in adequate participation in the program.

Staff Name	Job Title	Organization	Region
TBD	Supportive Housing Care Coordinator	Tri-County Cap	All Regions
TBD	Case Manager	Carroll County Corrections	Carroll County Region
TBD	Outreach Worker	Tri-County Cap	All Regions
TBD	Case Manager	Northern Human Services	All Regions
TBD	Outreach Worker	Tri-County Cap	All regions
TBD	Supportive Housing Care Supervisor	Tri-County Cap	Coos County
TBD	Case Manager	Northern Human Services	All Regions
TBD	Case Manager	Northern Human Services	All Regions
TBD	Case Manager	Northern Human Services	All Regions
TBD	Care Coordinator	Memorial Hospital	Carroll County
TBD	Care Coordinator	Weeks Hospital	Coos County
TBD	Case Management Supervisor	Carroll County Corrections	Carroll County
TBD	Outreach Worker	Tri County Cap	All Regions

TBD	Peer Support Specialist	Tri County Cap	All Regions
TBD	Peer Support Specialist	Tri County Cap	All Regions
TBD	Case Manager	Carroll County Corrections	Carroll County
TBD	Case Manager	Northern Human Services	Grafton County

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

Eligible individuals are those Medicaid eligible adults who have a primary diagnosis of serious and persistent mental illness/serious mental illness (SPMI/SMI) and are not already connected to community based care that is meeting their clinical needs. In addition, the individual needs to be at risk in a minimum of 3 out of 7 categories; homelessness, lack of natural supports, activities of daily living, basic needs such as healthcare, food, transportation, inability to manage money, substance use, employment. Individuals must also be experiencing a critical transition without connection to community or clinical supports. Examples of a critical transition are discharge from New Hampshire Hospital or Transitional Living; completion of incarceration or transitioning in or out of homelessness.

Clients can be referred to the program by anyone, including family, social service providers, jails, crisis services, medical or mental health providers. There is a no wrong door approach throughout all Region 7's plans. Region 7 will be utilizing the Sequential Intercept Model, a framework created and used in the interface of criminal justice and mental health to identify points of interception at which intervention can be made to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Utilizing the Sequential Intercept Model, we will develop a similar model to illustrate the points of interception as relates to individuals in need of CTI services. This model will be used throughout the Regional 7 projects. Providing opportunity to connect applicable clients to this program is critical. The no wrong door policy helps to address the challenge of connecting those individuals who are not connected to supports and services that can help them. This is about doing all that can be done to facilitate a connecting process to find and engage those that live under the radar expect when accessing emergency services. Written protocols for identification, The Sequential Intercept Model and A Referral/Consent form will be available in the C1 Toolkit.

An Assessment is required to enter the program. This can be a comprehensive clinical assessment that had been completed within the previous 12 months and is available, or a licensed CTI Worker will complete an abbreviated assessment. This assessment process is part of building the Standardized Transition Care Plan.

The Abbreviated Assessment includes:

- The individual's presenting problem
- The individual's needs and strengths;

- An admitting diagnosis (determination of diagnosis will be done within 30days of start of program)
- Social, family and medical history;
- Any evaluation/assessment that is pertinent such as psychiatric, substance use, medical.

The Abbreviated Assessment forms will be included in the C1 Toolkit.

Upon determining that the client meets eligibility, the CTI Provider will develop a Phase Plan with the client. CTI goals need to be simple and no more than three and inclusive of the client's input. In addition, the CTI worker will assist the client in the creation of a crisis plan, and then distribute that plan to all key partners with the client's consent. The Phase Plan and the Crisis Plan will both be included in the C1 Toolkit.

Standardized Care Transition Plan

Once a client has been approved for the CTI program and a CTI worker has been assigned, Pre-CTI services begin. Optimally this is up to 10 hours that is spent with the client as they prepare for their transition. This time allows them to form a relationship with the worker and establish goals.

Phase 1: Transition to the Community- First 3-month phase

- Assessment of client's health needs
- Assessment of client's social and natural supports
- Creation of Individualized Service Plan
- Frequent contact with the client in the community
- Active engagement with Behavioral Health Services
- Assessment of housing related issues

CTI Worker Activities to include: home (or location of the client) visits, introductions to supports and providers, negotiating ground rules for interaction, conflict management, addressing urgent needs (medical, food, etc.)

Phase 2: Try Out – Second 3-month phase

- Connection to Community Support Services
- Support of client's developing support system
- Working on Problem solving skills
- Supporting client in independent activities

CTI Worker Activities: monitors network of support for adjustments, home and community visits, provide psychoeducation, builds on successful activities, completion of any unfinished Phase 1 activities, assist client with application for needed benefits and services, crisis interventions, on-going problem solving, introduction to vocational services.

- Phase 3: Transfer of Care- Third 3-month phase
- Promotion of transfer of support from CTI to formalized treatment and community supports
- Promotion of transfer of support to natural supports
- CTI worker remains available to monitor and collaborate with client and supports

Activities: Consultation to client, support of client's own problem solving, facilitation of relationships and communication between caregivers and providers as a basis for a long term support plan, plans are developed with client for longer term goals such as education, housing, employment, celebration and recognition of completion of the 9 month program.

At the conclusion of the program the CTI Worker completes the CTI Closing Note with the client. This document goes through questions regarding initial risk assessment, barriers that were overcome, a summary of the CTI interventions, how CTI impacted the client, and other topics the client wishes to discuss. The Case Worker then completes the CTI Implementation Self-Assessment form which provides a look back at the previous 9 months and provides a basis for self-examination. This completed self-assessment will be part of the CTI worker's review with supervision and discussion in the Learning Collaborative. The CTI worker Self-Assessment tool and CTI Closing Note will be included in the C1 Toolkit. All protocols for the Standardized Care Transition Plan will be part of the training curricula.

CTI Case Worker Guidelines

The majority of time spent with the client will be in the community where the client and CTI worker is most comfortable
The individual receiving CTI services selects the goals to meet
The number of contacts is tailored to the client's needs, but expected to taper as the program moves through the stages

In Phase 1

- Minimum of 6 community –based meetings per month, with a total of 18 for phase 1. Out of the 18 2 meetings must be inclusive of the client's provider and informal supports

In Phase 2

- Minimum of 2 community-based meetings per month (total 6); again 2 must be with the client's provider or informal supports. Phone/text communication will increase

In Phase 3

- Responsibilities are transferred to the client and any formal or informal caregivers. Minimum of 2 community-based meetings for the entire phase. The majority of communication is by phone.
- The services end either at the conclusion of phase 3; when the client no longer wishes to participate and there are no safety issues or concerns, or client is in need of a higher level of care and has been disconnected from the service. Caseload maximum is 20 clients, although that is only if they are phased in and do not all start the program at the same time. The CTI Case Worker and CTI Peer Support Specialist both report to the Clinical Supervisor.

The CTI Worker Guidelines will be included in the C1 Toolkit

Roles and Responsibilities for CTI Team Members

All Team members will have completed the Critical Time Intervention training provided by a certified Trainer. Supervisors will have completed the Supervisors training in addition to the standard CTI Training. A CTI Team should be a minimum of two full time equivalent positions (2 FTE) with one position in the role of Fieldwork Coordinator/ Clinical Supervisor. Maximum caseload for a fulltime Supervisor would be 10 clients. Recommended caseload for a fulltime CTI Worker is 20 clients.

Admissions to the program should be staggered to assure a caseload that is balanced between all three phases.

Supervisors Role:

- provide supervision, clinical guidance, feedback and training to team members;
- assure quality services are being provided;
- assure all team members are maintaining the fidelity to the evidence-based program;
- share strategies and problem-solving techniques for overcoming obstacles;
- maintain documentation;
- completion of the CTI Caseload Review Form- Completed every 2 weeks to review current active CTI clients;
- completion of CIT Team Supervision Form- Completed every week during team supervision to document more in-depth discussion;
- oversight of the completion and current status of the CTI Phase –Date Form. This form is used as a reference, it includes a list of clients with the specific case worker that is assigned to them, including dates of starting pre-CTI, Phase 1, Phase 2 and Phase 3, and ending CTI. It also tracks the reason for the program to conclude.

Supervisor's Responsibilities

- Supervise CTI Team
- Coordinate and provide oversight of initial and ongoing assessment activities
- Monitor quality indicators and respond appropriately
- Ensure compliance with all local, state and federal requirements, policies and procedures
- Train Staff
- Coach Staff
- Produce accurate documentation of services and service planning
- Produce required reporting

CTI Worker and Peer Support Specialist Role Responsibilities:

- Provide Critical Time Intervention Services that meet the quality, performance and fidelity measures of the program.
- Meet the needs of the persons served and other stakeholders
- Be part of a therapeutic team
- Develop and maintain positive and constructive working relationships with community stakeholders, consumers of services and their families.
- Engage and enroll individuals who meet the criteria for CTI
- Be the primary contact person for up to 20 clients/families
- Assist clients in navigating resources to obtain benefits such as SSI/SSDI, Medicaid, food stamps
- Encourage clients to engage in integrated services that provide support for mental health, substance use disorders.
- Provide access or referral to recovery support services
- Be the liaison to community/state agencies that can provide services to the client
- Assist clients in addressing unaddressed needs such as education, housing, and medical
- Maintain client files, including reports, case files and case notes

- Work as part of the CTI team to help remove barriers to care and services within the community
- Additional/Ongoing Training required - within 90 days and on an annual basis all CTI staff are required to complete an additional 3 hours of training. Training topics include:
- Crisis Response
- Person centered thinking
- Introduction to Motivational interviewing
- Mental health/substance use 101
- Suicide Prevention
- WRAP- Wellness Recovery Action Plan

Roles and Responsibilities of all CTI Team Members, the CTI Caseload Review Form, the CIT Team Supervision Form, and the CTI Phase –Date Form will all be included in the C1 Toolkit.

Training Plan

The Region 7 IDN plan for CTI program implementation is inclusive of recruitment, training, implementation, oversight and evaluation processes. Eligible organizations will recruit internal or external candidates that meet the criteria for a CTI worker. CTI positions to be filled include a Fieldwork Coordinator/Clinical Supervisor, who has a least 2 years of experience with the population to be served and CTI Workers who may be Alcohol/Mental Health professionals, licensed or paraprofessional staff. Optional is a Peer Support Specialist with a min of two years working with the mental health population. The CTI team must be a minimum of 2, and recommended maximum of 5. CTI team members do not need to be located at the same organization, teams will be developed in 3 regions; Northern Grafton; Carroll County and Coos County.

Partnering with 4 other state IDN regions an initial statewide CTI training will be held in November 2017. Statewide CTI Supervisor training will be held within 6 weeks following the initial training, it is mandatory that all supervisors take the CTI worker training. A second round of statewide CTI worker training will be held in February 2018. A Train-the-Trainer training will be held at the end of the first 9-month cycle of the program, in August 2018. A Technical Assistance/Mentoring schedule will provide guidance and assure fidelity to the program. In addition, a Learning Collaborative will be formed that is inclusive of all statewide CTI program staff. The Learning Collaborative will meet monthly via remote technology and quarterly in person. All training, Technical Assistance/Mentoring and Learning Collaborative leadership will be provided by National CTI experts from (CACTI) The Center for Advancement of Critical Time Intervention.

Training Curricula

Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases, and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement and maintain fidelity.

Agreements with collaborating organizations

Placing the emphasis on collaboration, agreement templates will be provided to Region 7 partners as part of the C1 Toolkit. These agreements will cover collaborations between Region 7 partners, and between Region 7 partners and outside organizations that are not part of the Region 7 IDN but that do provide needed services or are referral agencies. An example of this would be an agreement drafted between a Region 7 partner CTI program and New Hampshire Hospital. This agreement would outline the roles and responsibilities of each organization and be part of the client's discharge plan. Those Region 7 partners that are participating in the CTI program will need to outreach to any potential referral agency or service provider to introduce the program and develop protocols for referrals.

Monitoring Plan

Organizations implementing Critical Time Intervention (CTI) will be required to monitor and report to the IDN Lead agency on a regular basis. Specific monitoring activities will include:

1) Tracking activities to monitor implementation and participation in activities.

2) Targeted qualitative methods (eg. semi-structured interviews) to understand how the project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively.

3) Review of available outcomes data related to the region to understand progress in population health. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data.

Measurement plan

The measurement plan for Region 7 provides information about collection data for each primary objective.

	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Provide adults with serious mental illness with effective transitions of care	50% of identified patients complete CTI	Patient Care Plan Template	Participating organizations complete tracking tool	Quarterly	IDN Program Manager
	50% of identified patients integrated into community	Patient Care Plan Template	Participating organizations complete tracking tool	Quarterly	IDN Program Manager

	services				
	75% of participating individuals and families provide feedback, eg..satisfaction	Program Survey	On-line survey program	Annually	IDN Program Manager
	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Provide IDN partner organizations with design and development of infrastructure to implement CTI model	Agreements in place between collaborating organizations	Program Documents	Signed agreements	Quarterly	IDN Program Manager
	75% of staff in identified organizations trained in CTI	Program Documents	Completed training of care managers Supervisors identified	Quarterly	IDN Program Manager & Northern New Hampshire AHEC
	Secured messaging in place for participating organizations	Patient care plan template	Participating organizations provide feedback and revisions for efficient template	Quarterly	IDN Program Manager & IT Manager
	CTI model is implemented with fidelity Participating	Program Documents	IDN Tracking Tool	Quarterly	IDN Program Manager

Throughout the Region 7 projects, services will function within sub –regions. These sub-regions will be primarily Carroll County, Coos County and Northern Grafton County. Because of the large geographic area that providers in the north need to cover and the limited resources and workforce, it is believed that this model will work the best for this region. The structure for building the CTI program is based upon the idea of centralized supervision in all three areas. CTI workers can be deployed from any organization, but all will report to this central supervision entity. For example, the Fieldwork Supervisor could be employed by Tri-County CAP and the CTI workers could be employed by Northern Human Services or Littleton Hospital. All would operate within the Northern Grafton County area. Working within these communities, CIT worker will become experts in their regions resources and serve as connections for service organizations and other Region 7 partners and projects.

