New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 3 (CY2018)

Semi-Annual Report January-June 2018

Region 7 IDN

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Introduction

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

This Reporting Guide is for use by the IDNs to identify required documentation for achieving project requirements according to the Special Terms and Conditions of the DSRIP Waiver. The state will use the information to review and document the IDNs' progress on project implementation and to award incentive payments. IDNs are required to complete separate implementation plans for each of their statewide projects (i.e., workforce, health information technology and alternative payment models), core competency project, and community-driven projects. Required deliverables must be submitted to the Department of Health and Human Services by July 31, 2017 and within 31 days after each six-month reporting period, as indicated in below. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.
See below for illustration of attachment for project B1 deliverable 2A:

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 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 was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points, evaluation metrics, and Community Input, IDN Network changes, Opioid Crisis Update, Governance, and Budget narrative accompanied by a budget spreadsheet.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Please provide a budget of actual expenditures and projected costs to complement narrative.

Governance Section:

Steering Committee:
Members of the Region 7 IDN Steering Committee continue to leverage their combined expertise and experience to provide guidance and oversight to IDN partner agencies as the region works to achieve the project metrics associated with the DSRIP project. Members of the committee have been actively involved in reviewing concept papers and providing guidance on what feedback should be given to IDN partner agencies to ensure full proposal submissions align with IDN goals and help the region meet performance metrics as it works to transform the delivery of behavioral health care. After full proposals are received, the IDN Steering Committee convenes to discuss the submission and make final funding decisions, taking into consideration the input from individuals involved with the proposal scoring process.

Steering Committee members have engaged in conversations related to IDN project deliverables and the need for the region to meet specific performance metrics to maximize incentive payments. The committee expressed the need to minimize new ideas within concept papers, so the region can focus on expansion of existing projects in a sustainable way and evaluate program effectiveness as the region works to improve the delivery of behavioral healthcare in the region. To assist the region in meeting performance metrics the Steering Committee suggested exploration of an alternative funding process to incentivize agencies as they work to meet IDN deliverables. Steering Committee members recommended that IDN program staff meet with IDN partner agencies to identify the barriers agencies are having as they work to meet IDN deliverables and use this information as one way to prioritize funding moving forward. Based on this guidance, NCHC is inviting members of the 4 governance workgroups to the July 2018 Steering Committee meeting to strategize on best ways to use funding to meet performance metrics moving forward and to discuss potential revisions to the current funding proposal process.

In addition to these funding conversations, the Steering Committee had conversations on partner accountability related to reporting needs, performance metrics, and the use of IDN funds. The Steering Committee advised IDN staff to revise the funding memorandum of agreements to include language related to meeting reporting requirements and creating dependencies on funding based upon performance metrics.

The IDN Steering Committee was informed about changes in the DSRIP funding methodology and the potential impact that this may have on regional funds. Many of the region's Steering Committee members attended the region's annual conference on June 14 to listen to Commissioner Meyers deliver an update on the funding issue, including how county funds impact the IDN funds available to the

region. The Steering Committee is aware that IDN staff have been meeting with County Commissioners and County delegations to showcase the impact of the IDN on the counties.

The IDN Steering Committee voted to provide $4000 to the NH Area Health Education Center to help offset the costs associated with revising and updating the Health Careers Catalog. The new edition of the catalog will include behavioral health careers, career pathways, and pipelines for behavioral health careers that were not included in the last addition of the catalog. All 7 IDNs were asked to contribute $4,000 toward this new addition.

The third round of full proposals were due on March 30, 2018. These proposals went through the region's 3-level review process and the IDN Steering Committee used information from the scoring process to guide conversations related to funding decisions. When funding decisions were finalized, IDN partners were sent a Memorandum of Understanding (MOU) for the period of June-December 2018. IDN partner agencies will receive the first 50% of funds once the MOU is fully executed; the next installment of 25% will be distributed with the interim report and the last 25% will be distributed with the final report. The following agencies received IDN funds during this 6-month funding cycle:

- *Ammonoosuc Community Health Services*: The partner was awarded $120,597 to continue their multi-pronged approach focused on integrating behavioral health into primary care. The partner will continue to imbed mental health clinicians in local schools, expand/enhance internal capabilities for SUD treatment, formalize new workflows to institute a feedback loop to behavioral health staff and patients seen in area EDs and provide primary care and behavioral health services to Grafton and Coos County Corrections, Friendship House, and North Country Serenity Center.
- *Carroll County Department of Corrections*: The partner was awarded $35,028 to focus on enhancing care transitions and care coordination for correctional clients upon reentry into the community following incarceration. The agency plans to provide Critical Time Intervention (CTI) and care coordination to their inmates prior and upon release to help ensure continuity of care and reduce recidivism. The Corrections Department plans to increase workforce development through training and improved coordination, increase access to services by collaborating with local partners, and identify and address gaps to these services by developing a strategic plan with local partners.
- *Whitehorse Addiction Center*: The partner was awarded $10,200 to hire a consultant to assist the agency as they promote their behavioral health and SUD services as the region works to integrate behavioral health and primary care services. The consultant will guide the agency through a Strength, Weakness, Opportunity, Threat analysis which will include participation from IDN partner agencies. Whitehorse will use results from this analysis to help as they focus their program efforts to meet the identified needs of the region.
- *Friendship House*: The partner was awarded $69,279 to address enhanced care coordination and service delivery. Friendship house plans to revamp their treatment program which includes purchasing new best-practices clinical treatment curriculum and enhancing their ability to provide comprehensive care for co-occurring disorders. The agency also plans to expand case management availability by integrating a trained Community Health Worker/Recovery Coach to assist clients with addressing treatment and recovery issues, social determinants of health, affordable housing, transportation barriers, and navigating availability of main stream resources.

- *Rowe Health Center*: The partner was awarded $15,000 to hire a consultant to help analyze current practice to determine how to most effectively integrate behavioral health into primary care. The agency will focus on enhancing capacity, improving community support services, and providing comprehensive care to their patients. The consultant will help build an integrated medical home type model, design training modules and deliver training to relevant staff. Rowe Health Center would also like to educate staff and community with resources as they relate to treatment, services, etc.
- *Mount Washington Valley Supports Recovery*: The partner was awarded $31,125 to focus on enhancing collaborative activities, care transitions, and services that impact the key determinants of health. The agency will use funds to hire a program director to oversee the functions of the organization's services and will train staff at the next CTI Worker training to help enhance care transitions of their clients. They plan to work on sustainability of their services and anticipate providing full services once funds are available to hire staff to cover the required hours. They will continue to collaborate with area partners to help clients reenter the community.
- *North Country Serenity Center*: The partner was awarded $50,000 to focus on developing a Peer Recovery Support workforce to help combat the opioid crisis. The center plans to hire a capacity building specialist to help create the infrastructure of unified support services. The center also plans to have three peer recovery coaches to complete the four trainings necessary for CRSW certification. The center will continue to collaborate with area partners to ensure smooth care transitions across care settings. They also plan to develop a Peer Recovery Support Service central access point protocol to help with enhancing care coordination.
- *North Country Healthcare (NCH) and affiliate organizations:*

  •*North Country Healthcare*: The partner was awarded $50,000 for a Regional Care Coordinator Project. The plan includes hiring a regional care coordinator to provide oversight to care coordination teams within North Country Healthcare. The Regional Care Coordinator, along with NCH affiliates' care coordination teams, will manage patient care across sectors and will work with multiple service agencies state-wide to link patients with all resources available. Establishing a Critical Time Intervention program is also part of the plan to successfully transition patients, especially those with severe mental illness, substance use disorders, homelessness, and other social determinants into their communities.

  •*Weeks Medical Center*: The partner was awarded $100,000 for a Medication-Assisted Treatment (MAT) Expansion Project. The plan supports collaboration with Littleton Regional Healthcare and Ammonoosuc Community Health Services by accepting referrals from these agencies for patients who will be screened for enrollment to Weeks' North Country Recovery Center (NCRC) program. Region 7 funds will be used to support salaries for existing staff and new behavioral health hires. Weeks has been providing MAT Services to its patients for approximately one year and is now able to expand services to other agencies in the region.

- *Upper Connecticut Valley Hospital*: The partner was awarded $50,000 to focus on the establishment of a regional call center which will include a resource directory, provider availability, and a scheduling component. This will give patients and providers 24/7 access to regional services, and on-call providers will be able to respond to emergent situations with more

ease. The goal of this call center is to reduce gaps in care by providing a real-time directory of available resources in the region.

- *Huggins Hospital*: The partner was awarded $86,794 for a Medication-Assisted Treatment (MAT) Readiness Project. The project tackles stigma as a barrier to treatment access through continuous quality improvement (CQI) and system-wide education using nationally experienced office based opioid treatment (OBOT) experts. The plan is to ready one primary care team to begin delivering MAT through OBOT and then spread those services to all primary care practices throughout the Huggins healthcare system. Another way Huggins will increase the regional capacity for MAT is by increasing the number of buprenorphine waivered prescribers in their primary care practices. The aim is to shift perception of substance use disorders and addiction from a problem of criminal behavior to a chronic disease problem.

The region's fourth round of concept papers were due in May of 2018, but a 30-day extension was granted pushing the due date to 06/15/2018 to allow the Steering Committee to have additional time to discuss the round 3 proposals. The committee reviewed the concept papers and provided guidance for full proposal submissions which are due in September 2018.

Due to staffing turnover at IDN partner agencies, the membership of the IDN Steering Committee has changed a bit, but Region7 IDN staff has worked to ensure that the committee is comprised of the required sectors still.

Community Engagement Workgroup:
The Community Engagement Workgroup spent the past six months discussing outreach strategies to effectively deliver IDN information to the community, IDN partners, and key stakeholders. The workgroup was routinely updated on IDN related activities and asked for guidance on how to strategically share this information throughout the region. Members of the Community Engagement Workgroup continued to work on a communication plan which addresses messaging for the different target audiences within the IDN and how to effectively deliver this messaging. The workgroup also revisited their roles and responsibilities, and how these relate to the region's communication plan. The goals of the workgroup were discussed which include outreach to engage all levels of the IDN, from partners to patients. The workgroup members were encouraged to promote upcoming trainings to increase partner participation in IDN activities. The workgroup was routinely updated on IDN related activities and asked for guidance on how to strategically share this information throughout the region. The members of the workgroup acknowledged community engagement activities of IDN partners, how these activities inform the work of the IDN, and that they should count toward community input. Workgroup member participation waned during this reporting period, so the group decided to revisit the recurring meeting schedule. A poll was sent out to determine the best time to meet moving forward and to identify new individuals to serve on the workgroup, if necessary. The new meeting time will be announced in July and start in August of 2018.