Throughout all three regional project plans there are multiple common threads. The first is the recognition that there is a continuum of care needed. Regional projects, including C1 will grow, guided by the continuum of care stages; Prevention, Early Intervention, Treatment and Recovery Support Services. Sub-regions will offer parallel programming to the priority Medicaid population across the lifespan. In addition, an overarching framework called 3-Pronged Approach, which outlines the principles of integrated care, will direct all program structure and movement and provide a solid base for sustainable truly integrated care. 3-Pronged Approach is described in B1 and addressed within the other two regional projects.

The C1 Toolkit in conjunction with professional training and the on-going Learning Collaborative builds a strong base for this project. Protocols and operating policies will continue to be refined through input from the Learning Collaborative and the expert input from CACTI. These protocols and operating policies will be reviewed and updated at a minimum of annually, and the updates and changes will be shared with the other CTI Regions.

With Region 7 taking the lead, all five IDN regions that are participating in this project have been working together since January 2017. Accomplishments of this cross regional team include extensive research on CTI, outreach and engagement with CACTI and Dr. Daniel Herman, a statewide CTI Kickoff with 75 in attendance with all regions represented and the negotiation of the contract with CACTI for professional training and technical assistance/mentoring. The plan is to continue to work side by side with the other IDN regions and build on the good work already accomplished.

C-2. IDN Community Project: Evaluation Project Targets

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of individuals served by CTI	120 by 2018			
# of partner organizations implementing CTI	3 by 2018			
# of CTI workers positioned in Region 7 IDN	15 by 2018			

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
CTI Workers	15 by 2018	0			
CTI Field Work Coordinator/clinical supervisor	3 by 2018	0			

C-4. IDN Community Project: Budget

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

Budget Period: 01/01/2017-12/31/2020
Care Transitions

Line Item	Direct Incremental	Indirect Fixed	Total	NOTES:
1. Total Salary/Wages	$ 300,975	$ 41,234	$ 342,209	**YR2-YR5**: Portion of Program Manager, HIT Lead, Data Specialist
2. Employee Benefits	$ 60,195	$ 8,247	$ 68,442	Benefits calculated at 20% of Salary
3. Consultants				
5. Supplies:				
Educational				
Office	$ 8,498	$ 1,164	$ 9,662	**YR2-YR5:** Org.-Wide Office Supply Allocation
6. Travel				
7. Occupancy				
8. Current Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	$ 3,333	$ 457	$ 3,790	**YR2-YR5:** Proposal Software
10. Marketing/Communications	$ 4,007	$ 549	$ 4,556	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$ 15,000	$ 2,055	$ 17,055	

12. Subcontracts/Agreements				
13. Other (specific details mandatory):				
Current Expenses: Administrative Lead Organizational Support	$ 15,747	$ 2,157	$ 17,904	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$ 747,332	.	$ 747,332	**YR2-YR5**: Personnel/Supplies/Travel/Software/Mrktg/ Training
TOTAL	**$ 1,155,087**	**$ 55,862**	**$ 1,210,950**	

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

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

Organization/Provider	Agreement Executed (Y/N)
Tri- County Cap	N
Carroll County Corrections	N
Northern Human Services	N
Memorial Hospital	N

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.

Standard Assessment Tool Name	Brief Description
Abbreviated Assessment	Only required if client has not had a comprehensive clinical assessment within the previous 12 months, contains basic assessment information.

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.

Protocol Name	Brief Description	Use (Current/Under development)
Identification	Criteria to identify	Under Development, will be completed by November, 2017
Sequential Intercept Model	Illustrated flow chart of points of interception with potential clients	Under Development, will be completed by November, 2017
Referral/Consent Form	Protocol for referring clients to the CTI program and obtaining client consent	Under Development, will be completed by November, 2017
Phase Plan	Outlines Client goals, is created with client input	Under Development will be completed by November, 2017
Standardized Care Transition Plan (Treatment Protocol)	Outline of processes and actions for all three phases of the CTI model; Transition to the Community, Try Out & Transfer of Care	Is completed
Crisis Plan	Actions to be taken, and contacts to be made if there is a client crisis	Under Development, will be completed by November, 2017
CTI Closing Note	Summary of interventions, impact on client, closing status, next steps and recommendations.	Under Development will be completed by November, 2017

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

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

Project Team Member	Roles and Responsibilities
CTI Worker	To initiate contact with client; be the primary contact person for up to 20 clients, provide access or referral to recovery support services; assist clients in navigating resources and obtaining additional benefits; maintain client files follow CTI Worker guidelines that Includes location of time spent with client; goals setting process, minimum of client meetings per phase. Follow all of the pre-determined steps of the CTI model and meet all of the required Supervision and Documentation requirements. Provide CTI services that meet the quality, performance and fidelity methods of the program, meet the needs of the client and the stakeholders, develop and maintain constructive working relationships with the community.
CTI Supervisor	Provide supervision, assure quality of all services provided, assure all team members are maintaining fidelity to the program, share strategies and problem-solving techniques, maintain documentation, complete CTI Caseload Review form and CTI Supervision forms, oversee the status and completion of the CTI cycle.

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

The Region 7 IDN plan for CTI program implementation is inclusive of recruitment, training, implementation, oversight and evaluation processes. Eligible organizations will recruit internal or external candidates that meet the criteria for a CTI worker. CTI positions to be filled include a Fieldwork Coordinator/Clinical Supervisor, who has a least 2 years of experience with the population to be served and CTI Workers who may be Alcohol/Mental Health professionals, licensed or paraprofessional staff. Optional is a Peer Support Specialist with a min of two years working with the mental health population. The CTI team must be a minimum of 2, and recommended maximum of 5. CTI team members do not need to be located at the same organization, teams will be developed in 3 regions; Northern Grafton; Carroll County and Coos County.

Partnering with 4 other state IDN regions an initial statewide CTI training will be held in November 2017. Statewide CTI Supervisor training will be held within 6 weeks following the initial training, it is mandatory that all supervisors take the CTI worker training. A second round of statewide CTI worker training will be held in February 2018. A Train-the-Trainer training will be held at the end of the first 9-month cycle of the program, in August 2018. A Technical Assistance/Mentoring schedule will provide guidance and assure fidelity to the program. In addition, a Learning Collaborative will be formed that is inclusive of all statewide CTI program staff. The Learning Collaborative will meet monthly via remote technology and quarterly in person. All training, Technical Assistance/Mentoring and Learning Collaborative leadership will be provided by National CTI experts from (CACTI) The Center for Advancement of Critical Time Intervention.

Training Curricula

Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases, and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement and maintain fidelity.

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

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

For the project with required focus on substance use, Region 7 has chosen D3; Expansion of intensive SUD Treatment Options, including partial-hospital, and residential care. Partners felt this project was a priority based on statistical data that showed an overwhelming need to increase substance use disorder treatment services in the region. Currently there is only one residential Substance Use Disorder (SUD) treatment provider in Region 7. As part of Tri County Community Action Program (TCCAP), Inc. Division of Alcohol and Other Drug (AoD), Friendship House provides person-centered, community based substance use disorder treatment. Current services include Recovery Support Services (RSS), Outpatient (OP), Intensive Outpatient services (IOP) and an impaired Driver Care Management Program. Priority

placement is given to Pregnant Women, Women with dependent children, IV drug users and any individual affected by HEP-C or HIV. Note: Plans are currently in place to transition AoD programs from TCCAP to the North Country Health Consortium by October 2017.

The 30 licensed treatment beds are split between the high and low intensity residential program, with a length of stay typically 28 days for High Intensity and 90 days for the Low Intensity. Friendship House provides services to all of Coos, Northern Grafton and Carroll Counties. To access treatment services, potential clients first receive a telephone screening within 2 days of initial contact, followed by a face to face substance use evaluation that includes social history, medical history, legal history and family history fully utilizing the Addiction Severity Index (ASI) assessment toll, DSM V and American Society of Addiction Medicine (ASAM) placement criteria tools. Assessment tools include: Mental Health Screening Form with follow up on mental health screening flags for anxiety, social phobia, PTSD, Mood Disorder and Depression. MAST- Michigan Drug Screening Test, Stages of Readiness and Treatment Eagerness Scale (SOCRATES 8D); and "Addiction Evaluation" ASI Addiction.

The Low Intensity Treatment Program has the capacity to serve 20 individuals annually. Programming includes case management, self-help and peer recovery groups, opportunities to obtain a GED, help seeking permanent housing, Vocational Rehabilitation and permanent employment. Evidence-Based Practices are utilized including: Cognitive Behavioral Therapy, Motivational Interviewing, MATRS Treatment Planning (Measurable, Attainable, Time-Limited, realistic and Specific), Living in Balance Curriculum, Key Components of Prime Solutions, and the Matrix Model Curriculums. 12 step programs are also available. The High Intensity Residential Treatment program has an enhanced treatment component to serve individuals with co-occurring substance use and mental health disorders. The program provides educational classes focusing on the fundamentals of the onset, progression and neurochemistry of addiction, stress coping skills, relapse prevention, anger management, states of change, and self-soothing skills. In addition, individuals participate in group therapy focused on skills needed to live a sober lifestyle; family therapy; Art therapy; meditation techniques; and outdoor activities for stress management. Friendship House takes a multidisciplinary clinical team approach; with written consent Friendship House invites all key stakeholders, which may include a Primary Care Physician, Mental Health, Legal, Faith or a Medication Assisted treatment provider, to be actively involved as a member of the multidisciplinary team. Friendship House also provides concurrent tobacco use disorder treatment. Clients have access to Recovery Support Services through peer recovery coaches, any time before, during or after the treatment process. Outpatient counseling services for substance use disorders are also provided. At the time of this plan submission, expansion of IOP services into the Tamworth and Berlin areas are being examined.

Friendship House will be breaking ground on a new facility in 2017. The proposed 18,500 square foot, energy efficient, 32 bed facility, includes four single occupancy rooms with integral bathrooms that may serve as a Detoxification Unit. This allows for expansion of SUD treatment services within the next several years. Additional services that may be offered in the future, in the new facility include: ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services. Medically monitored inpatient detoxification program will provide 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal. The primary emphasis will be on ensuring that the patient is medically stable. At this level of care a Physician will be available 24 hours per day by phone and a Nurse will be present to administer an initial assessment and monitor the patient's progress on an hourly basis. Once patients are stabilized they will be transferred into the appropriate treatment program for their substance use, mental health or co-occurring disorder.

In the first round of Region 7 IDN funding the focus was on capacity building. In addition to Friendship House expansion, there are many other initiatives in Region 7 that are in various stages of expansion and welcome IDN funding to move forward their plans. The first round of IDN funding has begun the process of building and expanding the SUD programming and supports needed in the Region.

In **Carroll County**, Carroll County Corrections is eager to expand on the innovative recovery and support programs they have initiated at the jail. They have hired a Community Based Clinician to build linkages from the criminal justice system to the community to promote a coordinated response to the needs of those with mental health, SUD and co-occurring disorders. White Horse provides walk-in substance use disorder treatment for men and women who are ages 18 or older. Individuals can receive individual and/or group therapy or enter the Intensive Outpatient Program. Recovery Support Services are provided through Recovery Coaches and Certified Recovery Support Workers for peer to peer support and/or care plan assistance. Memorial Hospital is increasing behavioral health capacity with the addition of a Behavioral Health Advanced Practice RN. Education has begun for staff in managing behavioral health issues, and understanding resources and referral options. Capacity building funds went to support the ongoing expansion of the New Life program for pregnant women who present with a Substance Use Disorder. Services include OB/Midwifery care, MAT, group addiction therapy, peer support, social worker services and education. Huggins Hospital is utilizing funding to hire a licensed social worker, LICSW, to provide behavioral health expertise to primary care. A woman's sober living facility is soon to open-Mount Washington Valley (MWV) Recovery has built positive, collaborative relationships with providers across the spectrum of care, including the Carrol County Corrections program and area Social Service organizations. The community support for this initiative is strong and local businesses and citizens have donated time, funding, building materials and furnishings to support this endeavor. In addition to sober living this facility offers multiple peer recovery programs including Art and 12 Step. There is a resource center available by phone or walk in. This is a model to be replicated across the region.

In **Coos County** the capacity building funds that went to Coos County Family Health Services are supporting ongoing integrated health efforts through the addition of a Behavioral Health Assistant who is providing clinical support, care coordination and outreach services for patients with substance use and mental health disorders. Androscoggin Valley Hospital is adding a Community Nurse Care Coordinator who will work with substance use providers at both the hospital and Coos County Family Health Services (inpatient to outpatient) and work with patients on healthcare needs, social services and substance use recovery resources. Upper Connecticut Valley Hospital has invested in telehealth equipment to be able to provide timely behavioral health treatment. Weeks Medical Center which includes a hospital and a rural health clinic, is leading the region by rolling out a MAT program that once developed can then be expanded to other affiliate facilities. Their future plans are to expand the MAT program to a comprehensive pain management program and hire a mental health case manager.