The workgroup had on-going discussions related to showcasing partner success across the region through website announcements, meetings, newsletters, etc. They also discussed how to provide an effective way to share approaches between partners, which is ultimately the key feature and role of Basecamp, Region 7's partner information sharing platform. Region 7 IDN also has a separate website in addition to Basecamp. The IDN Health Information Technology Integration Coach has spent significant time consulting with Community Engagement workgroup members and NCHC staff to revamp the IDN website to make it more user friendly and easier to navigate. Links leading to more in-depth

information have been added, and revisions have focused on the use of concise language to make the IDN website a more effective tool for community and partner communications.

With input from the Community Engagement Workgroup, IDN staff created a Region 7 IDN Facebook page as a mechanism to disseminate information and to share both IDN and non-IDN activities which will impact the success of the IDN. The workgroup members were encouraged to like, share, and follow the page to promote engagement throughout the region. This Facebook page will play a significant role in the region's communication strategy moving forward.

The workgroup began discussing the opportunity to use webinars to provide updates among IDN partner agencies. In addition to webinars, workgroup members discussed releasing a series of press releases, from IDN partner agencies, highlighting both partner and patient success stories. In addition, members of the workgroup also discussed the region's newsletter and made the recommendation for this document to be published on a quarterly basis instead of a monthly basis due to the tremendous amount of time it takes to put it together. The region will now see a spring, summer, fall, and winter edition of the newsletter. The spring edition of the newsletter was released during this reporting period.

Data Workgroup:

The Data Workgroup continued to work with MAeHC regarding statewide data outcomes reporting. The first part of the reporting period, members of the workgroup discussed definitions of data measures and worked to conceptualize how to extract the correct data from their systems. The first round of outcome data reporting was due to MAeHC in February to allow time for them to sift through the data before the state deadline in April. Data reporting concerns related to 42 CFR Part 2 continued to be a large concern for many partners throughout the past period, and this issue led to a statewide decision that all 42 CFR-covered data would be excluded from the first outcomes reporting period.

The Comprehensive Core Standardized Assessment became of great interest to the workgroup over the last period, which lead to discussions between the clinical and data workgroup to help the region address questions related to the Assess_01 measure. Hearing perspectives from both workgroups was beneficial as IDN agencies worked to implement a comprehensive core standardized assessment process in the region, which includes having the ability to report if a CCSA was completed for a patient. The workgroup was asked to provide feedback from a data perspective on how to get the CCSA process embedded into agency EHRs and workflows. Workgroup members were encouraged to use the region's request for proposal process and training & technology form to support HIT improvement throughout the region.

The Shared Care Plan was also a major focus of this group over the last period as more partners begin to engage with Collective Medical Technologies (CMT) PreManage Platform, ADT feed feature, and event notifications. The group discussed the importance of supporting care coordination efforts and workflows as partners implement CMT technology across the region. The IDN HIT Integration Coach provided statewide and regional updates about shared care plan implementation status, ADT feed participation, 42 CFR Part 2 concerns, and future roll out plans. In addition, CMT provided the workgroup with an overview of the shared care plan and demonstration of the PreManage product. Concerns related to 42CFR Part 2 delayed implementation of CMT technology in the region and, as a result, evoked the development of a universal consent form from CMT for all partners to use with all patients using PreManage. CMT spent time evaluating New Hampshire law relating to 42 CFR Part 2 and, to address IDN partner concerns in the State, developed resources and software modifications to support the use of the shared care plan by partners. Members of the data workgroup participated in

CMT webinars to learn more about the requirement of 42 CFR Part 2 and get an overview of CMT's new policy guidelines, universal consent form, and software modifications which track patient consent to disclose and redisclose information.

Clinical Workgroup

CCSA implementation was the primary focus of the clinical workgroup for this reporting period. The group reviewed the CCSA approach document released by NH DHHS and recommended that the region send out an updated survey to B1 partners in the region to assess which of the required domains are currently collected within each agency and to identify barriers related to CCSA implementation. The region's IDN Quality Improvement Coach created a draft CCSA protocol which was shared with the clinical workgroup and members were encouraged to provide feedback and adapt the protocol to fit their current practice needs. Members of the clinical workgroup joined in some of the IDN Data Workgroup meetings to discuss how to operationalize the CCSA within practice workflows to ensure both clinical and reporting needs were addressed as processes were developed. Clinical workgroup members also joined in conversations related to the rollout of the shared care plan and provided guidance to help the region clarify data measurement requirements.

Members of the clinical workgroup helped to disseminate a training needs survey and then assisted IDN staff with prioritizing trainings for the region. In addition, the workgroup discussed the region's toolkits and will continue to review these toolkits on a continual basis as feedback is received from IDN partners.

The group visited the topic of Managed Care Organizations (MCO) discussing how to work with the MCOs to avoid duplication, address uncertainty surrounding IDN metrics and specifications, and how these metrics relate to what is already being captured for the MCOs. Members of the workgroup discussed how the region could use MCO-generated reports, which are currently provided to provider agencies, to look at opportunities to improve practice performance and patient outcomes. The workgroup suggested that IDN staff consider inviting the MCOs to present to the region regarding these issues.

The IDN Clinical Workgroup spent a significant amount of time discussing the DSRIP requirements for the multi-disciplinary core team and the best way to have partners engage in case conferences. 42 CFR Part 2 has been a major issue throughout many of these discussions and continues to be a barrier for the region. The group identified busy provider schedules and the need to use non-billable hours to participate on a multi-disciplinary core team as barriers to meeting this deliverable. Lastly, the psychiatry requirement for the multi-disciplinary core team has been a continuous barrier for some partners, and IDN staff have been working to find solutions to address this barrier.

Attendance at the monthly clinical workgroup can be challenging due to busy clinical schedules. Region 7 IDN staff has been looking at ways to engage this workgroup, which may include the use of a workplan to guide discussions. Also, instead of convening a separate workgroup to address workforce related issues, the clinical workgroup now has this as a recurring agenda item.

Financial Workgroup

The IDN Finance Workgroup has been available to the IDN as necessary to review partner proposals and their anticipated budgets. The Financial Workgroup worked closely with the Steering Committee to provide financial feedback to these partner proposals. Members of the workgroup will be invited to participate in funding conversations as the region assesses the current funding process to ensure it is meeting the needs of the region as the demonstration project continues.

Opioid Crisis:

Region 7 IDN has been involved in numerous activities across the region that are positively impacting the opioid crisis, including the expansion of MAT services and collaboration to improve peer recovery services within the region. The IDN continues to work closely with North Country Health Consortium's Substance Misuse Prevention Program and the region's 2 Continuum of Care Facilitators to provide and promote opportunities of recovery and support. The progress of the region has been directly related to multiple partner projects, state initiatives, and substance misuse coalitions throughout the region.

A brand new residential treatment facility in the region, based on a medical model, will have a significant impact on the opioid crisis in the region. The new Friendship House facility is slated to open in July of 2018 and will provide 28 residential treatment beds and eventually, a 4-bed detoxification unit. The work Friendship house has been doing to prepare for this transition has been vital to expanding the capacity of SUD treatment for the region.

The region is working together to create an infrastructure for a sustainable peer recovery network. To accomplish this the region has developed a robust training plan designed to train peer recovery coaches and support these workers with additional trainings as they work to become Certified Recovery Support Workers and are then able to bill Medicaid for peer recovery services. The region will work together to develop referral processes and create a system to connect recovery coaches to patients who need those services. The four recovery agencies in the region will engage in collaborative conversations as the region's peer recovery network is developed.

The North County Substance Misuse Prevention (SMP) team has been working with the region to bring many initiatives into action. The SMP coordinator has been bringing local businesses to the table to learn about the Governor's "Recovery Friendly Workplace Initiative". Governor Sununu's advisor on addiction and behavioral health has visited the region numerous times to address business leaders about the Recovery Friendly Workplace Initiative. He also used these visits as an opportunity to meet with peer recovery coaches at North County Serenity Center to discuss their work and next steps and in June, to help facilitate a permanent drop box at Upper Connecticut Valley Hospital in Colebrook, NH. The SMP team also promoted and facilitated "Drug Take Back Day" on April 28th in the region. There was an increase in police department participation from 5 agencies during the last event to 9 agencies this time. Carroll County Coalition for Public Health also promoted the DEA Take Back Day by picking up materials from DEA and distributing to 10 Local Law Enforcement Agencies: Moultonborough, Tuftonboro, Tamworth, Ossipee, Madison, Bartlett, Jackson, Sandwich, Wolfeboro, Wakefield. A total of 834 lbs. of unwanted medications were collected. The SMP coordinator promoted and facilitated the addition of 5 more permanent prescription drop boxes throughout the region, located in Bethlehem, Lisbon, Groveton, Gorham, and Colebrook. The region offered 2 Drug Recognition trainings during this reporting period to help participants recognize street drugs and know how to handle situations involving these substances. Between the two events, approximately 50 community members were trained.

North Country Health Consortium has been involved in two initiatives to address the region's young adult population (18-25). The two grants focus on helping individuals navigate the difficult transition between school and a healthy successful adult life, as well as, train young adults to identify and support peers at risk for substance misuse, mental illness, or suicide. The Healthy Work Life program addresses anger and stress management, nutrition, tobacco, and substance misuse to help young adults connect their personal health behavior choices with a happy and productive work life. The 6-week program was

brought to three worksites in the region; Ammonoosuc Community Health Services, Schilling Beer Co., and Genfoot Inc., for employees in the age range of 18-25. Approximately 30 individuals participated. This program will be continued for 2019, as it is required to provide this program to 3 agencies for each year of the grant.

The second program NCHC is involved in, Young Adult Leadership, brought the Young Adult Prevention Training on Mental Health, Substance Use & Suicide Risk to NCHC by NAMI in May 2018 and also to Carroll County Coalition for Public Health (C3PH) in June 2018. In the North Country Young Adult Leadership Program, 8 young adults (ages 18 – 25) and one older adult learned to recognize substance misuse, mental illness, and suicide risk in their communities and to increase awareness among their peers. Five of these young adults went on to become young adult trainers to bring the training into their communities. NCHC trained two employees to deliver the training throughout the region moving forward. In Carroll County, 4 young adults (ages 18-25) and two adults over 25 completed the NAMI Connect Training. Four participants became trainers. In a collaboration between NCHC and C3PH, NCHC's two staff members were invited to train young adults in the Carroll County Program. The grant requires agencies to deliver two trainings throughout the fiscal year, which will continue into 2019. The future trainings will have a significant impact of the IDN, opioid crisis, and much more.