In **Northern Grafton County,** Cottage Hospital has utilized funding to hire a behavioral health APRN and consultation time from a Psychiatrist to aid in an overall behavioral health plan for the hospital. Northern Human Services (NHS) has a large role in this project as the Community Mental Health Center covering the top third of the state, including all of Region 7 and making it a central organization in this initiative. They provide professional support and services to people affected by mental illness, developmental disabilities, substance abuse, acquired brain injury or related disorders. The organization serves residents of Coos, Carroll and Grafton counties, and has facilities in Colebrook, Littleton, Berlin, Conway and Wolfeboro. The first round of funding has supported NHS in building IT capacity so as to utilize video technology to integrate behavioral health and substance use treatment into Primary Care. Capacity funds also supported focus on workforce development and retention by offering opportunities

for professional development, increased educational opportunities including obtaining needed CEUS, and a focus on the "Grow our Own" Program for LADC and MLADCs. "Grow our Own" is a regional movement that encourages students, on-the-job trainees, and current staff to build a career while living and/or working locally. The program is about the employer investing in local people by providing opportunities for professional development, training, mentoring and motivation. NHS also has numerous other initiatives that foster prevention and early intervention and serve clients across the lifespan and are motivated to expand these to make them accessible to more locations in Region 7. These include the Infant Mental Health program that targets pregnant woman with substance use and/or mental health issues and provides evidence based services through the birth until the child is 6 years old. This program is a collaborative effort that is inclusive of community resources and primary care. MATCH (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems) is an evidence-based treatment designed for children ages 6 - 15. Unlike most treatment approaches that focus on single disorders, MATCH is designed to treat four common behavioral health concerns among children, including anxiety, depression, posttraumatic stress, and behavior problems. NHS also offers the Referral Education Assistance and Prevention (REAP) program that provides outreach to those older adults that are identified with substance use and/or mental health issues with or without a disability and are not active clients of the mental health center. The program is designed to assist older adults with a broad range of concerns that impact their well-being: life changes/losses, stress, housing and safety concerns, mental health concerns, and problems related to medication misuse or alcohol. These services are also available to family members and professionals who are concerned about an older adult. In addition, the REAP program provides educational sessions on topics that are of interest to older adults. Educational sessions are typically offered at senior housing sites or locations frequented by older adults such as senior centers. Ammonoosuc Health Care Services (AHCS) is a Patient Centered Medical Home and a Federally Qualified Health Center, with five locations throughout Region 7. AHCS has a long history of delivering integrated care and providing both mental health and substance use disorder treatment, in addition to Primary Care. ACHS is a leader in prioritizing integrated care and care transition in patient care and is well positioned to expand services under this demonstration project.

North Country Healthcare, the affiliation of four hospitals in the Region (Androscoggin Valley Hospital, Berlin; Littleton Regional Healthcare, Littleton; Upper Connecticut Valley Hospital, Colebrook; and Weeks Medical Center, Lancaster) has just released their 2016 Community Health Needs Assessment. The assessment surveyed 180 community leaders and 528 community members. The top 5 regional needs included Substance Use Disorder at number one, Alcohol at number three and Mental Health at number five. The report stated that treatment resources for all three behavioral health issues are a priority for this group of hospitals and will move forward to support inpatient, partial hospitalization and intensive outpatient programs.

Work Force Plan: Staffing plan; recruitment; and retention strategies

There is a great need to reduce long wait lists for outpatient treatment services**.** Having services available when an individual reaches the readiness stage of contemplation is critical to engagement in treatment. Increasing the workforce and the available intercept points will facilitate access to needed care. Because of the behavioral workforce deficit in the region, creative options will be explored to create this access. These include deployment of Community Health Workers who will be able to fill the role of transition coordination across the spectrum of substance use disorder care allowing clinical personnel to function at their licensed capacity; encouraging and funding Psych certification for nurse practitioners so they can expand their expertise; regionalizing the access to Recovery Support Workers; and additional hiring of clinical behavioral health staff.

To increase access to substance use counseling NCHC is proposing the creation of a regional LADC. This position will travel the region to supplement the workforce and help meet demand. NCHC will be working with interested host partners such as Northern Human Services (NHS) to map out this approach. In addition, NCHC will be working to support NHS's "Grow our Own" workforce development and retention plan.

In addressing retention of workforce there is an understanding that many factors play a role in an individual's choice to stay in a practice. In interviews with partner organizations it has been shared that often retention is connected to the organization's ability to clearly share a strong vision, support a holistic approach to care and be part of a transformational process for better whole health care. In addition, access to professional development and training are both needed to meet ongoing certification requirements but also personal need to develop new skills. These and other retention factors will continue to be explored and discussed within Region 7 and best practices will be shared. As found in each regional project description, a retention plan will be built into the roles and responsibilities of both workers and supervisors of this program and will include, but not limited to:

- A robust training program that equips treatment providers and transitional care staff with the necessary tools and soft skills to effectively serve a more complex patient;
- Ongoing training and professional development;
- Strong supervision that guides, listens, provides problem solving expertise, and processes experiences that could lead to worker burnout;
- A clear vision of the goals of the treatment program that is clearly communicated to all staff and intersecting providers/social service partners. Everyone on the same page and moving in the same direction, eliminating delays in services and redundant services;
- Sharing of accomplishments and milestones on both a micro and macro level;
- The opportunity for peer review meetings to share and build on successes, new ideas, ways to overcome barriers, resources and training. These meetings would utilize Zoom technology and be open to all in Region 7.

Projected Annual Client Engagement Volumes: by the end of 2020 the region anticipates serving 125 new patients in MAT services, 60 new patients in IOP programs, 120 new patients for counseling services, and 25 patients will have received medical detox services through ambulatory or inpatient services.

Key Organizational/Provider Participants

- Friendship House
- White Horse Addiction Services
- Northern Human Services
- Indian Stream Health Center
- Huggins Hospital
- Coos Family Health
- White Mountain Community Health Center
- Saco River Docs
- Memorial Hospital
- Weeks Hospital
- White Mt Valley Recovery

- Ammonoosuc Community Health Services
- Rowe Health Center

With the opportunity provided through the 1115 Waiver, Region 7 will be able to increase treatment and recovery resources for those dealing with substance use disorders. As previously outlined, Region 7 partners are well on their way to expanding their programming to meet the demand for these services. Friendship House clearly is the central point of treatment and recovery resources, but with the geographical challenges of rural communities it is imperative that these needed resources are available throughout the Region 7 area. As treatment opportunities are built, it is critical to also build the care coordination, community based recovery resources and access to needed social determinants of health components. In planning for additional treatment and recovery resources and promotion of integrated care Region 7 is prioritizing the role of primary care as a direct referral source to these services, understanding the need to treat the whole person to ensure all is being done to strengthen the recovery process. Individuals in need of treatment and recovery resources do not all come into treatment in a specific or conventional way. It is critical that all touch points that intersect with this priority population are equipped to respond and intervene with appropriate treatment and/or recovery resources, and that there are guides in place to help those in need to navigate the system of care from the initial intervention through long term recovery.

Region 7's plan for expansion of SUD services is a four-pronged approach, which includes:

- expansion of the workforce and SUD treatment services;
- prevention and;
- early intervention to reduce the number of individuals in need of services and;
- improved and expanded transition and care coordination services to prevent relapse.

All four factors impact the need for services.

In recognition that there is a continuum of care needed, the plan moving forward is to define the action steps needed to build the treatment options and community based recovery resources that will support the continuum of care stages; Prevention, Early Intervention, Treatment and Recovery Support Services. In keeping with the overall 1115 Waiver plan and taking into consideration the size of the geographic area Region 7 covers, we will approach this project through regional areas called "Prongs". The four defined Prongs will be created in Carroll County, Coos County and Northern Grafton County with the fourth Prong for this project being Friendship House which covers the entire Region 7. Parallel programming will be offered within each Prong aimed at service to the priority Medicaid population across the lifespan.

Providers and social service organizations will be provided with the training, tools and skills that are needed to identify patients in need of treatment. After collecting feedback via one-on-one meetings with Region 7 partners it is been identified that the transition times between services is often problematic for patients who are utilizing behavioral health services and who may also have complex co-occurring disorders. This project provides the opportunity to not only address treatment but to also address transition times between treatment and/or recovery services.

Region 7's plan moving forward is to create a workgroup that is inclusive of a cross section of Region 7 partners that can provide their expertise in the development of a team of care transition workers that could be centrally located within each Prong and serve substance use disorder treatment clients and those who are heavy utilizers of Medicaid services. It is felt that this segment of the population would benefit from working with one individual who would guide them through treatment and recovery

services and provide community resources and connections to providers of the social determinants of health, such as is planned for the E5 project. The development of this program would include creating policies, tracking and monitoring systems, assessments around transition readiness, planning guides for the transition and how to complete a transition. This concept is complex and will require collaboration and coordination on the part of participating organizations; however, it would accomplish the goal of providing consistent 1:1, ongoing transition assistance provided by the same individual, that meets the need of these patients. This plan will mirror the care transition services described in E5. It is more efficient to develop one transitional service program model with the ability to serve the needs addressed in D3 and E5. Tools that will be developed and added to the D3 Toolkit: Care transitions for SUD treatment Policies, Tracking and Monitoring Systems, Assessments Around Transition Readiness, Planning Guides for the Transition and How to Complete a Transition.

To be successful, Region 7 must not only address the service side of delivering substance use treatment but must also make every effort to prioritize a "no wrong door" access policy. The Sequential Intercept Model is a framework created and used in the interface of criminal justice and mental health to identify points of interception at which intervention can be made to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Utilizing the Sequential Intercept Model, NCHC will develop a similar model to illustrate the points of interception as relates to persons with substance use disorder. Often the earliest point of intersection is with Primary care, but there are other significant points along the spectrum including: hospitals, criminal justice, social services, peer support organizations, schools, behavioral health providers, housing organizations, food pantries, families and faith organizations. To facilitate the "no wrong door" policy, Region 7 must first create a seamless process that guides the referral sources, to guide the patient to treatment. As part of the solution, there will be an outreach program that will connect with, and inform all resources in the regions of the program. This is a crucial area that will require Region 7 partners and the Administrative Lead to come together to develop the required oversight and evaluation tools that can demonstrate the effectiveness of this approach. This topic will be addressed at a full IDN quarterly meeting and a workgroup will be initiated.

By following the three-prong approach described in B1 which include SAMHSA's Core Competencies, the continuum of care, and addressing transitions, NCHC forecasts not only being able to add the services required under D3 but also create a sustainable structure that moves forward together to provide integrated, whole person care. In addition, Region 7 recognizes that it cannot successfully create treatment programs and systems of care without a planned approach to outreach and community education. The Region 7 community Engagement workgroup will focus an outreach plan on informing the community at large, with emphasis on informing and engaging peers.

The training proposals will play a large part in developing the knowledge, cultural competency and needed skills around these program initiatives, to facilitate not just the functional parts of providing care but the evolution of attitudinal changes that allow providers to think and interact with patients in an integrated way and without the stigma often associated with behavioral health issues.

Participating organizations and providers that are involved with specific initiatives are listed after each initiative is explained**.**

Increase supportive BH therapy- By increasing the workforce capacity Region 7 will in turn increase the availability of supportive behavioral health therapy. As part of this demonstration project representatives of the regional partners have worked with the Administrative Lead to propose building on the "Grow your Own" program that will foster additional behavioral health workforce; build and

organize peer support services; utilize technology to enable behavioral health therapies to be more accessible and looks to mobile treatment services. (See more detail in the workforce development plan). Partners include Northern Human Services, White Mountain Community Health Services, Coos County Family Health Services, Ammonoosuc Community Health Services, Weeks Medical Center, Huggins Hospital, Memorial Hospital, Cottage Hospital, Carroll County Corrections, White Horse, Upper Connecticut Valley Hospital, Tri-County Cap, Friendship House.

Increase MAT- Medication Assisted Treatment (MAT) has come to be an important tool in fighting the opioid epidemic. Currently there are providers that are building this program across Region 7. NCHC will work with these providers to shore up their programs to meet local demand and to increase new access points throughout the region. Partners may include but are not limited to: Weeks Medical Center, Northern Human Services, Coos County Family Health Services, Memorial Hospital, White Mountain Community Health Center, Ammonoosuc Community Health Services, Indian Stream Health Center and Friendship House.

Expand IOP. Region 7 is fortunate to have an existing regional treatment facility such as Friendship House offering a strong IOP program that they are expanding into two other locations. Their programming is also a model for other organizations that are interested in expansion of this program. White Horse treatment facility will be expanding their IOP program as they bring on new staff and build services. Partners include Friendship House, White Horse and Indian Stream Health Care.

Expand outpatient counseling- With the increased interest among the region's providers to bring in behavioral health and SUD specialists there is clearly support for expansion of outpatient counseling to include SUD and co-occurring mental health and substance use. This expansion is region wide and includes partners such as Cottage Hospital, Ammonoosuc Community Health Services (ACHS), Northern Human Services, Weeks Medical Center, Huggins Hospital, and Memorial Hospital. In addition, the proposed mobile LADC service will expand access.

Increased evidence based screening and identification of high-risk patients in primary care settings- Primary care is at the core of screening and identification of high-risk patients, in addition to providing early intervention by offering standardized screening and assessments. As they are central to many northern communities, health centers are also well positioned to provide family and community education adding value to the prevention side. Partners include ACHS, White Mountain Community Health Center, Rowe Clinic.

Institute a "no wrong door" program that includes the creation of regional care coordinating staff that act as the point of contact for all those seeking treatment and work to engage and educate providers, organizations, community and all possible points of contact with someone in need of treatment services.

Community, patient and family education on mental health and substance use disorders. Prevention and early intervention must be at the core of any plan to reduce substance use and thereby increase availability of treatment. Community members, patients, providers and social service organizations have all expressed this as a priority**.** Education counters the ignorance that prevents treatment seeking. Education is also the strongest tool for countering the stigma that prevents individuals from seeking treatment, families and neighbors from being supportive of the treatment process and providers from embracing truly integrated health care. Through community education efforts Region 7 IDN can move the dial on treatment and prevention programming. The northern parts of the state have pockets of greater understanding, resulting from the on-going Continuum of Care work and other local initiatives,

however there are equally areas where older attitudes, fear, and the misunderstanding of the illness base of mental health and SUD are prevalent. Region 7 also has a culture of self-sufficiency that is deep-rooted, and development of educational approaches that speak directly to this culture is imperative. A perfect example of the need for education is the Lancaster area's reaction to Weeks Medical Center offering MAT. Once the program was announced there was public concern over safety and how this program might negatively impact the community. This will be addressed as part of the training and community engagement woven into the increased access to services. The community engagement plan calls for listening sessions, educational outreach articles, and work through community resource groups. Training and educational programming around substance use prevention and mental health will be provided to the community, patients and their families. Trainings will also extend to provider and social service staff, including Emergency Departments, First Responders, front line provider staff and those that provide social determinants of health services. This effort has begun with the offering of Mental Health First Aid being taught in three locations. Participants included staff and patients at Friendship House, Granite State Independent Living workers, front line staff from two hospitals, and Community Health Workers

Expand SUD education, outreach and prevention. Region 7's Continuum of Care Coordinators work align with that of the IDN. Region 7 will incorporate and build on their programs around prevention, early intervention and community engagement. Part of this community outreach effort will be to share critical resources such as Regional Access Point Services (RAPS) which is a statewide network, accessible by phone or in person to help New Hampshire residents struggling with addiction, NHtreatment.org a website that lists treatment agencies and individual practitioners offering substance use disorder services, including evaluation (this is the first step to determine level of treatment needed), withdrawal management (detoxification), outpatient counseling, residential treatment, recovery supports and other services, and NHCarepath.org access to services and supports for caregivers, family member, older adults, and those living with a disability in New Hampshire.

Funded through the IDN, Ammonoosuc Community Health Services (ACHS) has plans to provide substance use prevention in schools through programming provided by an LICSW. This will be an initiative that could be duplicated in other schools in the region and compliments the current initiatives in the area such as Project Success, Project Aware, Youth Leadership through Adventure, and the Community Coalition work in Berlin, Woodsville, Littleton, Lancaster and Colebrook.

The work of the Region 7 IDN Community Engagement workgroup will continue and grow as this project unfolds. As previously outlined there will be ongoing education and outreach to the community around the goals of this project.

Peer Supports. Peer supports refers to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery. A strength of peer recovery support services is their adaptability to meeting an individual where they are and providing supports that extend recovery beyond treatment and into the community. This strength also creates challenges as peer supports are often not clearly defined, reside in various settings, and have different organizational structure, and recovery pathways. Peer providers work in many roles in a variety of settings, including, community, residential and in-patient facilities. The required hours of training, curriculum, and certification vary widely by state. Peer supports are often challenged with being accepted by clinical and non-peer providers and the stigma that is associated with their mental health and/or substance use disorder diagnosis. Because of the nature of the emerging peer support programs that often engage volunteers, there is little data documented on the number of individuals providing peer supports and the outcomes

of their work. Medicaid billing authorization is key to the growth of peer provider employment and sustainable funding.

Peer support services can be found within both the mental health and substance use treatment communities. Although there is clear recognition that these communities intersect, there is still work to be done in aligning them and providing those individuals seeking co-occurring recovery support, (collaborative) services. Peer Support services in the SUD community include:

- Recovery Coach Model
- 12 Step Programs
- Others

In the Recovery Coach model, coaches assist peers with tasks such as setting recovery goals, developing recovery action plans, finding recovery pathways and resources and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving one's job skills. A person in early recovery is often faced with the need to abandon social networks that promote and help sustain a substance use disorder, but has no alternatives to put in their place that support recovery. Peer recovery support service providers can help such peers make new friends and begin to build alternative social networks. The relationship of the peer coach to the peer receiving help is highly supportive, rather than directive. A recovery coach is a non -clinical person who helps remove personal and environmental obstacles to recovery there by linking the newly recovering person to the recovery community. Within a 12-step program the person seeking recovery gets a sponsor. A sponsor is someone in a long-term recovery. The sponsor works within the 12-Step framework and is expected to help the person in early recovery understand and follow the specific guidance of the 12-Step program.

Other SUD peer support programs are emerging within local communities, providing services that address the needs of individuals in early recovery. Many of these supports have no formal context, but illustrate the need for adaptable peer support programming. Although Peer Support is not a new concept, recognition of its' vital role in recovery and new evidence to support its' value is evolving.

Standardized Assessment Tools

Region 7 will assemble a Tool Kit containing recommended Assessment Tools to be used in Behavioral Health and Primary Care settings. Tools will include standard assessments and screenings that should be administered as part of annual physicals, ED or inpatient admissions. Also, assessment tools that need to be administered upon entry into any outpatient, inpatient or residential or counseling program. The Tool Kit will include the screening and assessment tools, instructions for administering and recommendations for processes to follow.

- Recommended Assessment Tools will include but not limited to:
- Screening, Brief Intervention Referral to Treatment
- Mental Health Screening Form
- MAST Michigan Drug Screening Test
- Stages of Readiness and Treatment Eagerness scale (SOCRATES 8D)
- "Addiction Evaluation" ASI Addiction
- Addiction Severity Index (ASI) assessment tool
- DSM V diagnostic tool
- American Society of Addiction Medicine (ASAM) placement criteria tool to determine appropriate level of care placement.

Patient Assessment, treatment, management and referral protocols
Patient Assessment Protocols
The American Society of Addiction Medicine (ASAM) defines the standard of care for treatment of Substance Use Disorders. This criteria is intended to provide flexible, clinical guidelines and includes six assessment dimensions to be evaluated in making placement decisions. All the following protocol tools including the Assessment Protocol will be developed with the input and clinical guidance of the Region 7 Clinical Workgroup.

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications
- Readiness to Change
- Relapse, Continued Use, or Continued Problem Potential
- Recovery/Living Environment

With these in mind, clinical judgement and consideration of a patient's circumstances are required for the appropriate placement. These Assessment and Screening tools and their protocols are being compiled to add to the D3 Toolkit.

Patient Treatment Protocols
Following this prescribed Care Flow, a Patient Treatment Protocol tool detailing each step will be added to the D3 Toolkit and include:

- Assessment and Diagnosis
- Withdrawal Management
- Treatment Planning
- Treatment Management
- Referral
- Care Transition & Care Coordination
- Continuing Care Management

Treatment Protocols will be added to the D3 Toolkit and include:

- Coordination of Medical care-
- Providing Therapeutic Alternatives- psychosocial and pharmacological
- Evaluating Safety- addressing risks
- Addressing co-morbidity- concurrently
- Involving Social Support Networks-family
- Documentation of Clinical Decisions-knowledge of patient, options discussed, patient preferences and mutually agreed upon plan of actions

Patient Management Protocols will be added to the D3 Toolkit and include:

- Assuring Quality of Care- oversight of patient care including medication
- Determining Clinical Progress- regularly assess progress
- Assuring Support Service Referrals

- Assuring Continuity in Addiction Care- encouragement of patient to meet with physician or designated care provider to monitor and assess patient's maintenance of recovery. This can include a patient interview, physical or psychological examination, structured rating scales, medication review, laboratory studies and patient's engagement in recovery activities

Patient Referral Protocols

An estimated one half of patients who visit primary care has some type of problem related to substance use. As the clinician is often the first point of contact, the initiation of treatment may begin there. The provider should prepare the patient by facilitating an alliance between the patient and the treating provider. This should include providing the patient and the family with information on the withdrawal management process, and substance use treatment options, in addition to providing needed medical care.

In an Urgent Care or Emergency Department a timely and accurate assessment is of the highest importance, as this allows for a rapid transfer to the appropriate treatment setting. Referrals to treatment or continuing care providers can be made throughout the treatment process or at the end of residential care. Referrals could include peer supports, primary care, SUD treatment services that are not available in residential such as MAT. Referring a patient to a new service or to a service that will be utilized in conjunction to the current treatment both have the potential for challenges. Patients may not follow up on the new referral and may drop out of care. This is a critical stage that a transition worker can help facilitate. New services that are happening in conjunction with ongoing treatment need communication and shared strategies between providers. This is an example of where the care transitions worker could step in to facilitate the patient's movement to treatment and/or recovery services.

A Referral Protocol Tool will be created and added to the D3 Toolkit and will include:

- Coordination of Treatment(s)
- Sharing of Confidential Patient Information and Privacy
- Assuring that the Level of Care is Appropriate- as informed by biopsychological evaluation, patient preferences and patient's history of response.
- Providing a Referral- to Substance Use Treatment or Mental Health Facility, Primary Care, SUD and mental health treatment providers, Peer Recovery Support Services, other
- Role of Care Transitional Worker

Roles and Responsibilities for Team members

Effective chronic illness interventions rely on the skills and experience of a multidisciplinary care team, whose roles and responsibilities are outlined in section B1. An effective multidisciplinary patient care team is a group of diverse clinicians and support staff who communicate on a regular basis regarding the patients they care for. This can include professionals and specialists who are outside the group. Patients with a Substance Use Disorder or other behavioral health diagnosis often deal with multiple physical and oral health concerns. A multidisciplinary care team can bring together the expertise in all areas of health and create a treatment plan that addresses the patient's whole health.

Defining roles and responsibilities is an essential step in creating a cohesive team that can provide the most effective and coordinated treatment for a patient around multiple health issues or substance use/co-occurring disorder treatment. This requires developing respect and trust and agreed upon protocols of communication, team interaction and the decision-making process, in addition to a clear understanding of the skills that team members have.

As part of the D3 Toolkit, a Roles and Responsibilities Tool will include:

- Role Mapping
- Identifying core functions of the disciplinary group
- Identifying staff competencies and qualifications/credentials
- Identifying what each discipline can offer to the team and clear expectations
- Identifying areas to join efforts
- Protocols for team communication and interaction
- Protocols for decision making
- Sample Job Descriptions for new positions

Monitoring Plan

Organizations implementing projects related to expansion in intensive SUD treatment options, including partial-hospital and residential care, will be required to monitor and report to the IDN Lead agency on a regular basis. Each project will be reviewed quarterly by the appropriate Work Group to ensure progress that the project is in line with overall improvement of outcome measures. If sufficient progress is not being made toward identified outcomes, Work Group members will designate an appropriate member to work with the organization and the Administrative Lead to assess the project and propose alternative activities. The types of evaluation questions that may be addressed include:

Focus of Evaluation	Evaluation Question
Process	How well was the project designed and how is implementation going?
Outcome	Is the project meeting overall needs? Was there/is there any significant change and to what extent was it attributable to the project? How valuable are the outcomes to the organization, stakeholders, IDN region?
Learnings	What worked and what did not? What were unintended consequences?
Investment	Was the project cost effective? Was there another alternative that may have represented a better investment?
What's On-Going; What's Next?	Can the project be scaled up? Can the project be replicated elsewhere? Is the change self-sustaining or does it require continued intervention?

All organizations will be required to have adequate workforce to carry out activities related to this project. Organizations participating in this project will determine their capacity and have a work plan that reflects their ability to implement all project activities. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring activities will include: 1) tracking activities to monitor implementation and participation in activities; 2) targeted qualitative methods (eg. semi-structured interviews) to understand how the project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively; and 3) review of available outcomes data related to the region to understand progress in population health. A detailed

project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data. Organizations will be responsible for reporting progress on project activities on a quarterly basis.

The draft measurement plan below for this project provides information about collection of data for each primary objective. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard, similar to the format outlined in the previous community-project plan.