Carroll County Coalition for Public Health has been a key player in fighting the opioid crisis, along with multiple other agencies throughout the region. C3PH has assisted in outreach to promote Memorial Hospitals New Life Prenatal Program that provides Medication-Assisted Treatment services to prenatal and postpartum women with substance use disorders. This collaboration helped promote the program and increase referrals of eligible patients. The coalition acted as a convener to bring together and facilitate a collaborative proposal to address the opioid crisis written by four IDN partner agencies; Memorial Hospital, Saco River Medical Group, Children Unlimited and Visiting Nurses Home Care & Hospice of Carroll County. The agency created a data collection tool for the Central NH VNA SBIRT Screening initiative and participated in a public health panel for a session with Leadership MWV Class of 2018, an initiative of Mount Washington Valley Chamber of Commerce. Together with their Substance Misuse Prevention Coordinator, C3PH also facilitated meetings of community stakeholders across sectors to network and share resources related to SUD needs of the region. Carroll County has been exploring an opportunity to bring the Recover Together MAT program to the area. The contact person has been connected with treatment and recovery providers for further discussions. The agency participated and/or facilitated multiple events and trainings over the last 6 months including:

- Prevention Leadership Team meeting on 4/4/2018
- State Prevention Meeting on 4/5/2018 & 6/20/18
- Meeting with Project L.E.A.D Team to discuss dissemination of Law Enforcement Against Drugs curriculum
- Straight Talk: Be Prepared at Huggins Hospital (Fair) April 14, 2018
- Prevention Leadership Team meeting 6/5/2018
- Project L.E.A.D. Graduation, Sandwich Central School, 6/13/2018
- Mental Health First Aid 6/6 and 6/22 Huggins Hospital
- Young Adult Training 6/25-26/2018 (Suicide Prevention)

Conversations between Carroll County Sheriff Department, Carroll County Department of Corrections and White Horse Addiction Center led to the coordination of transportation by Whitehorse Addiction Center for individuals upon release from Carroll County House of Corrections. White Horse Addiction Center has also opened a new office in North Conway to deliver services in the North and South end of

the county. Whitehorse Addiction Center has continued to expand their services in direct response to the opioid crisis flooding the region. The partner has treated nearly 100 clients over the past 6 months.

Coos County and northern Grafton County have 5 coalitions combined, made up of community members and coordinated by the SMP Coordinator, are also doing their part to fight the opioid epidemic. Stand Up Androscoggin Valley (SUAV), Haverhill Area Substance Misuse Prevention Coalition (HASMPC), Littleton Alcohol Tobacco and other Drugs (ATOD), Lancaster/Groveton Coalition, and North Woods Action Committee (NWAC) in Colebrook and surrounding area all hold monthly meetings to plan actions, bring about awareness, and provide support and resources for their communities. Members are grassroots volunteers and concerned citizens that want to make a difference. Each coalition strives for representation from twelve sectors in the community including; youth (persons <= 18 years of age), parents, business community, media, schools, youth-serving organizations, law enforcement agencies, religious or fraternal organizations, civic and volunteer groups, healthcare professionals, state, local or tribal agencies with expertise in the field of substance abuse, and other organizations involved in reducing substance abuse. Huggins Hospital has teamed up with the Carroll County Coalition for Public Health and Team Wolfeboro to develop the Eastern Lakes Region Coalition for Healthy Families, dedicated to supporting families and the community address the issue of substance misuse.

NCHC brought motivational speaker Brandon Novak to the region to deliver his presentation titled “A Conversation on Addiction & Recovery with Brandon Novak” in February 2018. Almost 200 people from across the region convened in northern Grafton County to hear about Brandon Novak’s journey to recovery and what the next steps are for individuals who desire to become sober. The session was so well attended that NCHC asked Brandon to return in May of 2018 to deliver 2 additional presentations in Coos County, which were attended by approximately 80 more members of the region.

All these events, projects and initiatives show how Region 7 IDN is working together to address the opioid crisis.

Community Input:

Region 7 IDN works continuously to engage the community for input relating to the issues the DSRIP project is addressing. One example of a way the IDN is receiving community input is the Eastern Lakes Region (ELR) Coalition for Healthy Families in Carroll County. The ELR Coalition hosts events to share resources and information designed to support families and the community as they work to address substance misuse. The coalition held a second “Straight Talk” event at Huggins Hospital in April 2018 to bring the community together for a free family and caregiver educational event.

Northern Grafton County held a Vision to Action Forum in Haverhill for the community to join a discussion planning for Haverhill's future. The forum took place on April 13 and 14, with a total attendance of approximately 160 people, and resulted in many great ideas on how to make the community a healthier place. The conversations touched upon substance use disorders, access to healthcare, access to social services, and much more.

Region 7 IDN is working with multiple agencies within the community to foster conversations like the ones described above to gather community input as the region works to advance along the continuum of integrated healthcare. The Region 7 IDN Facebook page is anticipated to elicit community input and help raise awareness of the IDN and its goals. It is important to get feedback from the community and IDN partners to be able to develop a more comprehensive community-based approach as the DSRIP Waiver project continues. The impact on the patient is an essential aspect on the project that continues to be addressed.

Network Development

Region 7 IDN witnessed increased partner collaboration over the past six months, with many partners enhancing existing partnerships or developing new ones. The IDN quarterly meetings provide partners in the region with an opportunity to have collaborative conversations and have evolved into an excellent venue to showcase partner progress. The strategic seating plan at these meetings continues to be a great way to get partners to interact and brainstorm about how to work together.

Multiple collaborative efforts have occurred within the region during the January-June 2018 reporting period. Carroll County continues to strengthen their collaborations with a continuation proposal for Saco River Medical Group, Children Unlimited, Memorial Hospital, and Visiting Nurse Home Care & Hospice to work together to address substance use disorders by utilizing existing resources without duplication. White Horse Addiction Center and Mount Washington Valley Supports Recovery are also working in the county to develop a partnership to provide recovery support services. Cross-regional collaboration of the 4 recovery centers in the region will lead to a comprehensive Peer Recovery Support Network in Region 7 IDN.

Coos County has been working to develop and strengthen partnerships between the North Country Healthcare Affiliation, Indian Stream Health Center, Ammonoosuc Community Health Services and more. The affiliation is working to provide MAT services to the Littleton and Colebrook area as the region moves forward. Androscoggin Valley Hospital and Coos County Family Health Center (CCFHC) are working to enhance their workflows and protocols for the treatment of shared patients. CCFHC and Northern Human Services have collaborated to open CrossRoads Clinic, a co-located primary care office embedded within a community mental health center.

The region continues to move forward with many networking opportunities. Partners are developing effective, valuable, and sustainable relationships which go across agencies, and this will help partners as they advance along the continuum of integrated healthcare and lead to enhanced patient care in the region.

Region 7 IDN Total Project Budget

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
Workforce	**CY 2017 Actuals**	**CY 2018 January to June Actual**	**CY 2018 July to December Projected**	**CY 2019 Projected**	**CY 2020 Projected**	**CY 2021 Projected**
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$ 12,082	$ 798	$26,655	$53,309	$53,309	$26,655
6. Travel	$ 7,028	$ 4,592	$30,320	$60,640	$60,640	$30,320
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions		$150,322	$74,991	$149,983	$149,983	$74,991
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$ 5,527	$2,527	$5,053	$5,053	$2,527
10. Marketing/Communications	$ 13,558	$ 9,297	$23,251	$46,501	$46,501	$23,251
11. Staff Education and Training		$ 6,461	$39,542	$79,085	$79,085	$39,542
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$ 20,399	$ 11,591	$11,936	$23,872	$23,872	$11,936
Support Payments to Partners	$ 820,922	$ 751,435	$875,562	$1,751,124	$1,751,124	$875,562
			$0			
TOTAL	**$ 1,148,128**	**$1,156,435**	**$1,245,560**	**$2,491,119**	**$2,491,119**	**$1,245,560**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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				

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

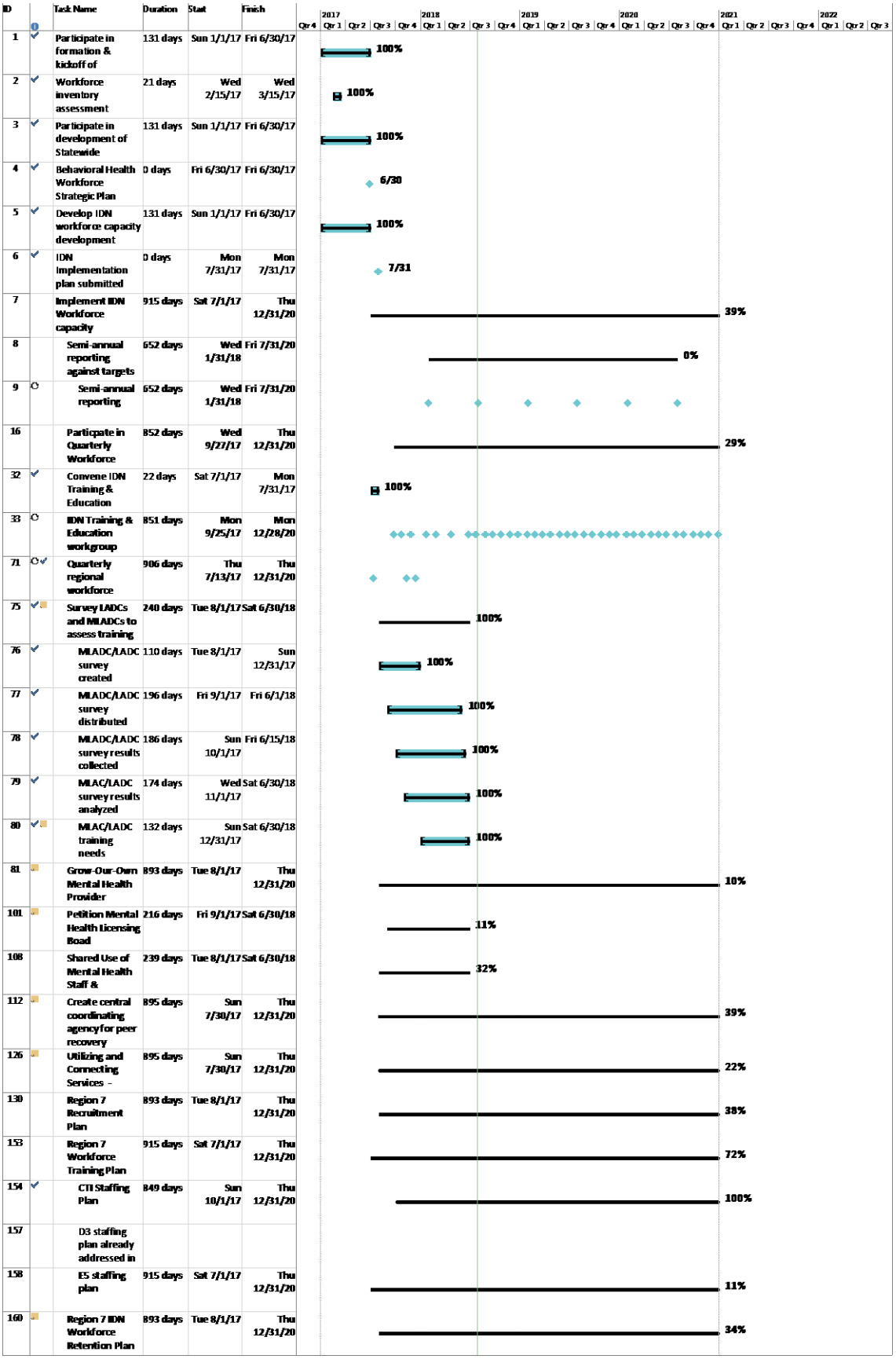
Each IDN was required to complete an IDN level Workforce Capacity Development Implementation Plan, inclusive of the workforce needed to complete projects A1, A2, B1 and the IDN selected Projects C, D, and E.

Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. The narrative should relate to tables A1-4 through A1-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

In addition, the narrative should include detail on each of the bullets below identifying the accomplishments and progress made on the strategies to address identified workforce gaps, identified barriers, and IDN plans to address identified barriers 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.



Attachment_A1_3

During the reporting period of January 1, 2018 – June 30, 2018, Region 7 IDN had 1 new member agency, The Family Resource Center at Gorham, join the network, and no members leave.

Region 7 IDN has made progress on Project A1, the statewide Behavioral Health Workforce Capacity Project during the reporting period of January-June 2018. The Executive Director for Region 7 IDN is involved with numerous workforce related initiatives which is beneficial to the region as work is being done to increase workforce capacity without duplicating efforts happening with initiatives. Examples of these initiatives include: Northern New Hampshire Area Health Education Center, Bi-State Primary Care Association, Primary Care Workforce Commission, New England Rural Health Roundtable, North County Community Care Organization, NH Behavioral Health Roundtable, Statewide Behavioral Health Workforce Taskforce, and the IDN Training and Education Subcommittee. Participation in these various initiatives has been instrumental as the region has come together to address workforce issues related to education, training, recruitment, and retention. Region 7 IDN's Executive Director continues to serve as the vice-chair of the Behavioral Health Workforce Taskforce, as well as Co-Chair for the Training & Education subcommittee. Region 7 IDN members have continued to actively participate in both the quarterly meetings of the Behavioral Health Workforce Taskforce, and monthly meetings of the Training & Education Subcommittee.

Region 7 IDN used information from the 4 sub-committees of the Behavioral Health Statewide Taskforce to assist the region in making decisions related to meeting DSRIP deliverables. An example of this is the work that the IDN Training & Education sub-committee has done to compile a list of training modules which support the integration of behavioral health and primary care. The sub-committee has spent a significant amount of time reviewing the work of the New Hampshire Primary Care Behavioral Health Workforce Initiative through Antioch University, and NH Children's Behavioral Health Workforce Development Network through the University of NH. Antioch University staff have worked with UMass Medical School Center to negotiate a 25% reduction in cost of the on-line training programs designed to help integrate primary care and behavioral health. In addition, Antioch staff have developed Practice Facilitator training modules, created a list of post-degree programs for licensed behavioral health clinicians who could use training in how to adapt their clinical skills to a primary care environment, assembled a list of master's degree programs for employees interested in becoming a licensed behavioral health clinician, and are working to develop integrated primary care training modules for future behavioral health students. Staff at the University of NH have been working to design concrete behavioral health workforce development pathways, with a focus on attracting workers from under-represented populations and peer support workers into the behavioral health field.

Additional information on training modules discussed during the subcommittee meetings included information on Medication-Assisted Treatment (MAT) training modules, Initial Training on Addiction & Recovery, and Mental Health First Aid. Region 7 IDN team has used this information to help them schedule trainings for the region and will discuss modules with the IDN Steering Committee as the region discusses prioritization of funding. As these training modules are finalized the Region 7 IDN team will share this information with IDN partners and explore how to efficiently access these resources for the region.

The IDN Training and Education Subcommittee gets updates about the behavioral health revisions in the upcoming edition of the AHEC Health Careers Catalogs and updates about the NH Higher Education Behavioral Health Workforce Roundtable convened by the Area Health Education Center. The NH Higher Education Behavioral Health Workforce Roundtable was convened to bring higher education organizations together to determine educational gaps as they relate to behavioral health workforce and enhance programs to ensure that students are adequately prepared to work in an integrated healthcare

environment. Region 7 IDN staff attended the January and April 2018 roundtables and will ensure that the region is represented at the next meetings scheduled for September 2018 and January 2019.

Region 7 IDN staff also get updates from the other 3 subcommittees of the Behavioral Health Statewide Taskforce: The Recruitment and Hiring Subcommittee, Policy Subcommittee, and Retention and Sustainability Subcommittee; and share this information with the IDN; and use it as necessary to inform decisions made within the region.

Region 7 IDN has seen successes and challenges when it comes to recruiting new staff in the region. One challenge the region experiences is when behavioral staff move from one agency to another agency in the region. While it is encouraging that many of the behavioral health professionals are staying within the region, the overall behavioral health workforce numbers are not increasing significantly, and it can be challenging to get accurate reporting numbers which reflect staffing this turnover. Region 7 IDN will continue to report on staffing changes only when the number changes. For example, ACHS reported hiring a primary care provider during this reporting period, but another primary care provider left the agency so there was no net gain or loss to the region.

Staffing:

For the reporting period of January-June 2018, below is what Region 7 IDN partners have reported for workforce capacity:

- Cottage Hospital hired a LICSW who works 32 hours a week.
- Northern Human Services hired an Integrated Health Project Manager, started 4 Bachelor level staff toward certification for LADC, supporting 2 LCMHC to obtain their MLADCs, and have one LADC who recently became an MLADC. The agency lost 3 LCMHCs, 2 LCSW's, and 2 Master of Arts in Counseling Psychology staff.
- Carroll County Department of Corrections hired a CTI case manager.
- Family Resource Center in Gorham trained 6 CTI workers, and the agency reports that they currently have 7 peer recovery coaches who are training to become CRSWs and anticipates having a total of 20 trained CRSWs by June 2019.
- White Horse Addiction Center – 2 CTI workers; 1 full-time LADC and 1 full-time MLADC and has 2 new recovery support workers working toward CRSW certification.
- Tri-County Community Action Program: 2 CTI workers, and a case manager, a CTI Project Coordinator, and a CTI Supervisor all of whom are waiting for training in late 2018.
- Coos County Family Health Services (CCFHS) had two providers obtain waivers to deliver MAT services and hired an individual who holds dual certification as both a MLDAC and Mental Health Counselor, and a part-time peer counselor. They hope to add a second MLDAC / Mental Health Counselor in September.
- North Country Health Consortium (NCHC) has added one more Community Health Workers (CHW) to their Ways2Wellness Connect program, to bring their total up to four. They also have added 1 CTI worker to their staff, due to this individual having been trained when working at another agency in the region. In addition, the agency has one new Mental Health First Aid trainer who can co-train with another NCHC staff person who was previously trained in the model.
- Friendship House hired 11 recovery support workers during this reporting period, all of which are working towards CRSW certification. In addition, the agency has a LADC intern, and recently

contracted with a nurse practitioner who has a waiver to deliver MAT services. This program has not been implemented yet though. Friendship House is also recruiting for an Administrative Director.

- Memorial Hospital had 2 nurse practitioners get waivers to deliver MAT services. The agency shifted existing staff around to create a behavioral health patient care coordinator.
- White Mountain Community Health Center (WMCHC): 2 APRNs received their psychiatric nurse practitioner certification during this reporting period. The 2 individuals now work their part-time seeing behavioral health patients and part time for Northern Human Services. In addition, WMCHC reported hiring one full-time APRN and one full-time PA for their primary care services. The agency will be adding another CHW in July 2018.
- Saco River Medical Group currently has one provider integrating MAT services into primary care and anticipates a second provider starting in September 2018. Saco River Medical Group added 4 Medical Assistants to their staff during this reporting period.
- Ammonoosuc Community Health Services had 2 providers get waivers to deliver MAT services
- Weeks Medical Center hired 3 employees during this reporting period; a behavioral health case manager to replace the current behavioral health case manager who accepted a position as behavioral health team leader, a care coordination assistant who works with the behavioral health and physical health providers and care teams, and a LCMHC to provide counseling services. Weeks Medical Center is in the process of obtaining a waiver for their PMHNP and is recruiting for an additional PMHNP as they expand services
- Huggins Hospital currently has one buprenorphine-waivered prescriber but does not offer MAT services to patients. However, the agency has received IDN funding to launch a MAT education and implementation program in July 2018 and expects to begin offering services in early 2019. The agency lost their RN Population Health nurse during this reporting period and will have a new RN Care Coordinator starting in July 2018. The agency also continues to support an LICSW who provides BH/SUD case management.
- Mount Washington Valley Supports Recovery recently hired their own MLDAC for one hour per week to do peer supervision to help their recovery coach academy graduates obtain hours as they work to become CRSWs.
- North Country Serenity Center hired a part-time Operations and Administration Coordinator to provide oversight to the business and financial operations of the center, a part-time Peer Lead/Telephone Recovery Support Coordinator, and a part-time Outreach and Events Coordinator. All these individuals are working to become CRSWs. In addition to this staff, the agency currently has 7 active volunteers.
- The region had 3 Peer Recovery Coach Academies during the reporting period, training a total of 36 new peer recovery coaches.
- Visiting Nurse Home Care and Hospice in Carroll County hired a 4-hour/week position dedicated to outreach services.

Mental Health First Aid

NCHC had one staff member attend the April 2018 Mental Health First Aid train-the-trainer session sponsored by Riverbend Community Mental Health Center (RCMH). RCMH secured a grant to provide the training, educational materials, and food for 25 people across the NH IDN network to attend the five-day training. Because of this training, NCHC now has two staff trained as Mental Health First Aid Trainers, one of which is an experienced Mental Health Trainer and has been teaching Mental Health First Aid for over six years. Having two trainers within Region 7 IDN has helped make the training more readily available to the region and easier to schedule trainings that meet the needs of our partner organizations.

Since the train-the-trainer session, the two NCHC Mental Health First Aid trainers have facilitated three trainings together, one at Memorial Hospital in North Conway and two at Huggins Hospital in Wolfeboro, NH. A strategic approach was used to train as many staff at each partner agency as possible. The registration was opened for just the host organization first and then filled with other Region 7 IDN partners, as needed. These three trainings together provided 72 participants with knowledge about mental disorders that can aid in recognition and management. These trainings have reached a variety of interprofessional health care staff, professionals, and support staff targeting especially those on the front lines seeing patients and clients coming into facilities. Nurses, LNAs, EMS, administration staff and maintenance staff are among the different groups attending. Attendees often have personal and professional experiences that enrich the materials and discussions. In the post training evaluations, attendees reported a *"better understanding of mental health patients in crisis" as well as a "better understanding of family members with issues."* When asked ways the training would change their approach on mental illness, one person reported, *"my wording, my empathy, my whole approach at mental illness!"*

To meet workforce goals and address the challenges identified, the region has continued to primarily address four workforce projects: (1) "Grow Your 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

Grow Our Own Mental Health Provider Workforce:

Region 7 IDN has continued to work on identifying strategies to increase the behavioral health provider capacity in the region and encourages the "Grow Your Own" Workforce model which supports existing staff as they work to advance from one level of certification to another. This model addresses both recruitment and retention. As the region looks at prioritizing funding moving forward, Region 7 IDN staff will talk with the IDN Steering Committee to see if the region should explore the use of IDN funds to help offset the amount of money that IDN partners need to use for matching funds as part of the New Hampshire State Loan Repayment Program (SLRP). This may encourage more agencies to participate in the program and serve as an incentive for existing staff to move up the career ladder.