Measurement plan for Region 7

	What	Where	How	When	Who
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Expand capacity to delivery intensive outpatient (IOP) services	# new health clinicians	Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	Procedures and protocols in place for effective delivery	Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	75% of participating individuals and families provide feedback, eg..satisfaction	Program Survey	On-line survey program	Annually	Program Manager
	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Expand outpatient counseling for SUD across the spectrum of health and human service programs, including MAT	# new clinicians	Reporting template	Tracking tool	Quarterly	Program Manager
	# clinicians trained/licensed	Reporting template	Tracking tool	Quarterly	Program Manager

	# sites implementing expanded services, eg. MAT	Reporting template	Participating organizations provide feedback and report barriers to process of expansion	Quarterly	Program Manager
	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Increase evidence-based screening and identification of high-risk patients in primary care settings	# sites with increased capacity to implement SBIRT	Reporting template	Tracking tool	Quarterly	Program Manager
	# patients assessed to determine level of readiness for intervention	Reporting template EHR	Tracking tool	Quarterly	Program Manager

[1] http://evaluationtoolbox.net.au/index.php?option=com_content&view=article&id=20&Itemid=159

A tracking tool will be shared with participating partners and require quarterly submissions to the Administrative Lead. It includes the following:

Expand capacity to deliver outpatient services (intensive)
Tracking Tool
- # of new clinicians
- Procedures and protocols in place for effective delivery
- 75% of participating individuals/families provide feedback (satisfaction survey)

Expand outpatient counseling for SUD across the spectrum of health and human services programs, including MAT
Tracking Tool
- # of new clinicians
- # clinicians trained and licensed
- # of sites expanding services and MAT

Increase evidence based screening and Identification of high risk patients in primary care settings
Tracking Tool
- # of sites with increased capacity to implement SBIRT
- # of patients assessed to determine level of readiness for intervention

D-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list of 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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of new MAT services in Region 7	3 by 2018			
# of individuals to be served with new MAT services in Region 7	35 by 2018			
# of new sites offering intensive outpatient (IOP) services	1 by 2018			
# of individuals to be served with IOP services	144 by 2018			
# of existing IOP providers expanding services	3 by 2018			
# trained Peer Recovery Coaches	6 by 2018			
# of individuals served by Peer Recovery Coaches	50 by 2018			

D-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Community Health Workers	4	0			
Psychiatric Nurse Practitioners	3	1			
Peer Recovery Coaches	6	2			
MLADC	3	0			
Case Management	2	2			

D-4. IDN Community Project: Budget

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

Budget Period: **01/01/2017-12/3/2020**
Expansion in SUD

Line Item	Direct Incremental	Indirect Fixed	Total	NOTES:
1. Total Salary/Wages	$ 84,151	$ 11,529	$ 95,680	**YR2-YR5**: Portion of Program Manager, HIT Lead, Data Specialist
2. Employee Benefits	$ 16,830	$ 2,306	$ 19,136	Benefits calculated at 20% of Salary
3. Consultants				
5. Supplies:				
Educational				
Office	$ 8,498	$ 1,164	$ 9,662	**YR2-YR5:** Org.-Wide Office Supply Allocation
6. Travel				
7. Occupancy				
8. Current Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	$ 3,333	$ 457	$ 3,790	**YR2-YR5:** Proposal Software
10. Marketing/Communications	$ 4,007	$ 549	$ 4,556	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training				
12. Subcontracts/Agreements				
13. Other (specific details mandatory):				
Current Expenses: Administrative Lead Organizational Support	$ 15,747	$ 2,157	$ 17,904	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insuranc
Support Payments to Partners	$ 747,332		$ 747,332	**YR2-YR5**: Personnel/Supplies/Travel/Software/Mrktg/Training
TOTAL	**$ 879,898**	**$ 18,162**	**$ 898,060**	

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.

Organization/Provider	Agreement Executed (Y/N)
Friendship Houses	N
White Horse Addiction Services	N
Northern Human Services	N
Indian Stream Healthcare	N
Huggins Hospital	N
Coos County Family Health	N
White Mountain Community Health	N
Memorial Hospital	N
Weeks Medical Center	N
WMV Recovery	N
Ammonoosuc Community Health Services	N

D-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
SBIRT	Screening, Brief Intervention, and Referral to Treatment (**SBIRT**) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
Mental Health Screening Form	A comprehensive 12- page screening tool designed to gather the client's mental health experiences and screen for symptoms.

Standard Assessment Tool Name	Brief Description
(MAST)Michigan Drug Screening Test	The Michigan Alcohol Screening Test (MAST) is one of the oldest and most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98 percent accuracy.
Stages of Readiness and Treatment Eagerness scale (SOCRATES 8D)	SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially-derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (TS)
Addiction Evaluation ASI Addiction	ASI is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client's life that may contribute to their substance-use problems.
Addiction Severity Index (ASI) assessment tool	(ASI) is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client's life that may contribute to their substance-abuse problems.

Standard Assessment Tool Name	Brief Description
DSM V Diagnostic Tool	The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook used by health care professionals as the authoritative guide to the diagnosis of mental disorders. *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders.
American Society of Addiction Medicine (ASAM) placement criteria tool	The ASAM criteria is most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

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.

Protocol Name	Brief Description	Use (Current/Under Development)
Assessment and Screening Protocol	The six assessment dimensions outlined by ASAM for making placement decisions	The ASAM six-dimension assessment and screening tool is in place and adopted. Written protocol for use to be finalized by 11/17; reviewed by clinical workgroup and adopted by 12/17.
Patient Treatment Protocol	Protocol to include coordination of medical care, therapeutic alternatives, safety, co-morbidity, social support networks and mutually agreed upon plan of action	Components of protocol are in place and adopted, additional research and review complete by 9/30/17. Development of written protocol to be finalized by 11/17; reviewed by clinical workgroup and adopted by 12/17.
Patient Management Protocol	Protocol includes oversight of patient care and medications, assessment of clinical progress, continuity in addiction care.	Components of protocol are in place and adopted, additional research and review complete by 9/30/17. Development of written protocol to be finalized by 11/17; reviewed by clinical workgroup and adopted by 12/17.
Referral Protocol	Protocol includes coordination of treatments, confidentiality, referral process, matching level of care with patient's preferences and history	Components of protocol are in place and adopted, additional research and review complete by 9/30/17. Development of written protocol to be finalized by 11/17; reviewed by clinical workgroup and adopted by 12/17.

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
Community Based Clinician	Based at Carroll County Corrections, this position supports inmates before and after release with behavioral health issues
Case Managers white horse	Providing case management for patients receiving IOP

Project Team Member	Roles and Responsibilities
Licensed social worker- Huggins	Addressing the behavioral health needs of patients and providing consult to physicians
Peer Recovery Coaches	Recovery support services for individuals with substance use disorder
Psych Nurse Practitioner	Behavioral Health, including MAT services
Physician's Assistant	Assisting providing Behavioral health services at Friendship House
Community Nurse Care Coordinator	Assisting behavioral health patients connect with needed services
Behavioral Health Assistant	Providing support to behavioral health staff at community health center
Behavioral Health APRN	Providing behavioral health services at hospital

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

Training Plan and Curricula

In looking at the Region 7 overall implementation plan and recognizing the complimentary nature of the B1 and the regional plans, NCHC has created a master Training Plan that is divided into tracks. The main tracks are trainings specific to deliverables under B1 Integrated Health/Core Competencies, C1 Care Transitions, D3 Expansion in Substance Use Disorder Treatment, E5 Enhanced Care Coordination. In addition, Region 7 developed a list of supplemental trainings to promote professional development and provide community education and engagement. Most of the trainings listed can be useful in any or all the IDN projects. Please see Training Plan below with Curricula descriptions**.**

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1
Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5
Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing	B1

	mental health patients	
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in health care. This interactive workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	B1, E5
Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe "integrated care," and the SAMHSA levels of integration,	B1
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1
Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be	B1

	experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1
Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	B1
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination, organization, teaching, capacity building, motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	E5, B1
Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies	B1, C1, E5

	(OARS), and MI Tools and Change talk (DARN	
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1
Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	D3
Health Equity	Providers Linking Patient With Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	B1
Self-Management and Recovery	Participants get motivated to	D3

Training (SMART) program-	address substance use disorders, and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery and enhance the treatment process.	D3
Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	D3, E5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly	B1, D3, E5

	webinars, core training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	B1
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support	B1

	services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	B1
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the current evidence to support the transition.	B1
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for	D3

	individuals who have a mental health issue (MHI) or substance use disorder (SUD), describe the return on investment of helping patients quit smoking, discuss strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	D3
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction on all the Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills	E5

	and Tracking and Reporting required.	
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	B1
Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

Agreements with Collaborating Organizations

Agreement/ Memorandum of Understanding (MOU) templates will be developed and provided in the D3 Toolkit. All organizations will be encouraged to formalize agreements with collaborating organizations to clearly define expectations. Templates will include the following recommended content:

- Details about specific projects and initiatives on which the organizations will collaborate, including the scope of projects and the length of time the projects will last.
- Agreed upon deliverables
- Responsibilities of each partner
- How the collaboration will function and communicate.
- Information detailing how costs associated with joint efforts will be authorized and paid for.
- Guidelines defining the use of each organization's logo and name in joint materials such as press releases, fact sheets, brochures, websites. For example, does an organization have branding guidelines that must be followed when creating joint materials?
- Guidelines defining ownership of jointly developed materials and use of those materials after the MOU has expired.
- The time frame; when it starts and when it ends.
- A point of contact for each organization who will facilitate collaboration.
- A process for additions or termination of the Agreement/MOU
- Signatures from leadership within the organizations, such as the executive director, board president, or other designated decision maker, and the date the document was signed.

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.

Enhanced Care Coordination for High Need Populations

Region 7's choice of the E5 project was based on both group and individual partners input and the recognition that care/transition coordination is key to achieving and maintaining the greatest possible level of wellness for those with complex health and behavioral health issues across the lifespan. Care Coordination also compliments the C1 Care Transition Teams project and provides additional supports and services to the D3 Expansion of SUD Treatment which will also utilize the model of care transition services described in detail within this section.

It is recognized that a small percentage of patients use a disproportionate share of behavioral and physical health care services. In addition, a large contributing factor to this increased utilization is the lack of connection and access to essential social determinants of health such as food, heat, transportation and social connectedness. As stated in the work by the Center for Health Care Strategies other factors that can influence an individual's choice to seek treatment include early-life instability, trauma, and a history of difficult interactions with providers.

Clearly the medical, behavioral health treatment and even social service offerings have become complex and difficult to navigate. It is not just what is not being offered or available to a patient with complex

health care needs, it is also the abundance of various types of treatment options and supports. Navigating these complexities can be overwhelming for someone with good health; for someone with compromised health this task becomes impossible. The most successful way to assist a patient in accessing treatment and supports that will positively impact their overall health is to provide them with a guide or advocate to lead and support them in finding the services and supports that meet their needs. The Care Advocate would take the central role of coordination care and transitions for that patient. From the moment of outreach or referral, the patient will have just one person that will guide them. This Care Advocate would coordinate with the patient's multidisciplinary team, other care coordinators, and community services, taking the lead role in drafting and managing the patient's care plan. This one-on-one approach will help prevent gaps in transitions, and be easier and more comfortable for the patient which will encourage engagement.

Many of the Region 7 partners already have a version of care coordination. Multiple different position names and descriptions have been created around care coordination. Positions such as Care Navigators, Care Coordinators, Case Managers, and Care Assistants are utilized to direct patient care. However, it is also recognized that those patients with complex needs are often unable to connect with, and follow through with the care recommendations even when the path to them is clearly articulated. Chronic illness affects a person's ability to create a plan and follow through as they are often side tracked with illness related barriers.

The outcome of implementing this project will be that those who utilize a greater amount of services and have greater needs, will have the supports to reach their greatest potential, therefore reducing the demand on emergency services in both the behavioral health and primary care areas.

Workforce plan, staffing plan, recruitment and retention strategies

As previously stated, many if not all the Region 7 partners already have some type of care coordination/transition service program that was created to address this need, because of this much of the work force exists. However, as we implement this demonstration project around care transitions there is an expectation that heavier staffing will be required. Our plan includes first a detailed analysis of the current care coordination workforce and their skill levels. Second, is the need for an analysis of higher utilizers of both behavioral health, medical and emergency services for the three county areas we are focused on. The initial staffing plan will be projected based on historic numbers of eligible clients in a region, the average level of acuity and history of hospital and emergency service use. The staffing plan will be evaluated on a quarterly basis as this demonstration project evolves.

One of the promising avenues for workforce development around this project is the use of Community Health Workers (CHW). With the growing demand for lay health workers, individuals that have been trained as CHWs are a prime fit for this position. Because this position does not require the level of education or clinical certification that accompanies provider roles, it opens the door to many more applicants who already reside in the region and state. With the roll out of CHW trainings over the last year, the availability of candidates is promising.

A retention plan will be built into the roles and responsibilities of both workers and supervisors of this program and will include, but not limited to:

- A robust training program that equips workers with the necessary tools and soft skills to effectively serve a more complex patient;
- Ongoing training and professional development;

- Strong supervision that guides and receives input from field workers, provides problem solving expertise and processes experiences to prevent worker burnout;
- A clear vision of the program that is clearly communicated to all intersecting providers and social service partners. Everyone on the same page and moving in the same direction, eliminating the delay in services and redundant services;
- Sharing of accomplishments and milestones;
- Regularly scheduled meetings of all transition workers by county, creating an opportunity for sharing of successes, new ideas, strategies to overcome barriers, resources and training.

Projected annual client engagement volumes

In the first round of Care Advocates (CA) training we approximate training 5 CAs in each county with trainings being late winter, summer and fall of 2018. CAs will start off with up to 3 clients each for the first 3 months to demonstrate the effectiveness of the program and evaluate for needed changes. Guided by the results, for 2018 we would project client engagement of 45. For 2019 we project the number of clients for the first round of CAs trained to increase to a minimum of 6 per CA equaling a projected client engagement of 90. After the 2019 training of 5 additional workers in each county and given that new CAs would build clients with experience we would project an additional 50 clients engaged to equal 140 clients for 2019. We project a client engagement of 180 for 2020.

Key organizational/provider participants

Key provider organizations that are prime candidates to participate in this project includes: Memorial Hospital, Tri-County Cap, Weeks Hospital, Rowe Health Center, White Mountain Health Services, Northern Human Services, Amoonoosuc Community Health Services, Life Coping and Crotched Mountain. We will be exploring their unique roles and how they can work together in regions to provide this level of care transition services.