- Region 7 IDN reported that White Mountain Community Health Center used funds to support 2 nurse practitioners as they worked to become psychiatric nurse practitioners. These staff members passed their psychiatric nurse practitioner exam in spring of 2018. Since this exam, both individuals have cut back hours at WMCHC and now focus only on behavioral health patients. However, they are both also now working 3 days a week each at Northern Human Services.

- Northern Human Services reported that they have started 4 bachelor's level staff toward certification for LADC through their "Grow Your Own" program and are supporting 2 LCMHCs to obtain their MLADCs and have one LADC who recently became an MLADC.
- White Horse Addiction Center also reported using a "Grow Your Own" program which included hiring a LADC and supporting him as he works to get his MLADC and providing an existing LADC with his MLADC internship. White Horse supported 2 peer recovery support staff as they worked to obtain their CRSW certifications, and now these individuals are currently providing case management as well as recovery support. White Horse is continuing this model by working with two part-time staff members to obtain their CRSW certifications. All these CRSWs are being supervised by a MLADC from White Horse Addiction Center.
- Recovery support staff at Friendship House are all working toward becoming CRSWs. As the region continues to build the CRSW workforce, it is the hope that some of these individuals may move along the career ladder and works towards LADC licensure. As Region 7 IDN staff continue to work with IDN partner agencies, they will assess how many other agencies are following a similar "Grow Your Own" model.

The region has continued trying to determine how many LADCs and MLADCs are in the region; however, this number fluctuates as staff move from one agency to another. It continues to be difficult to accurately capture what level of certification mental health professionals are at, since so many are working on certifications. Region 7 IDN staff will continue to work to create a reporting structure to track the region's behavioral health workforce including level of certification or licensure.

Region 7 IDN has continued to offer educational trainings to support the integration of behavioral health and primary care in the region. Based on the 2017 educational needs assessment, additional survey feedback from providers in the region, and agency sponsored trainings, below are the trainings that occurred during the reporting period of January-June 2018:

- 3/19/18 - Drug Recognition Training at NCHC
- 03/19-03/24 - Recovery Coach Academy, sponsored by NHADACA at Northwood Training Center
- 3/19-3/20 - CTI Worker Training in Plymouth
- 3/29-3/30 - Regional Care Coordination in Chocorua
- 5/1-5/2 - Motivational Interviewing at AMC Highland Center by NCHC staff
- 5/9/2018 - Mental Health First Aid at Memorial Hospital by NCHC staff
- 5/14/18 - Drug Recognition Training at Groveton
- 5/14/2018 - Introduction to Management of Aggressive Behavior at Littleton Regional Healthcare by NCHC staff
- 6/4/2018 - Introduction to Managing Physical Confrontation at Ammonoosuc Community Health Services by NCHC staff
- 6/14/2018 – IDN Annual Conference
- 6/8/2018 - Mental Health First Aid at Huggins Hospital by NCHC staff
- 6/22/2018 - Mental Health First Aid at Huggins Hospital by NCHC staff

The training schedule for the rest of the year is as follows:

- 7/25-7/27/2018 - Ethical Considerations for Peer Recovery Coaches
- 8/8/2018 - HIV/AIDS for Recovery Coaches

- 8/23/2018 - Suicide Prevention for Recovery Coaches
- 8/23-8/24/2018 - CTI Train-the-Trainer
- 9/2018 - Peer Recovery Coach Academy
- 9/13/2018 IDN Regional Quarterly Meeting: Trauma Informed Care
- 9/17/2018 Introduction to Management of Aggressive Behavior by NCHC staff
- 9/20/2018 - Initial Training on Addiction & Recovery
- 9/27/2018 - Co-Occurring Medical Conditions within Behavioral Health
- 9/28/2018 - Co-Occurring Psychological Conditions within Primary Care
- 10/4/2018 -Introduction to Managing Physical Confrontation by NCHC staff
- 10/11-10/12/2018 – Train-the-trainer for Peer Recovery Coach Academy
- 10/19/2018 - Behavioral and Medical Professionals Working Together to Address Co-Occurring Conditions
- 10/24-10/25/2018 - Motivational Interviewing by NCHC staff
- 11/5-11/7/2018 - Ethical Considerations for Peer Recovery Coaches
- 11/7/2018 - Ethics Train-the-Trainer
- 11/29/2018 - Suicide Prevention for Recovery Coaches
- 12/13/2018 – IDN Regional Quarterly Meeting – training topic to be determined
- 12/14/2018 - HIV/AIDS for Recovery Coaches
- Late fall 2018 - Regional Care Coordination Training
- Late fall 2018 - Stigma/Language training
- Late fall 2018 – CTI supervisor training
- Late fall 2018 – CTI worker training
- Fall 2018 - Community Health Worker training

In addition to these trainings, the Region 7 IDN team plans to have additional conversations with the Addiction Technology Transfer Center Network regarding trainings on Compassion Fatigue, MAT, SBIRT, Opioid Use Disorders, and Foundations of Clinical Supervision and determine next steps for these trainings.

Now that the Region 7 IDN team has a better understanding of the training needs of the region, the team has worked to identify trainers to deliver the content. The Region 7 IDN team is working closely with the IDN Training & Education Subcommittee to identify both regional and statewide subject matter experts who would be willing to utilize their skills for training purposes. NCHC has asked the members of the subcommittee to send NCHC a list of any local subject matter experts and will compile this list of individuals and share it back with the subcommittee. The Region 7 IDN team will continue to explore connecting local subject matter experts to training programs at Plymouth State University, Springfield College, White Mountains Community College, and Granite State College as a way for them to become adjunct faculty and train additional staff within the region. This conversation will be brought to the IDN Steering Committee for further discussion.

Region 7 has been working with the Northern NH Area Health Education Center to recruit new behavioral health providers and staff into the region. The NCHC/IDN 7 staff continue to provide a stipend and oversight to behavioral health students through their *Live, Learn, Play in Northern New Hampshire (LLP-NNH)* Program. Although the region has not had any new students enter LLP program this reporting period, one student recently completed her yearlong Clinical Mental Health Counseling rotation at

Friendship House. In exchange for educational support to help with housing and expenses through the *LLP-NNH* project, she completed a community project involving clients at Friendship House. Sixteen people volunteered to participated in this project.

In her internship summary, the LLP student wrote that her clinical supervisor gave her "endless opportunities to expansively learn all of the areas necessary to be a good clinician." She was able to co-facilitate process groups with the other clinicians and learn many other valuable skills with lots of support and supervision. She learned a diverse set of skills to prepare her in the behavioral health workforce including: completing intake for new clients and understanding their needs, assessing for level of care needed and mental status exams, understanding the ASAM criterion, and applying the six-criterion assessment for client need. This LLP experience was a wonderful opportunity for the student and the community service project was enjoyed by the residents. The student is now a full-time staff member at Friendship House.

Over the last 6 months, Region 7 IDN staff have participated in and facilitated conversations with regional and state academic institutions and leaders in health care institutions with the goal of bringing more behavioral health students to intern and work in northern NH upon graduation. The academic institutions Region 7 IDN have engaged with include: The University of New Hampshire, Springfield College of Human Services, Vermont Technical College, White Mountains Community College and Rivier University. One of the challenges of precepting behavioral health students in rural northern NH is there have not been many qualified on-site preceptors in our partner healthcare organizations, and our small community hospitals and non-profits are overwhelmed by both the number of students and the diversity of students they are being asked to precept. One of the North Country Health Care affiliates, Littleton Regional Healthcare, is interested in precepting psychiatric nurse practitioner students; however, they do not have a psychiatric nurse practitioner on staff with the required experience level to precept students. Medical students completing rural rotations are also required to complete behavioral health rotations, and due to limited preceptor sites in the region, often behavioral health students and medical students find themselves competing for rotation sites. Other challenges include qualified staff without enough time or training to accept preceptor positions.

Despite these challenges, the region continues to engage with academic institutions and health care partners. Memorial Hospital is interested in precepting Psychiatric Nurse Practitioner students from UNH. Region 7 IDN staff have reached out to facilitate a meeting between the UNH psychiatric nurse practitioner program and Memorial Hospital. Memorial Hospital is also planning to take psychiatric nurse practitioner students from Drexel University starting in January 2019 as well as University of Southern Maine students. The Director of Behavioral Health at Memorial Hospital is a psychiatric nurse practitioner and came from a large institution in Maine where she precepted NP students. In addition, Memorial Hospital also has an experienced MSW who is willing to precept students.

Region 7 IDN staff will continue to find ways to support both the behavioral health workforce and behavioral health students, by working with academic institutions and Region 7 IDN partners in creative ways.

<u>Petition Mental Health Licensing Boards Regarding Supervision Rules</u>

Due to the work happening at the state level around supervision rules, Region 7 IDN has decided to wait and see the results of this before proceeding with a separate petition. The Region 7 IDN team will continue to monitor the updates from the IDN Policy Subcommittee, a sub-group of the Statewide Behavioral Health Taskforce, and share this information with the region.

Shared Use of Resources

The region continues to experience a shortage of psychiatrists and has had to use creativity to meet the DSRIP requirement stating that a psychiatrist needs to be part of the multi-disciplinary core team. To meet this requirement, agencies in the region are using consultant arrangements with psychiatrists to provide this coverage. The region is using telehealth services to help connect psychiatrists to primary care practices in some instances.

Another example of shared use of resources is North Country Serenity Center and Friendship House. North Country Serenity Center has reached out to Friendship House to offer peer recovery support services in exchange for supervision of their staff from a MLADAC at Friendship House. In addition, the region continues to address the option of mobile LADCs as an approach to shared resources, and as conversations around the Regional Peer Recovery Network evolve, these conversations will continue.

The work happening within North County Healthcare is a great example of shared resources involving staff. NCH has identified two ACO Care Coordinators, employed by affiliates Littleton Regional Healthcare and Weeks Medical Center, to create a unified care coordination structure which encompasses all 5 entities within the affiliation. North Country Healthcare also has many other potential opportunities for shared resources, including use of technology and cost savings associated with group purchasing of supplies and employee benefits.

Region 7 continues to work with 4 other IDNs across the state to implement Critical Time Intervention. The collaboration of these 5 regions has proven to be valuable as it relates to resource sharing and has helped all regions shared lessons learned, successes, barriers, and challenges during their CTI implementation, along with using financial resources efficiently. Conversations began about renewing the contract that will expire during the next reporting period.

Centralized Peer Recovery Support

There has been a lot of momentum across the region to deliver peer recovery support services, and Region 7 IDN has seen significant progress in creating a central coordinating agency for recovery support services. North Country Serenity Center and Mount Washington Valley Supports Recovery submitted full proposals that were approved to continue building recovery support services within their organizations. This will directly affect workforce capacity as it relates to delivering recovery services. In addition, White Horse Addiction Center and Mount Washington Valley Supports Recovery have been invited to submit a joint proposal to develop an on-call recovery support program. Although the region proposed to have a centralized coordinating agency for peer recovery services, due to the region's large geographic area and the demand for these services, it may be necessary to focus on a peer recovery network with 2 coordinating hubs, one in the Coos/northern Grafton County area and the other in Carroll County. Each of these hubs would work closely with on another and collaborate to design a peer recovery network with an infrastructure to: coordinate required trainings to support peer recovery staff; keep a list of active peer recovery coaches who are willing to connect with patients; develop systems to connect coaches to patients in a variety of locations within the community, including hospital emergency rooms; address sustainability by increasing the amount of CRSWs in the region; provide required supervision for the CRSWs; and define consistent tracking measures to show program effectiveness and patient outcomes. To facilitate conversations related to a centralized peer recovery network, NCHC reached out in June to Mount Washington Valley Supports Recovery, Hope for NH Recovery, North Country Serenity Center, and Whitehorse Addiction Center, the four peer recovery agencies in the region, to begin

conversations about this model, building off what they have already been working to implement, and discuss next steps. Region 7 IDN staff and the region's 2 Continuum of Care Facilitators will continue meeting with these agencies to facilitate conversations as the agencies work together to create a framework to support the regional peer recovery network.

Since the region is working to increase the number of CRSWs in the region, Region 7 IDN staff developed an 18-month training plan designed to provide the trainings which are required to become a CRSW. This training plan will help build workforce capacity and help with the sustainability of a centralized peer recovery network. The region's peer recovery training plan is below:

Training	Dates
Ethics	July 25-27, 2018
HIV/AIDS	August 9, 2018
Suicide Prevention	August 23, 2018
Peer Recovery Coach Academy	September 13-14 & 27-28, 2018
Train the trainer for Peer Recovery Coach Academy	October 11-12, 2018
Ethics & Train the Trainer	November 5-7, 2018
Suicide Prevention	November 29, 2018
HIV/AIDS	December 14, 2018
Peer Recovery Coach Academy	April 2019
Peer Recovery Coach Academy	September 2019
Suicide Prevention	October 17, 2019
Ethics	November 2019
HIV/AIDS	December 5, 2019

The region had 36 peer recovery coaches trained during the reporting period through 3 separate Peer Recovery Coach Academies. There is another Peer Recovery Coach Academy scheduled for August 2018 hosted by our new IDN partner, Family Resource Center, and one scheduled for September 2018 as part of the Region 7 IDN peer recovery training plan.

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

From the IDN Workforce Capacity Development Implementation Plan, use the format below to identify the progress toward targets or goals that the project has achieved.

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	3	3	
# 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	1	1	
# of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018	0	0	
Expanded supervision for master's level clinicians	1 by 2018	0	0	
# contracts in place in Region 7 for consultation with psychiatrists as member of multidisciplinary teams	1 by 2018	0	1	

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 current 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	11	13	
Licensed Mental Health Professionals	23 by 2018	14	18	16	
Peer Recovery Coaches	6 by 2018	2	22	59	
CTI Workers	15 by 2018	0	11	24	
CTI Supervisors	3 by 2018	0	3	3	

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 by 2018	0	13	13	
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2	5	
Care Advocates	15 by 2018	0	0	5	
Other Front-Line Provider	1 by 2018	0	10	16	
Care Advocate Supervisors	1 by 2018	0	0	1	
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	
Physician assistant (round 1 funds for baseline 6/30/17)	1	1	1	3	
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	
IDN QI Coach	1	0	0	1	
HIT Integration Coach	1	0	1	1	
IDN Data Specialist (NCHC)	1	0	0	0	
Data Specialists for IDN partners	Up to 3	0	0	0	

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

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the workforce capacity development implementation plan which must include financial reporting on actual spending to recruit, hire, train, and retain the workforce.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
Workforce	**CY 2017 Actuals**	**CY 2018 January to June Actual**	**CY 2018 July to December Projected**	**CY 2019 Projected**	**CY 2020 Projected**	**CY 2021 Projected**
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$ 2,916	$105	$11,180	$22,360	$22,360	$11,180
6. Travel	$ 2,233	$1,108	$7,580	$15,160	$15,160	$7,580
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$1,334	$421	$842	$842	$421
10. Marketing/Communications	$ 3,272	$1,722	$10,613	$21,226	$21,226	$10,613
11. Staff Education and Training		$1,547	$14,907	$29,815	$29,815	$14,907
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$ 4,923	$2,790	$1,989	$3,979	$3,979	$1,989
Support Payments to Partners	$ 198,135	$181,979	$220,389	$440,778	$440,778	$220,389
TOTAL	**$ 277,087**	**$229,443**	**$300,623**	**$601,247**	**$601,247**	**$300,623**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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 within the reporting period. 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	Substance Use Disorder Provider, Therapy for co-occurring disorders (mental health and substance use disorders); Recovery Resources, Advocacy and Support.	A1, A2, B1, D3
Carroll County Department of Corrections	County Corrections Facility	A1, A2, C1
Androscoggin Valley Hospital	Hospital Facility	A1, A2, 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	A1, A2, B1, D3, E5

	Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services	
Upper Connecticut Valley Hospital	Hospital Facility	A1, A2, 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, C1, E5
Rowe Health Center	Rural Health Clinic	A1, A2, B1, C1, D3, E5
North Country Health Consortium Clinical Services /Friendship House	Substance Use Disorder Treatment (After 10/01/2017)	A1**,** A2**,** B1**,** D3
Mount Washington Valley Supports Recovery	Peer Recovery, Transitional Housing	D3
North Country Serenity Center	Peer Recovery	D3
Tri-County Community Action Program	Community-Based Organization	A1, C1, E5
Family Resource Center, Gorham	Community-based Organization providing social and support services	A1, C1
Children Unlimited	Community-based Organization providing social and support services	A1, E5
Visiting Nurse Home Care & Hospice	Skilled nursing, home health, homemaker	A1, E5

Project Scoring: IDN Workforce Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Narrative & Microsoft Project or similar platform				
A1-4	Evaluation Project Targets	Table				
A1-5	IDN-level Workforce Staffing Targets	Table				
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet				
A1-7	IDN Workforce Key Organizational and Provider Participants	Table				

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

A2-3. IDN HIT/HIE: Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan

Each IDN was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables A2-4 through A2-8 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Region 7 IDN had one new member, Family Resource Center, join the network, and no members leave the network.

Project Component 1: Support Care Coordination

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).

IDN Region 7 had targeted a stretch goal of all regional hospitals sending ADT information to PreManage by 06/30/2018. Work began in January and continued through June to accomplish this goal. As this (along with statewide outcome reporting) has been one of the areas of focus for the early project, find below a facility by facility breakdown for each hospital (the North Country Healthcare affiliation hospitals) were addressed as a group:

North Country Health Care (Androscoggin Valley Hospital, Littleton Regional Healthcare Upper Connecticut Valley Hospital, Weeks Medical Center): A generous offer on the part of Dartmouth Hitchcock Medical Center to send Collective Medical Technologies the ADTs which they were already receiving from Androscoggin Valley Hospital, Weeks Medical Center and Upper Connecticut Valley Hospital ultimately allowed these three facilities to become engaged with CMT. These three hospitals signed the requisite documents allowing this structure in late March/Early April (March 30th for Weeks, April 2nd for UCVH and April 3rd for AVH). Littleton Regional Hospital was given repeated presentations and as of 07/09 has agreed to proceed in sending ADTs to Collective Medical. Additionally, Weeks has agreed to trial an implementation of PreManage ED in the hopes that such a test case could provide framework for implementation at the other three hospitals. As of the time of this writing, projects are underway for both LRH ADTs to be sent to CMT and for Weeks to Implement print notifications out of PreManage ED.

Hospital	ADTs sending	Goal Date	PreManage ED Implementation	Goal Date
Androscoggin Valley Hospital	Yes	n/a	No	12/31/2018
Cottage Hospital	No	10/01/2018	No	12/31/2018
Huggins Hospital	Yes	n/a	Pending	09/01/2018
Littleton Regional Hospital	No	09/01/2018	No	12/31/2018
Memorial Hospital	No	11/01/2018	No	03/01/2019
Weeks Medical Center	Yes	n/a	No	09/01/2018
Upper Connecticut Valley Hospital	Yes	n/a	No	12/31/2018

Huggins Hospital (Wolfeboro): Huggins had signed their agreements and began to roll out ADTs prior to 12/31. However, their EMR integration took longer than expected and they are still pending a Collective Medical Technologies training for their ED staff. These trainings are pending and once complete will clear the way for a PreManage ED implementation at Huggins in the near term.

Cottage Hospital (Woodsville): Cottage had been offered the chance to implement CMT early in the process but has elected to delay a PreManage ED until resources currently tied up in a long-running EMR upgrade for their two facilities could be free up to focus on this project. New projections for ADTs being sent to Collective Medical is now 10/01/2018 with a PreManage ED implementation tentatively projected between then and the close of the year.

Memorial Hospital: Staff at Memorial have continued to indicate that a yearlong EMR migrations are underway and taking all available resources. Region 7 has been meeting with Memorial staff in order to at least establish a one-way ADT flow to CMT in order to power other hospital implementations and to assist the good work being done with PreManage Primary in the Memorial service area. Region 7 is targeting a 12/31/2018 ADTs live date for Memorial, with a full PreManage ED implementation in March of the following year after the EMR migration is completed.

Moving Towards Regional Coverage:

With PreManage Primary implementations taking root in Carroll County and entering the planning phase in other parts of the region, it is important from a coordination of care perspective to cover as much of regional emergency department visits with this technology as possible. With this in mind, we have prepared the following numbers from DHHS provided databooks based on Medicaid ED visits and inpatient admissions in calendar year 2015. Bolded providers are those currently sending ADTs to Collective Medical Technologies. These percentages do not add up to 100% because of attributed population visits/admissions to other hospitals.