Description of target population and eligibility criteria, including rationale for intervention with this target population that aligns with the goals of the Transformation Demonstration

The target population will be those individuals who are heavy utilizers of Medicaid and emergency services including inpatient services. If there is access to available claims data, the target population can be identified by their utilization history, diagnosis, medication information, co-occurring disorders, and previous costs. This population may include those with complex behavioral health and medical illnesses including serious mental illness and/or substance use disorders including opioid addiction, with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors that are barriers to community living and well-being. In addition, we will work to identify Region 7 partners with expertise around the following populations in order to provide services to the broadest population base possible: children under 18 diagnosed with chronic serious emotional disturbance, developmentally disabled population, aged blind and disabled population with co-occurring behavioral health disorders.
In addition, the priority population may include Medicaid eligible recipients:

- who are newly diagnosed with complex health issues or possibly newly located to our region, that meet the criteria even if they do not have a current history of service use in Region 7;
- deemed eligible for services by their Primary Care or Behavioral Health provider and;
- who are under 18 with complex needs and their parents/guardians are in agreement to the services and are willing and able to sign off on privacy consent including HIPAA and 42 CFR Part 2;

- who are adults or have guardians that are willing and able to sign off on privacy consent including HIPAA and 42 CFR Part 2;
- are homeless;
- recently incarcerated and diagnosed with complex medical/behavioral health issues;
- youth/young adults who are transitioning from the children's system of care to the adult system of care.

The Region 7 Care Advocate Workgroup will examine these criteria and share their experience and expertise to expand on it. They will also input to the development of:

- a detailed process to identify the target population;
- an outreach tool that will define the program and services in simple and easy to understand language, free from medical jargon and suggest ways to approach candidates for this service;
- an assessment tool that will be utilized to assess the individual's level of need for services and coordination;
- a template for creating a person-centered care plan that is inclusive of input from the patient and family/caregivers;
- a process and criteria for identifying the members of the interdisciplinary care team of providers that will represent the clinical, behavioral health, long term services and supports, social services including social determinants of health and other community resources that are needed for the individual to improve or maintain their functional status;
- an analysis of the need for program thresholds such as # of Emergency Department visits or inpatient hospitalizations in 6 months.

As stated within the descriptions of D5 and C1, to be successful, Region 7 must not only address the service side of delivering substance use treatment but must also make every effort to prioritize a "no wrong door" access policy. The Sequential Intercept Model is a framework created and used in the interface of criminal justice and mental health to identify points of interception at which intervention can be made to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Utilizing the Sequential Intercept Model, we will develop a similar model to illustrate the points of interception as relates to persons in need of transition care. Often the earliest point of intersection is with Primary care, but there are other significant points along the spectrum including: hospitals, criminal justice, social services, peer support organizations, schools, behavioral health providers, housing organizations, food pantries, families and faith organizations. To facilitate the "no wrong door" policy we must first create a seamless process that guides the referral sources, to guide the patient to transition care. An outreach plan to educate and engage medical, behavioral health, social services and community resources will be created. The Region 7 Care Advocate Workgroup will review and assess the progress of this plan on a regular basis and make recommendations to improve the plan.

For E5 we will also follow the three-prong approach described in B1. Integration of these core components will guide and provide a structure of accountability to all the Region 7 demonstration projects. True integration of care with the inclusion of prevention, intervention, treatment and recovery support services is critical to proposed transition services.

Standardized Assessment Tools

The Region 7 Care Advocate workgroup will be tasked with development of the most effective and efficient methods to assess, treat, manage and refer.

Patient Assessment- Within the E5 Toolkit there will be assessment tools, including but not limited to:

- Care Transition Risk Assessment- This assessment will gather information from the patient or family regarding: prior hospitalizations, principle diagnosis, problems around medications; does the patient understand when and how to take them, can the patient afford their medications, does the patient take their medications on time, support systems; will the patient be living with someone, is there family or caregiver support, access to ambulatory care, access to behavioral health services, financial security, legal or insurance issues, psychological; has the patient been feeling down or anxious, connections to social service supports in community.
- Screening for Health-Related Social Needs- Utilizing CMS 10-item screening tool; "Accountable Health Communities Core Health-Related Social Needs Screening" to identify patient needs in 5 domains; housing instability, food insecurity, transportation, utility assistance needs, interpersonal safety.

The Region 7 Care Advocate workgroup will review all options for assessment tools and make their recommendations to the Clinical workgroup for final approval. These screening and assessment tools will work in conjunction with standard assessment tools that may have already been administered.

Patient Assessment, treatment, management and referral protocols including: method for rapidly identifying and engaging the target population in community delivered care or self-management strategies; Model for ongoing care coordination/management and intervention with the target population, indicating strategies and mechanism through which the model will improve management of the chronic conditions.

The Region 7 Care Advocate workgroup with input and review by the Clinical workgroup will be tasked with final development of patient assessment, treatment, management and referral protocols. These protocols will be included in the E5 Toolkit.

***Assessment Protocol**:* Once the Care Advocate has evaluated the patient's eligibility for transition services an assessment will be completed using the finalized Assessment/Risk Tools. The eligibility criteria and assessment will then be presented to the patient's multidisciplinary care team for discussion and approval. Once approved, the Care Advocate will meet one-on-one with the patient and/or family to explain the information sharing consent agreement. This in-person meeting will provide the patient and family with the time and opportunity to learn about and understand the consent language and feel comfortable in signing off and allowing sharing of patient information. The needs assessment process must include an effort to build a foundation for partnership with the patient/family based on trust. The needs assessment should be viewed as an on-going activity that adapts to the changing patient/family circumstances. Also, more information may be shared as the patient and Care Advocate's relationship solidifies. The tools used to assess the needs must take into consideration all key medical, behavioral, social and environmental needs are included, however it may take time for the patient/family to reveal or acknowledge these needs. How questions are asked must be considered. Different approaches may be needed depending on the patient/family. The Care Advocate must develop a repertoire of approaches that can be used based on the patient/family's learning styles, health literacy, culture and communication preferences. This is especially relevant when it comes to discussion of more sensitive topics. The assessment process provides an opportunity for the Care Advocate to share team roles and talk about expectations and transparency. It is also important to have the patient/family identify who will be the primary contact person for the patient. Past experiences dealing with multiple care providers may have created fears or expectations that will need to be revealed and discussed, this will most likely happen over time. Together there will be a creation of an action plan that identifies the most crucial

issues, but remains fluid. A formal protocol will be developed by the Region 7 Care Advocate workgroup and include these criteria:

- Assessment must be inclusive of input from the patient's multidisciplinary team; if the client does not have a multidisciplinary team one must be created.
- Definition of the roles and responsibilities of Multidisciplinary team members.
- A clearly articulated presentation to the patient/family/guardian regarding privacy consent inclusive or HIPAA and 42 CFR Part 2.
- Building of trust and engagement
- Inclusive of all key medical, behavioral, social and environmental needs
- Communication skills and techniques
- Patient's/family priorities
- Patient's/family perspective, knowledge, health literacy and past experience;
- Patient's/family culture
- Addressing patient's/family fears and perceived threats
- Defining the most critical issues which may be medical, behavioral or social
- Creation of an action plan with patient/family and multidisciplinary team input an agreement
- Re-assessment on a regular basis, dependent on each individual.

Crisis Planning- A Crisis Planning Template will be available in the E5 Toolkit

Treatment Protocol for Care Transitions: Following a prescribed Care Flow, a Patient Treatment Protocol tool will be developed by the Region 7 Care Advocate Workgroup in concert with the Clinical Workgroup, detailing each step and will be added to the E5 Toolkit. Elements to be included:

- Patient's need is defined;
- Care Advocate (CA) works with the patient/family to make an appointment with the applicable medical, behavioral health or social service provider;
- Patient electronic health record is shared with the provider;
- CA assists patient/family with logistical arrangements (ongoing);
- electronic health records and a shared care plan;
- the Multidisciplinary Team has access to recommendations resulting from the appointment;
- CA and the Multidisciplinary Team address updates or changes to care plan;
- CA communicates with patient/family, providing needed education and guidance;
- CA reviews the process, makes necessary connections with providers, assures documentation is in place, and documents any recommendations for improvements to the process, which will be shared with the Multidisciplinary Team.

A shared care plan is a document that depicts a plan of care for a patient, which can be shared with other organizations involved in the patient's care with appropriate consent. Tied to the shared care plan is a process known as Event Notification Service (ENS). ENS is a means to alert a patient's care team at the time of an acute event such as a hospital admission, a transfer to another hospital, and discharge from a hospital. As detailed in B1, Region 7 IDN will be contracting with Collective Medical Technologies (CMT) to implement PreManage Primary and PreManage Ed in the region. This technology will fully support this care transition project and the model that will be defined. In the case of an acute care situation patient accesses emergency or acute care services and primary care and CA are notified immediately through direct secure messaging.

- Use of HIT to facilitate accurate and current health information especially pertinent in an acute care situation where the attending physician may not be the primary care doctor;
- CA monitors the situation, is in contact with patient/family;
- CA provides education and guidance to patient and family, including additional resources;
- CA follows up with patient/family assists with logistics;
- CA is responsible for assuring there is a flow of information to and from providers or services;
- Crisis Planning is reviewed with patient/family;
- CA reviews the process, makes necessary connections with providers, assures documentation is in place, documents any recommendations for improvements to the process, which will be shared with the Multidisciplinary Team.

Continuing Care Management Protocol: The comprehensive Care Plan is the roadmap for the patient's care and therefore determines the transition needs. The Care Advocate, working with the patient/family will prioritize the goals and clearly communicate all the steps both verbally and in writing. The Care Plan will identify needs such as: medical and behavioral health treatment, social determinants of health supports, education, family inclusion (if the adult patient agrees), and socialization. The management protocol will include on-going reassessment done at specified intervals of time to be sure patients are receiving the appropriate level of support. The Management Protocol and Re-assessment tool and instructions will be available in the E5 Toolkit. An essential component of reassessment is the patient and family input and feedback. The reassessment will be shared with all members of the multidisciplinary team for their input. Final recommendations for changes and re-prioritizing will be shared with the patient/family and agreed upon. All changes will be documented in the Care Plan. The proposed Management Protocol would be a cyclical process including:

- Care Plan review with Multidisciplinary Team and Care Advocate
- Care Plan review with patient/family and Care Advocate
- Supports and Service Connections
- A positive or negative occurrence
- Care Plan adjustment
- Re-Assessment
- Gap analysis
- Back to the Care Plan review with Multidisciplinary Team and Care Advocate

Core Elements of the Management Protocol include:

- Engagement and Re-engagement
- Communication
- Education
- Problem solving
- Assurance

The Region 7 Care Advocate Workgroup will determine the best Gap Analysis model to be used to reduce hospital re-admissions. This Gap Analysis Model will be included in the E5 Toolkit. RARE (Reducing Avoidable Readmissions Effectively) has published a gap analysis that identifies the best practice strategies and asks if they are present or if they show a gap or opportunity.
The best practice strategies include:

- System in place to define care accountability for the patient between discharge and the first follow-up appointment, if issues arise

- Process in place to inform the patient who is responsible for their care and how to contact them post-discharge
- An after-hospital care plan is given to patient that includes patient diagnosis, test results, prescribed medications, follow-up appointments, who to call with issues and what issues to look for.
- Patient understanding of the discharge plan is assessed by asking them to explain in their own words the details of the plan (teach-back)
- Process in place to assure that the patient has a follow-up appointment with their provider 5 – 7 days post-hospitalization prior to discharge
- System in place to assure the patient has the means to keep the appointment (e.g, transportation, reminders)
- Process in place to assure the patient knows and understands what issues require immediate intervention and why (teach-back, simple instructions)
- System in place ensuring post-discharge providers (clinic, LTC, HH, other) have pertinent information in a timely manner to support effective transition of care
- Support system in place to follow-up with patient post transition (coaches, calls, telehealth)
- Community network established to help address patient and care giver needs.
- Post discharge outpatient services and medical equipment arranged prior to discharge. Patient and family informed of the providers and services they should expect and when.

***Referral Protocol**:* As previously stated, this project will adopt a no wrong door policy for referrals. Referring partners include medical and behavioral health providers, families, the patient, or social service organizations. The challenge here is that patients receive many referrals to different providers or supports. And many patients have had the experience of those referrals not being completed, either because of a system or employee error. For patients that are trying to manage complex health and or mental health treatment this becomes overwhelming and frustrating and the patient drops out of care. This in turn is frustrating for providers of care and so the breakdown of communication ensues. Referral Protocols will be developed by the Region 7 Care Advocate Workgroup and will be available in the E5 toolkit. Protocol will address:

- Accountability- being accountable for processing the referral and providing timely response to both the patient and the referring entity.
- No wrong door- referrals can be made by anyone
- Support of patients- being sure that patients/family get all the information they need about being referred, what it means and how it will assist them.
- Relationships- the Care Advocate needs to build good working relationships with the different providers and service organizations that may refer, and establish shared expectations that are mutually agreeable. This requires being responsive to their referrals and information sharing.
- Connections- Development of connections to providers, peer supports, services that provide social and healthy living supports are essential to promote referrals to the care transition services. The goal is to have the connections and relationships that will help identify the neediest patients and the connections and the relationships to find those patients the care and services they need.
- Agreements- Agreements or mutually agreed upon processes for making referrals will be created and shared with all possible referral sources.
- Outreach- It is understood that there may be times that a patient whose health situation or history identifies them as good candidate for transition care may require direct outreach. This outreach could involve locating them and meeting face to face in a place that is comfortable for them and safe for the Care Advocate.