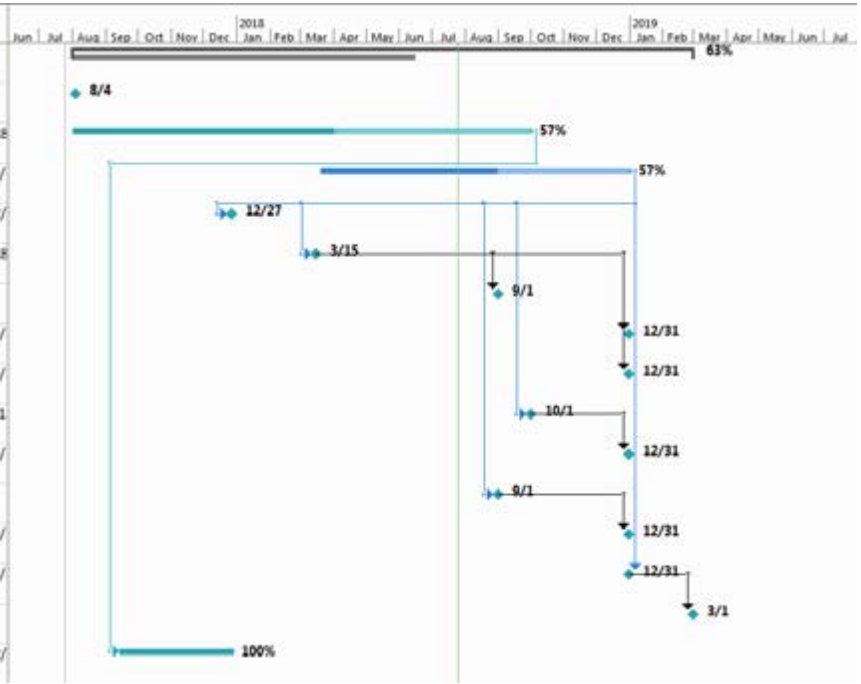
	Region 7 Attributed Population Emergency Department Visit Percentage (2015)	Region 7 Attributed Population Inpatient Admissions (2015)
AVH	**18.40%**	**12.11%**
Cottage	5.78%	1.12%
Huggins	**12.81%**	**3.08%**
Littleton	18.31%	14.92%
Memorial	15.69%	16.62%
UCVH	**6.05%**	**1.65%**
Weeks	**11.30%**	**3.29%**

This means that as of this writing, 48.56% of regional Medicaid population ED along with visits are being tracked in Collective Medical Technologies PreManage system along with 20.13% of inpatient admissions.

It is important to note that the same data set identified Dartmouth Hitchcock Medical Center (who is also sending ADTs to CMT) as receiving 15.73% of regional Inpatient Visits.

Once ADT feed are active at Littleton Regional Healthcare the percentage of regional Medicaid population ED visits going to CMT will jump to 67.93% and the percentage of regional Medicaid population inpatient admissions will increase to 50.77% (both numbers are inclusive of DHMC contributions for IDN 7 population).

ID	Task Mode	Task Name	Duration	Start	Finish
4		**Component 1/1 Suport Event Notification Feeds From Hospital Facilities**	**413 days**	**Tue 8/1/17**	**Fri 3/1/19**
5		Premanage Demos For Hospital Sites	0 days	Fri 8/4/17	Fri 8/4/17
6		CMT agreements signed at each hospital site	61 wks	Tue 8/1/17	Sun 9/30/18
7		Work to connect ED ADT Feeds to CMT System	41.2 wks	Mon 3/19/1	Mon 12/31/
8		Huggins Feed Active	0 days	Wed 12/27/	Wed 12/27/
9		AVH, Weeks, UCVH and Cottage Feeds Active	0 days	Thu 3/15/18	Thu 3/15/18
10		PreManage ED Active At Weeks	0 days	Sat 9/1/18	Sat 9/1/18
11		PreManage ED Active At UCVH	0 days	Mon 12/31/	Mon 12/31/
12		PreManage ED Active at AVH	0 days	Mon 12/31/	Mon 12/31/
13		Cottage feed active	0 days	Mon 10/1/1	Mon 10/1/1
14		PreManage ED Active at Cottage	0 days	Mon 12/31/	Mon 12/31/
15		Littleton Regional Feeds Active	0 days	Sat 9/1/18	Sat 9/1/18
16		PreManage ED Active At LRH	0 days	Mon 12/31/	Mon 12/31/
17		Memorial Feed Active	0 days	Mon 12/31/	Mon 12/31/
18		PreManage ED Active at Memorial	0 days	Fri 3/1/19	Fri 3/1/19
19		Select ENS Triggers at Regional Level	76 days	Wed 9/13/1	Wed 12/27/



(A2 Project Component 1-1)

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 include Carroll County, Northern Grafton Count and Coos County.

Through this period the IDN has worked to increase staffing working on the shared care plan (SCP), educate IDN and North Country Health Consortium staff and engage partners on the Shared Care Plan initiative.

In January, The IDN employed a Health Information Technology Coach with a focus on promoting and assisting partners in working with the SCP. THE HIT Coach also works closely with Collective Medical Technologies to ensure strong working relationships between CMT, partners and the IDN staff.

Partner engagement has been a significant focus, but overall, adoption of the shared care plan is slow. IDN staff have focused on helping partners understand the larger vision of the IDN and healthcare changes in the State of New Hampshire that the DSRIP project represents. Partner engagement meetings have included discussion on how the elements of the project like the comprehensive core standardized assessment, shared care plan and multidisciplinary team meetings are all key components to establishing an integrated care approach across providers in the State with new payment mechanisms. In this context, the partners have been educated on the installation and use of the shared care plan.

The current status of IDN partners most likely to adopt the Shared Care Plan is outlined below:

Huggins Hospital and Outpatient Clinic: Huggins Hospital has done the most work to adopt the SCP in the region. They have completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process.

IDN Staff have stayed in close communication with the team at Huggins to educate and facilitate where needed. A North Country Health Consortium Practice Transformation consultant has also worked with the group on workflow analysis. We look forward to active use of the SCP by this partner soon.

Memorial Hospital: Memorial is not currently engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. The organization was recently integrated in to the MaineHealth system and they are engaged in an Epic electronic health record implementation. IDN staff have had on going communications and one meeting with Memorial staff that included a demo of the shared care plan and these meetings will continue.

North Country Health Care: NCH is comprised of Weeks Hospital, Androscoggin Valley Hospital, Littleton Regional Healthcare and Upper Connecticut Valley Hospital. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives. In this period, Androscoggin, Upper Connecticut

Valley and Weeks were able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. Recently, we have initiated a project to establish ADT connections for Littleton Hospital and we hope that can be completed quickly.

NCH has also agreed to begin implementing the shared care plan. This will occur first at the Weeks hospital emergency department. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. While no specific time line has been established yet, it is hoped that we will see active use by the end of the next reporting cycle.

Cottage Hospital: Cottage Hospital is not currently not engaged in active work on the SCP and is not contributing ADT feeds to the CMT network yet. IDN staff continue to engage this partner on how the tool can help the organization and other IDN partners.

White Mountain Community Health: This organization has done significant work in developing a process to deliver integrated care including hiring a care coordinator, developing an assessment process and establishing a multidisciplinary team process. They have worked closely with a North Country Health Consortium Practice Transformation facilitator in this regard. They are actively working on a shared care plan install. IT resources are currently developing the census file upload and leadership is defining parameters for SCP users, cohorts and notifications.

Indian Stream Health Center: Indian Stream is not engaged in active work on the SCP at this time. IDN Staff have met with their team and while they are supporters of the SCP initiative, resources to implement are a challenge since the organization is engaged in a significant EHR upgrade at this time.

Coos County Family Health Services: IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking. We are scheduling an initial project call now with Collective Medical Technologies and the organization will be moving forward with an installation of the shared care plan in the coming weeks.

Northern Human Services: NHS is not engaged in active work on the SCP at this time. IDN staff have had a several meetings with the group. They have been doing due diligence on consent requirements and related processes. It is hoped that the organization will adopt the SCP in the coming months, particularly in light of the work being done by primary care organizations in the region.

Saco River Medical Group: Saco River and IDN staff have met twice to discuss the SCP. Resources to install and provider workflow and productivity impact have been concerns. Additionally, SRMG's primary hospital partner, Memorial Hospital, is currently not submitting ADT information and the SCP is viewed as less valuable without that information.

Challenges:

- A perception that partners need to wait to use the shared care plan because it is not ready or still in development
- Engaging management to discuss the use of the shared care plan.
- Staff time to implement the shared care plan
- Concerns regarding 42 CFR part 2 and patient consent for the shared care plan
- A perception among partners that the shared care plan will have a high impact on provider productivity
- Workflow concerns that providers cannot take the time to look at the SCP.

- Competing priorities and related staff time to address IDN deliverables… core comprehensive assessments, multidisciplinary teams, data reporting, shared care plan, etc.
- Active EHR implementations that dominate time for HIT projects
- SCP is not integrated to partner electronic health records.

Mitigation:

- Strategy: Raise awareness and understanding of the shared care plan with partners by highlighting implementation activity in Region 7 IDN and in the State at large, messaging readiness, implementation process and value/benefits.
- Strategy: Educate partners on the implementation process, functionality and workflow of using the shared care plan. Work to highlight previous Collective Medical Technologies successes, realities of use of the shared care plan and flexibility of implementation.
- Strategy: Address known concerns about the shared care plan such as consent and 42 CFR requirements
- Strategy: Leverage other IDN and North Country Health Consortium staff to address concerns in specific subject matter areas e.g. workflow, network connectivity, data reporting, etc.
- Strategy: Integrate SCP into the IDN regional discussion on care coordination and highlight SCP as a vital tool making care coordination more effective and efficient.
- Tactic: HIT Coach conducts regular outreach to partners via phone and email
- Tactic: HIT Coach established and maintains IDN Basecamp project for the shared care plan to assure easy access to resources and to raise the profile of the shared care plan. Utilize IDN Basecamp site for announcements.
- Tactic: HIT Coach provides initial SCP orientation and regular SCP updates in committee meetings
- Tactic: Scheduled individual SCP demonstrations with partners as possible
- Tactic: HIT coach attended and coordinated a presentation at the spring Care Coordination training in Carroll County to discuss opportunities and concerns for the SCP. Collective Medical Technologies presented to the group highlighting successes, implementation process and software demonstration.
- Tactic: Engage partners at the IDN's quarterly meeting on the potential for the SCP as a care coordination tool through facilitation of a care coordinator panel.
- Tactic: Conduct regular webinars speaking to the SCP implementation, functionality and concerns. IDN staff feel that webinars have been an effective way to keep the SCP on the mind of providers and to educate partners about installation process, use and successes. We will continue to look for topics to offer partners in this format.
    - General SCP webinar hosted by the IDN and presented by CMT with the agenda being overview, successes, software demo, implementation overview, next steps.
    - SCP and 42 CFR Webinar presented by CMT describing requirements and their newly developed consent form and consent tracking functionality.
- Tactic: Onsite partner engagement meetings at key partner locations with the IDN Program Manager. To date, this has included North Country Healthcare, Northern Human Services, Huggins Hospital, Weeks, Cottage Hospital, Indian Stream Health Center, White Mountain Community Health Center, Saco River Medical Group, Coos County Family Health and Ammonoosuc Health Center.

- Tactic: More effectively communicate to partners on the approach, level of effort and value of IDN HIT initiatives through coordinated and streamlined use of mass email, basecamp, Facebook and the IDN website.