Model for ongoing care coordination/management and intervention with the target population, indicating strategies and mechanism through which the model will improve management of the chronic conditions: "Opportunities to Improve Models of Care for People with Complex Needs: Literature Review, published by Center for Health Care Strategies outlines the results of multiple studies exploring the evidence base for effective approaches to high-need/high-cost populations. "This review was designed to identify effective strategies for improving outcomes and lowering costs for high-need, high-cost populations and critical gaps that must be addressed to better integrated health and social services and produce desired outcomes for this population." Findings indicate that effective models of care for high need populations do reply on an intensive care management program. The models that demonstrated the most positive outcomes included: outreach, engagement, initial assessment, goal setting, care plan development, health education/coaching, frequent contact, patient follow up after discharge or change, linkages to housing, substance use disorder services, community resources, face-to-face care management, patient centered, use of interdisciplinary teams, medication and pain management. This documented research outlines numerous models that have been successfully piloted and proven that a truly integrated health approach coupled with intensive care management and the inclusion of social determinants of health connects lead to both improvement in patients' chronic health conditions and decreased health care costs. An analysis of high-cost Medicaid beneficiaries revealed the high prevalence of multi-morbidity and that mental illness is nearly universal among Medicaid's highest utilizers and that mental illness and substance use disorder is associated with much higher costs and hospitalization rates. The Region 7 Care Advocate Workgroup will examine several of the models that closely align with the IDN work and craft a model that is appropriate for this region.

The following outline will provide a framework for summarizing best practices to include in the Region 7 model of transition, including but not limited to:

- Determining Provider knowledge around the care needed for a transitioning patient. How do providers prepare their patients for self-management;
- Accountability in all stages of the transition process, defining the roles and responsibilities for all care providers along the way, strategies for ensuring patient access to providers during transitions;
- Cross venue coordination including mapping out needed communication routes;
- Standardized processes for each step;
- Exploration of technology innovations that might improve the transition process;
- Use of the electronic shared care plan, PreManage;
- Performance assessment tools both qualitative and quantitative, utilizing this feedback for program improvement;
- Patient and family/caregiver education and engagement;
- Outreach, education and engagement of all needed partners and resources;
- Inclusion and prioritizing of peer supports.

Patient Engagement

Patient engagement is dependent on the ability to provide Person Centered Care; defined as the importance of patients finding the right care for their individual characteristics, needs, preferences and situation. Patients and their families/caregivers bring personal knowledge that needs to be part of a successful care plan. By treating patients as the center and a partner in their care motivates engagement. Informed patients equal engagement**.** When patients, their families and other caregivers, are not meaningfully engaged in care or as partners in its improvement there is less likelihood of

engagement. Care transitions, such as being discharged from a hospital or specialist care, or beginning behavioral health treatment or connecting with a social service can be an abrupt change. Patients can receive little information on what their next steps should be; or complex information that they cannot remember or know how to apply. Communication is key to patient engagement. Understanding health information can be difficult especially when trying to apply it to one's own health needs. Recommended communicatio**n** tools and supplemental training around methods of communication will be available in the E5 Toolkit and the Training plan. Several useful communication techniques, such as motivational interviewing, can promote certain health behaviors and adherence to treatment plans by drawing out the patient's motivation for change. Emphasis will be placed on increasing health literacy customized to patients' circumstances as lower levels of health literacy have been linked with increased ED and hospitalization visits and lower use of preventative visits. How, what, when and where information is shared needs to be informed by the individual being cared for. In chronic care management, the number of appointments in a number of settings that may be constantly changing is overwhelming and unmanageable for many patients. The actions of the Care Advocate and how the patient views their assistance will help secure on-going engagement. Within our larger or local community, many communities of commonality have grown. In person and on-line communities come together to access peer support and understanding. Introduction and assistance in participating in a specific community can open the door to another level of support and engagement for the patient.

Roles and Responsibilities for care team members

Defining roles and responsibilities is critical in creating a cohesive multidisciplinary care team. This enhanced care transition model is complex; the Care Advocate must be able to rely on the team members to meet expectations. This requires developing respect, trust and agreed upon protocols of communication, team interaction and the decision-making process; in addition to a clear understanding of the skills that team members have and the responsibilities they must meet. As part of the E5 Toolkit, a Roles and Responsibilities Tool will include:

- Role Mapping
- Identifying core functions of the disciplinary group
- Identifying staff competencies and qualifications/credentials
- Identifying what each discipline can offer to the team and what the expectations are
- Identifying areas to join efforts
- Protocols for team communication and interaction
- Protocols for decision making
- Sample Job Descriptions for the Care Advocate and the Care Advocate Supervisor.

Evaluation plan, including metrics that will be used to measure program impact (# of successful linkages to social support services, change in utilizations of ED and inpatient services for those enrolled/active for more than 3 months)

Organizations participating in providing Care Advocate services will be required to complete a report, due on a quarterly basis. This reporting will provide the data to evaluate and measure the program's impact. Specific areas that will be reported include: the number of individuals served within this program; the reduced number of hospital admissions; the reduced number of emergency department visits with behavioral health indicators, and the number of partners who have agreed to the specific referral process.

The quarterly reporting will include information from the following: Referral Tracking Forms that will provide data on linkages to support services in addition to primary care, specialty care and behavioral

health; Encounter Forms/Outreach Logs to track who is participating and progress in outreach to heavy utilizers of hospital services; Targeted Qualitative Methods that include interview and observation no to gain insight into motivations and behaviors; and EHR and Hospital Data (if available) to measure progress and input into evaluation of this demonstration project. Reporting data will be reviewed and analyzed to determine if modifications to the program are needed. Participating organizations will be part of the review process.

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

Monitoring Plan
Organizations participating in providing Care Advocate services will be required to monitor and report to the Administrative Lead on a specific time frame. Each project will be reviewed by the Region 7 Care Advocate Workgroup on a quarterly basis to ensure progress and fidelity to the program components. By channeling partner's information through this workgroup there will be an opportunity to share best practices and provide support to any organization that is struggling to meet the required goals.
Quarterly reporting will include: Referral Tracking Forms, Encounter Forms/Outreach Logs, Targeted Qualitative Methods and EHR Data and Hospital Date if available. Participating organizations are asked to ensure a collaborative model that will include coordination with other programs or resources that serve similar patients to have only one care coordinator who is playing a lead role in the management of a patient's care plan. Organizations will be required to include agencies that are new partners, and must have a collaborative spirit.

Participants in this project will be asked to complete a "Care Coordination Template" adapted from the National Rural Health Resource Center. Duluth, MN

Care Coordination Template			
1.Target Population: improving the care, health, and reducing costs for a specific group of people		**2. Assessment Tool(s)** to be used by the care coordinator to assess a person's level of need: -Social, environmental, mental health, physical and psychosocial functional needs -Risk or severity level of a diagnosis and/or disease	
1a. Is it specific enough? Clearly define the goal or outcome of the identified problem Be specific. It must be measurable**.**	**1b. How will the target population be identified?**	**2a. Is one needed?** Commonly the target population is generally defined, and an assessment can help determine the level of coordination needed or what types of services are needed	**2b. What is the type or how will it be used?** The type will be determined by the target population and desired outcomes
1c. How will you		**2c. How will the results**	

communicate and engage the person? By phone, in-person or a combination. Where will it take place and how often?		**be communicated?** Where will it be stored? Do the results need to be shared with the care team, do they help identify members of the care team? Can the results be used for evaluation and measurement?	
1d. How will technology be used to perform these functions? Technology can be of great assistance to 'mine' data. Communication: secure messaging**,** portals?		**2d. How will technology be used to perform these functions?** The assessment tool can be electronic, web based and saved to EHRs. Can be communicated via secure messaging, portals.	
3. Care Plan: An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs		**4.Care Team: Providers identified with the person and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to meet the person's goals and outcomes.**	
3a. **What approach to developing the care plan is being taken, so that it is:** Developed with the person, Based on assessed needs, Accounts for medical, behavioral health, wellness and human service's needs (social determinants) Incorporates existing care and treatment plan information	**3b. What is included?** Goal or outcome, Clinical and social needs, Instructions and interventions, Interdisciplinary Care Team Members including contact information, Person demographics	**4a. Who is the coordinator or Care Advocate?** Dependent on the needs of the population and what the focused outcomes are. Can be: community health worker, social worker, nurse, physician assistant, medical assistant, etc.	**4b. How will you build collaboration with the provider and partners of the care team?** Team meetings to effectively build out the work flow. Communicating so each member of the team knows their role, expectations, and warm hand off processes.
3c. How will the care plan be communicated		**4c. How will the care team communicate with**	

to engage the person, and include the care team? How will updates be shared and the care plan updated		**the person, coordinator, and amongst themselves?** This is the workflow.	
3d. How will technology be used to perform these functions? EHRs, secure messaging, portals		**4d. How will technology be used to perform these functions?** EHR, secure messaging, portals, phone, video conferencing	
5.Leadership next steps? Community coaches, Develop advocates, Community education and information meetings, Focused conversations		**6. What is your Organizational Model?** Community mental health Primary care integration Provider based Social support based	

Mechanisms to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

The required quarterly reporting to the Administrative Lead and the Region 7 Care Advocate Workgroup is to ensure the progress of the project is in line with overall improvement of outcome measures. If sufficient progress is not being made toward identified outcomes, Work Group members will designate an appropriate member to work with the organization and the Administrative Lead to assess the project and propose alternative activities. The types of performance measures that will be used to monitor care coordination programs will include:

- Number of direct/indirect encounter or visits
- Number of duplication/unduplicated encounters
- Number of care coordinators trained to serve patients using evidence-based curricula
- Number of healthcare providers offering care coordination services
- Number and level of participation of organizations involved in the program
- Number of referrals to other providers
- Number of people receiving services from a care coordinator
- Number of participants who have a self-management plan
- Changes in patient's healthy behaviors
- Changes in patient costs (e.g. streamlining visits with specialty care

Monitoring criteria implemented for enhanced care coordination projects will be adapted from the Care Coordination measurement framework from the Agency for Healthcare Research and Quality (AHRQ). AHRQ identifies certain domains required to achieve care coordination. Broad approaches to measure care coordination include:

- Teamwork focused on coordination
- Health care home

- Care management
- Medication management
- Health IT-enabled coordination

Organizations participating in this project will be required to have an adequate workforce and determine what their capacity is and have a work plan that reflects their ability to implement all project activities. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants. Specific monitoring sources will include: 1) referral tracking forms; 2) encounter forms and/or outreach logs; 3) targeted qualitative methods (eg. semi-structured interviews or surveys) to understand how the project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively; and 4) EHR data and/or hospital data when available. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data. This tracking sheet will be included in the E5 toolkit.

Tracking of Process Data

The Administrative Lead will create an online reporting system featuring web-based form (or forms) feeding into a spreadsheet that captures process measure data (such as number of staff trained) 30 days prior to the regional reporting deadline, participant organizations will be prompted to fill these forms out within 2 weeks. If entry into the forms is not possible, a fillable PDF will be provided on request. Once the data has been entered and received, Administrative Lead staff will combine data collected this way with data collected from workgroup meetings, event attendance lists and any sub-recipient interim or final reports that have been submitted in the last six months. These data will, together, form a master process measure data tracking sheet for the past 6 months. This master process measure data tracking sheet will be used, in conjunction with outcome data captured from EHRs through the data aggregator to support all regional data reporting.

Measurement plan for E5

	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Improved provider relationships	# new provider/ organization collaborations	Care Plan/Reporting template	Participating organizations complete tracking tool	Quarterly	IDN Program Manager
	Clearly articulate responsibilities of participants in patient care	Care Plan/Reporting template	Participating organizations complete tracking tool	Quarterly	IDN Program Manager
	Facilitate transitions	Referral/tracking form EHR	On-line survey program	Quarterly	IDN Program Manager
	What	**Where**	**How**	**When**	**Who**

Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Increased quality of patient care	Resources aligned with patient	Care Plan/Reporting template	Tracking tool	Quarterly	IDN Program Manager
	Medication management	Care Plan/Reporting template	Tracking tool	Quarterly	IDN Program Manager
	Proactive care plans created and communicated	Care Plan/Reporting template	Tracking tool	Quarterly	IDN Program Manager
	Monitor, follow up and respond to change necessary for patient progress toward care and coordination goals	Care Plan assessment EHR	Tracking tool	Quarterly	IDN Program Manager
	Support self-management goals	Care plan	Tracking tool	Quarterly	IDN Program Manager
	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Reduced cost of care	Decreased visits to specialty care	Care Plan/Reporting template EHR	Tracking tool	Quarterly	IDN Program Manager
	Reduced hospital readmissions and ED visits	Reporting template EHR	Tracking tool	Quarterly	IDN Program Manager

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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of individuals served	45 by 2018			
Reduced hospital inpatient readmissions for patients with BH indicators	20% decrease in annual 30-day hospital readmissions rate for patients with behavioral health indicators rate per 1,000 population from 9.1 in 2015 to 7.2 by 2020			
# of ED visits for patients with BH indicators	20% decrease in annual emergency department visits for patients with behavioral health indicators rate per 1,000 from 1073 in 2015 to 858 by 2020.			
# of trained Care Advocates	15 by 2018			

Performance Measure Name	Target	Progress Toward Target		
# of partner organizations that have agreements in place for referral process	4 by 2018			

E-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Advocate	15 by 2018	0			
Regional Care Advocate Supervisors	1 by 2018	0			

E-4. IDN Community Project: Budget

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

Budget Period: **01/01/2017-12/31/2020**

Care Coordination

Line Item	Direct Incremental	Indirect Fixed	Total	NOTES:
1. Total Salary/Wages	$ 84,151	$ 11,529	$ 95,680	**YR2-YR5**: Portion of Program Manager, HIT Lead, Data Specialist
2. Employee Benefits	$ 16,830	$ 2,306	$ 19,136	Benefits calculated at 20% of Salary
3. Consultants				
5. Supplies:				
Educational				
Office	$ 8,498	$ 1,164	$ 9,662	**YR2-YR5:** Org.-Wide Office Supply Allocation
6. Travel				
7. Occupancy				
8. Current Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	$ 3,333	$ 457	$ 3,790	**YR2-YR5:** Proposal Software

10. Marketing/Communications	$ 4,007	$ 549	$ 4,556	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training				
12. Subcontracts/Agreements				
13. Other (specific details mandatory):				
Current Expenses: Administrative Lead Organizational Support	$ 15,747	$ 2,157	$ 17,904	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$ 747,332		$ 747,332	**YR2-YR5**: Personnel/Supplies/Travel/Software/Mrktg/Training
TOTAL	**$ 879,898**	**$ 18,162**	**$ 898,060**	

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

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

Organization/Provider	Agreement Executed (Y/N)
Tri- County Cap	N
Northern Human Services	N
Weeks Hospital	N
Rowe Health Center	N
Life Coping	N
White Mountain Health Services	N
Ammonoosuc Community Health Services	N
Crotched Mountain	N
Memorial Hospital	N
*(This list is subject to change based on Region 7 IDN's sub-recipient Proposal process. NCHC anticipates other organizations to join the E5 Project through the proposal process over the course of the DSRIP Demonstration. Agencies which may join the E5 work include Coos County Family Health Services, Cottage, Huggins, Indian Stream Health Center Littleton Hospital, and Upper Connecticut Valley Hospital. The region will work With the first cohort to assess program effectiveness, and will then work to expand E5)	

E-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
Care Transition Risk Assessment	An assessment of the patient's current and past medical and behavioral health, social supports and social determinants of health.
Screening for Health-Related Social Needs	Accountable Health Communities Core Health-Related Social Needs Screening: identify patient's needs in 5 domains: housing, food, transportation, utility assistance needs, interpersonal safety.

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.

Protocol Name	Brief Description	Use (Current/Under Development)
Assessment Protocol	Protocol includes: gathering input from Multi-Disciplinary care team, patient and family, communication techniques, relationship building with patient/family; patient's culture, past experience, health literacy, priorities, fears, HIPAA & 42 CFR part 2 consent process; on-going reassessment	Researched components of the Assessment Protocol are to be reviewed by Care Transitions Workgroup and adopted by 10/30/2017. Written protocol containing these elements to be finalized by 11/30/17 and reviewed and adopted by clinical workgroup by 12/31/17.
Crisis Planning	Actions to be taken, and contacts to be made if there is a client crisis	Crisis Planning Protocol to be reviewed by Care Transitions Workgroup by 10/30/2017. Finalized by 11/30/17.

Protocol Name	Brief Description	Use (Current/Under Development)
Patient Treatment Protocol	Protocol includes process of identifying patient need, connecting to provider(s), shared care plan, coordination of logistics, changes to care plan, communication. Protocol includes process for acute care situations.	Researched components of the Patient Treatment Protocol are to be reviewed by Care Transitions Workgroup and adopted by 10/30/2017. Written protocol containing these elements to be finalized by 11/30/17 and reviewed and adopted by clinical workgroup by 12/31/17.
Management Protocol	Cyclical process of care plan review with Multi-disciplinary care team, and patient and family, supports and service connects, positive/negative occurrence, care plan adjustment, re-assessment, Gap analysis, review with multi-disciplinary care team	Researched components of the Management Protocol are to be reviewed by Care Transitions Workgroup and adopted by 10/30/2017. Written protocol containing these elements to be finalized by 11/30/17 and reviewed and adopted by clinical workgroup by 12/31/17.
Referral Protocol	Protocol includes: Accountability, no wrong door, patient support, connections, agreements on referring, outreach	Researched components of the Referral Protocol are to be reviewed by Care Transitions Workgroup and adopted by 10/30/2017. Written protocol containing these elements to be finalized by 11/30/17 and reviewed and adopted by clinical workgroup by 12/31/17.

E-8. IDN Community Project Member Roles and Responsibilities

Use the format below to identify team members and their roles and 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
Care Advocate (CA)	The role of the CA as a member of the Multidisciplinary team is to take the lead to provide comprehensive care coordination/management services for individuals across the lifespan with complex health/behavioral health needs. As described in the protocols, the CA is the patient's advocate for: timely, accessible treatment and management of illness, access to the social determinants of health, the patient and family's health literacy and education, to maintain or improve the patient's health and functional status.
Care Advocate Supervisor	Provide supervision, assure quality of all services provided, assure all team members are maintaining fidelity to the program, share strategies and problem-solving techniques, maintain documentation.

Project Team Member	Roles and Responsibilities
Multi-disciplinary Care Team	Multidisciplinary teams may include: physicians, physician assistants, nurse practitioners, nurses, medical assistants, licensed clinical social workers, psychologists, and other bachelor-level providers. Roles and responsibilities include following determined communication, team interaction and decision-making protocols; identification of competencies and qualifications of each member of the team and role mapping to clearly define the specific roles of each member of the team. The Multidisciplinary team has the responsibility of assessment and diagnosis, creation of a treatment plan, referrals to providers/social services, evaluation of safety, addressing co-morbidity concurrently, involving family and social supports, care re-assessment and care management.

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

2e Training plan

The need for continuity and fidelity to the defined model of delivery of the care transition services in all of Region 7 cannot be stressed enough. The developed Care Advocate model will be a program that is duplicated in each county across the region. As with the CTI worker program, we will explore having central supervision for the Care Advocates. The model will be defined, and the toolkit assembled and reviewed by the IDN Clinical Workgroup by the end of 2017. The implementation process will be to follow the roll out of the Shared Care Plan as it is an essential element of the transition work.

The Care Advocate training will be held in conjunction with the Regional Care Coordination training described in B1. The morning of the first day will be devoted to learning how to use PreManage, the shared care plan of the region, and the value of using the tool to deliver integrated health. Time will also be spent on how to use the multi-agency consent form, and how to explain the consent process to the patient. In addition, participating sites will have the ability to access on-line trainings for instructions on how to use PreManage, and the IDN HIT Integration Coach will be following up with sites to offer assistance with the integration of PreMange into workflows. The second day will be for the training of Care Advocates. This training will include a comprehensive overview of the Care Advocate model, including the Care Advocate Toolkit. Care Advocates will be encouraged to attend additional trainings including: health literacy, cultural competency, Integration 101, co-occurring mental health and substance use disorder, patient outreach strategies, patient advocacy.

Additional niche training that addresses patients across the life span, along with specific subsets of the populations such as older adults, youth, and parents/caregivers will be offered on an annual basis.
In looking at our overall implementation plan and recognizing the complimentary nature of the B1 and the regional plans, we have created a master Training Plan. The trainings are listed specific to deliverables under B1 Integrated Health/Core Competencies, C1 Care Transitions, D3 Expansion in Substance Use Disorder Treatment E5 Enhanced Care Coordination. In addition, there are some additional supplemental trainings to promote professional development and provide community education and engagement. Most of the trainings listed can be useful in any or all the IDN projects. We

also will build in an evaluation method that allows for input once or twice per year to improve the training based on the experiences of the transitional workers.

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1
Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5
Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5, D3
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients	B1
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in health care. This interactive workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	B1, E5

Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe "integrated care," and the SAMHSA levels of integration,	B1
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1
Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	B1
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1
Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	B1
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination, organization, teaching, capacity building,	E5, B1

	motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	
Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN	B1, C1, E5
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1
Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	D3
Health Equity	Providers Linking Patient With Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	B1
Self-Management and Recovery Training (SMART) program-	Participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges;	D3

	Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery and enhance the treatment process.	D3
Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	D3, E5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly webinars, core training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	B1, D3, E5
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral	B1

	health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	B1
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	B1
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the	B1

	current evidence to support the transition.	
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for individuals who have a mental health issue (MHI) or substance use disorder (SUD), describe the return on investment of helping patients quit smoking, discuss strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	D3
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	D3
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction on all the Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills and Tracking and Reporting required.	E5
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	B1

Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

Training Curricula, including standard set of care coordinator/manager knowledge and skills requirements and qualified training resources for care managers/coordinators

The specific training curricula will be based upon the model chosen by the Region 7 Care Advocate Workgroup. The workgroup will prioritize making this decision with input from the Clinical Workgroup. Because of the nature of this project and the intersection with the majority of providers of care and social services, it is critical to the success of this project to have partner support and buy-in.

Agreements with collaborating organizations, including community based social support organizations

Agreement/ Memorandum of Understanding (MOU) templates will be developed and provided in the E5 Toolkit. All organizations will be encouraged to formalize agreements with collaborating organizations to clearly define expectations. Templates will include the following recommended content:

- Details about the supports and services on which the organizations will collaborate, how services will be delivered;
- Agreed upon deliverables, the actual services that will be delivered;
- Roles and responsibilities of each partner, who does what and when;
- How the collaboration will function and communicate;
- Information detailing how costs, if applicable, associated with joint efforts will be authorized and paid for;
- Guidelines defining the use of each organization's logo and name in joint materials such as press releases, fact sheets, brochures, websites. For example, does an organization have branding guidelines that must be followed when creating joint materials;
- Guidelines defining ownership of jointly developed materials and use of those materials after the MOU has expired;
- The time frame; when it starts and when it ends;
- A point of contact for each organization;
- A process for additions or termination of the Agreement/MOU

Signatures from leadership within the organizations, such as the executive director, board president, or other designated decision maker, and the date the document was signed.

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

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap, a "plan to plan", currently under CMS review, articulates the process by which the state will work with the IDNs, Medicaid managed care organizations (MCO), and other Medicaid services stakeholders, develop a statewide APM workgroup and develop the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid

provider payments in an APM by 12/31/2020. IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics. Each IDN will be required to develop an IDN-specific APM Implementation Plan. Once finalized and CMS approved, the DSRIP APM Roadmap will be posted to eStudio.

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

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

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

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

Region 7 will participate in all Statewide APM Taskforce activities, including completion of a Statewide APM Implementation Plan, and completion of the IDN APM Implementation Plan. While participating in Statewide initiatives, Region 7 will collaborate with partners to put infrastructure in place that will support a shift to value based payment. Region 7 will work with the Statewide Taskforce to help identify the role of the MCOs as the state moves toward alternative payment models. Initial development will take place from July 2017 through December 2018, with on-going support for implementation during the remainder of the demonstration project. Projects described in this Implementation Plan incorporate several provider supports that will enhance capacity and increase support for APMs, including: intensive practice coaching to assist with adoption of new models and integration challenges; HIT integration support; creation of "toolkits" of practice transformation models, templates, resources, and best practices; and opportunities for joint learning. Once the Statewide Taskforce determines the Alternative Payment Model framework, Region 7 will be well positioned. Initially, the primary focus will be establishment of an IT system that incorporates all necessary elements to ensure management of clinical, patient-centered, and financial data that can be integrated with essential care partners to monitor and evaluate patient and population health data. NCHC is well-positioned to provide practice facilitators who provide coaching in order to move toward alternative payment models. As a partner in the Northern New England Practice Transformation Network (NNE PTN), NCHC currently employs several highly skilled practice facilitators that assist practices throughout the state as they move toward value based care. NNE PTN staff will assist with training and mentoring of new IDN staff that will be hired to assist practices with implementation of integration as well as monitoring of quality and outcome measures.

State policy makers are increasingly focused on social determinants of health because of their important influence on health care outcomes and Medicaid spending. In the context of Medicaid, unaddressed social determinants of health surface as intergenerational health disparities that drive healthcare spending. One recent study weighed each factor's contribution to health outcomes and ascribed 30 percent to health behaviors, 40 percent to social and economic circumstances, 10 percent to the environment, and 20 percent to medical care. The DSRIP program will provide an opportunity for the State of NH to incorporate the social determinants of health into an alternative payment model.

Implementation of an HIT infrastructure that supports not only health and behavioral health organizations, but also includes agencies that address the social determinants of health will allow for data collection that includes alternative services. Region 7 IDN will collect data on non-medical services to address social needs and social service screening. Region 7 will also explore possible measures for recovery-based care models for high-need populations that indicate a pathway toward recovery-oriented outcome measurement. Ideally, programs will use recovery-oriented metrics to measure meaningful patient progress as defined by the individual and focus on wellness, stability, and functionality. Strategies to support movement toward alternative payment models include:

- Provide on-going technology support to partners
- Analytics capabilities to identify high needs patients
- Enhanced care coordination for high risk/high need patients
- Clinical Quality Reporting
- Work with MCOs to maximize value of data that may benefit IDN participants

Region 7 will consider various measures that may be phased-in as an approach to assist providers as they move toward new models of payment. Examples may include:

- Infrastructure measures: care coordinators in place, shared care plans in place, electronic health records with specific functionalities in place, care advocates available;
- Quality measures: patient-level information on depression screenings; social determinants of health such as housing, employment, family supports
- Process measures: antidepressant medication management

DSRIP Outcome Measures for Years 2 and 3

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

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

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	**Year 3 (CY 2018)**	
	Incentive Payment for Reporting Measures	**Incentive Payment for Performance Improvement Measures**
Use of Comprehensive Core Standardized Assessment by Medicaid Billing IDN Providers	Recommended U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by IDN Providers (reporting)	Physical Health-Focused HEDIS Measures for BH Population: Summary Score (reporting)

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
Appropriate Follow-Up by Medicaid Billing IDN Providers for Positive Screenings for Potential Substance Use Disorder and/or Depression	Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by Medicaid Billing IDN Providers (reporting)	Experience of Care Survey: Summary Score
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners	Timely Transmission of Transition Record After Hospital Discharge (reporting)	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Develop an IDN-specific roadmap for using APMs	Potentially Avoidable Emergency Department Visits
		Follow-up After Emergency Department Visit for Mental Illness Within 30 Days
		Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days
		Follow-up After Hospitalization for Mental Illness Within 7 Days
		Follow-up After Hospitalization for Mental Illness Within 30 Days
		Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose

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

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

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

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

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

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

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