ID	Task Mode	Task Name	Duration	Start	Finish
20		**Component 1/2 Support Electronic Shared Care Plan/Event Notification (receive) Adoption By Direct Care Providers**	**433 days**	**Wed 8/2/17**	**Sun 3/31/19**
21		CMT agreements signed at each care coordination site	283 days	Wed 8/2/17	Fri 8/31/18
22	✓	Selection of Regional Data Fields	322 days	Wed 10/4/1	Thu 12/27/1
23	✓	Regional care plan data fields provided to CMT	0 days	Fri 12/28/18	Fri 12/28/18
24		Begin sub-regional CMT trainings	261 days	Wed 10/4/1	Wed 10/3/1
25		Core Teams in First Sub Region Trained and Adopts PreManage	0 days	Thu 3/1/18	Thu 3/1/18
26		Core Teams Second Sub Region Trained and Adopts Premanage	0 days	Mon 12/31/18	Mon 12/31/18
27		Core Teams Third Sub Region Trained and Adopts PreManage	0 days	Sun 3/31/19	Sun 3/31/19

(A2 Project Component 1-2)

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 region has found a test case for finding a recommended vendor. In May, using the "Training and Technology Request Form" which allows IDN partners to submit for training and IT related expenses totaling $5000 or less once per year, Service Link of Carroll County entered a proposal to purchase KNO-2's Direct Secure Messaging solution to allow for secure communication amongst their various sites and with partners. KNO-2 had previously been the vendor of choice for the Statewide New Hampshire Health Information Organization and still has significant presence in the region. Given this, and the affordable price point at which this software is offered, approval was given for Service Link to move forward with this purchase using IDN funds. IDN Region 7 will follow up with Service Link to ascertain its usefulness and features for Service Link. The region will then review KNO-2 at the HIT/Data committee and determine if it will be a recommended solution for social determinant providers and others who are currently operating without direct capability. This recommendation will be in place by 12/31/2018.

ID	Task Mode	Task Name	Duration	Start	Finish
28		**Component 1/3 Support Adoption of Direct Secure Messaging By IDN Participants**	**499 days**	**Tue 8/1/17**	**Mon 7/1/19**
29		Select Vendor Recommendation For Direct Secure Messaging	240 days	Tue 8/1/17	Sat 6/30/18
30		Submit vendor recommendation to steering committee	1 day	Mon 12/31/	Mon 12/31/
31		Solicit and Respond to RFPs for support of direct secure messaging	0 days	Tue 1/1/19	Tue 1/1/19
32		Community Based Providers In First Sub Region Trained and Adopts Direct Secure Messaging	0 days	Thu 1/31/19	Thu 1/31/19
33		Community Based Providers In Second Sub Region Trained and Adopts Direct Secure Messaging	0 days	Tue 4/30/19	Tue 4/30/19
34		Community Based Providers In Third Sub Region Trained and Adopts Direct Secure Messaging	0 days	Mon 7/1/19	Mon 7/1/19

(A2 Project Component 1-3)

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

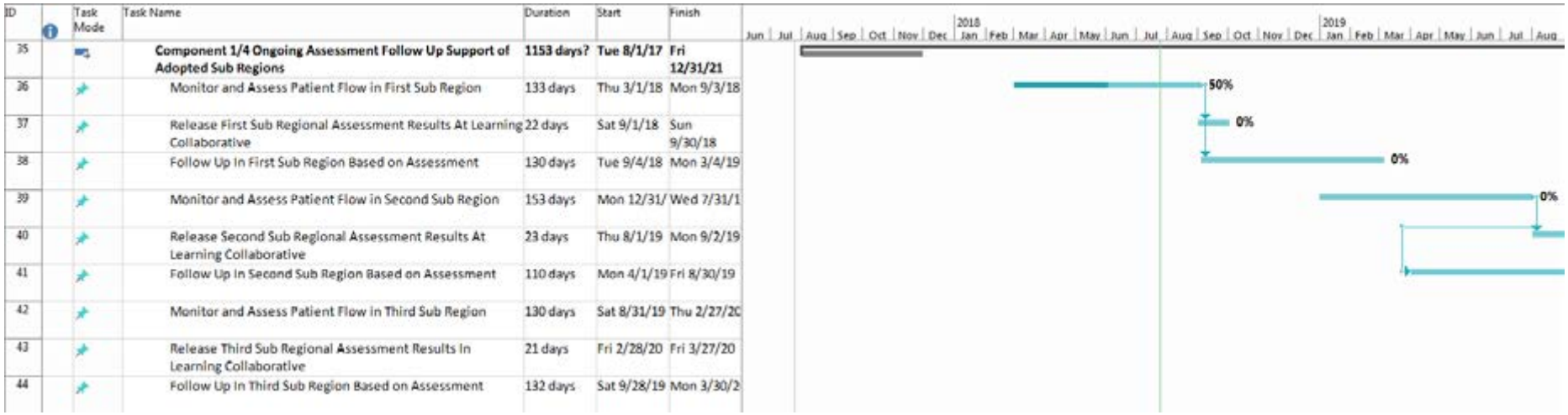
Recognizing the complexity of the systems involved and the need for ongoing support in the face of a changing care landscape and other challenges, IDN Region 7 commits to the ongoing support of its network as it moves towards meeting the criteria for integrated care and begins the transition into an 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.

Given that the initial integration trainings began in March of 2018 and that the rest of the region only received a limited dosage training in June, only limited follow-up actions have been taken by the IDN at this point, including ongoing messaging to the providers about the value of shared care planning and event notification components. Individual follow up has been progressing with the initial Carroll County provider utilizers in order to assure their utilization of the software is proceeding smoothly but any assessment will need to wait for implementation to take root in Partners Sites. Region 7 has a soft target of 09/30/2018 to follow up with Carroll County providers and determine what successes and challenges have transpired. A similar plan will be utilized to follow up with Coos and Grafton County providers as they come on board. Once we have regional implementation, a utilization survey will be prepared and sent out to key stakeholders to assess overall regional performance as it relates to IT-supported Care Coordination.



ID	Task Mode	Task Name	Duration	Start	Finish
35		**Component 1/4 Ongoing Assessment Follow Up Support of Adopted Sub Regions**	**1153 days?**	**Tue 8/1/17**	**Fri 12/31/21**
36		Monitor and Assess Patient Flow in First Sub Region	133 days	Thu 3/1/18	Mon 9/3/18
37		Release First Sub Regional Assessment Results At Learning Collaborative	22 days	Sat 9/1/18	Sun 9/30/18
38		Follow Up In First Sub Region Based on Assessment	130 days	Tue 9/4/18	Mon 3/4/19
39		Monitor and Assess Patient Flow in Second Sub Region	153 days	Mon 12/31/	Wed 7/31/1
40		Release Second Sub Regional Assessment Results At Learning Collaborative	23 days	Thu 8/1/19	Mon 9/2/19
41		Follow Up In Second Sub Region Based on Assessment	110 days	Mon 4/1/19	Fri 8/30/19
42		Monitor and Assess Patient Flow in Third Sub Region	130 days	Sat 8/31/19	Thu 2/27/20
43		Release Third Sub Regional Assessment Results In Learning Collaborative	21 days	Fri 2/28/20	Fri 3/27/20
44		Follow Up In Third Sub Region Based on Assessment	132 days	Sat 9/28/19	Mon 3/30/2

(A2 Project Component 1-4)

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 a 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.

IDN Region 7 participated fully in the vendor demos and reviews organized at the state level to ensure that the correct vendor was selected for this important task. The regional HIT leads and data/HIT representatives of 3 partner organizations all participated in this process, which resulted in the selection of Massachusetts Area E-Health Collaborative (MAeHC) to fulfill this need. A combination of MAeHC's success in similar initiatives and a demonstrated ability to report cross-platform made them the consensus selection of Region 7 respondents as well as the state.

In the first IDN reporting cycle, covering two measures that had reporting periods from 07/01/2017 through 12/31/2017, closed on April 1st, 2018. The reporting processes, while successful was faced with several challenges.

42 CFR Part 2:

It was discovered early in the reporting process that neither the data agreements between the IDN and the partner agencies, nor the structure of reporting proposed by MAeHC would satisfy the stringent guidelines required under 42 CFR Part 2. 42 CFR Part 2 is a federal regulation which holds certain providers of substance use disorder treatment services to a more stringent threshold for disclosures than those found under the more general HIPAA regulation. The disclosure structure proposed by MAeHC was found to not be conducive to these more stringent guidelines, and therefore the entire

process needed to be re-considered from data sharing agreements through reporting system structure. MAeHC has since made system changes to alleviate this issue by adding a field to indicate 42 CFR Status in order to "hold aside" this data from visibility by others in the system. In a similar manner IDN 7 legal representation has crafted an amendment to the original business associates agreement which establishes a qualified service organization agreement between the IDN and partner agencies. However, the time lost while these solutions were crafted meant that no IDN Region 7 provider submitted data that was deemed to be 42 CFR Part 2 covered. This meant that some partners who consider themselves to be "wholly covered entities" were ready to report in total but had to withhold all data in order to stay in compliance with 42 CFR Part 2.

IDN Region 7 had targeted all providers who had reportable data on these measures to be included. Because both measures related to primary care and behavioral health sites, the subset of participants was smaller than both the total IDN partner list and those subsets who were direct billing providers. Those providers who participated in the initial round were.

Ammonoosuc Community Health Services engaged with Region 7 on reporting early on in the process and successfully reported on both measures required for the first reporting period, holding out only those data points deemed to be covered by 42 CFR Part 2.

Coos County Family Health Services engaged with Region 7 on reporting early on in the process but elected to curtail participation until the issue with 42 CFR Part 2 had been resolved. Once fixed, they re-engaged. At this point the deadline for the first reporting period had been missed, but Region 7 expects them to be full reporters in the second and consecutive reporting periods.

Cottage Hospital/Rowe Health Center engaged fully throughout the reporting process but elected to hold off on reporting until issues with the 42 CFR Part 2 could be fully addressed through MAeHC system modifications and the QSO language. Like Coos County, this meant that they missed the deadline for the first reporting period. Migration to a new EMR, which took place in April and May at their facilities means that their participation in the second reporting period has been limited, but they are working towards submitting data

Huggins Hospital engaged early in the reporting process but quickly discovered an issue with their EMRs reporting system when it came to isolating denominator patients for ASSESS_SCREEN_02. However, they reported successfully on ASSESS_SCREEN_01. Going forward, they are working to fix the issue so that they can report successfully on ASSESS_SCREEN_02 in the second and consecutive reporting periods.

Indian Stream Health Center engaged with Region 7 on reporting early on in the process and successfully reported on both measures required for the first reporting period, holding out only those data points deemed to be covered by 42 CFR Part 2.

Memorial Hospital dealt with two internal issues which compromised their ability to report full. The first, a disruption to IT operations due to a flooding incident during the late winter and the second a yearlong migration to a new EMR further reducing IT resources. Nevertheless, through the ingenuity of Memorial staff and the guidance of MAeHC, they were able to successfully report on ASSESS_SCREEN_01.

Northern Human Services was technically ready and able to submit data on both measures but had to curtail reporting due to the fact that they consider themselves to be a 42 CFR "Covered Entity" meaning that they were reliant on the change to the MAeHC structure and the QSO amendment to be in place before they reported. We have achieved both aims and expect full reporting from NHS for the second reporting period and beyond.

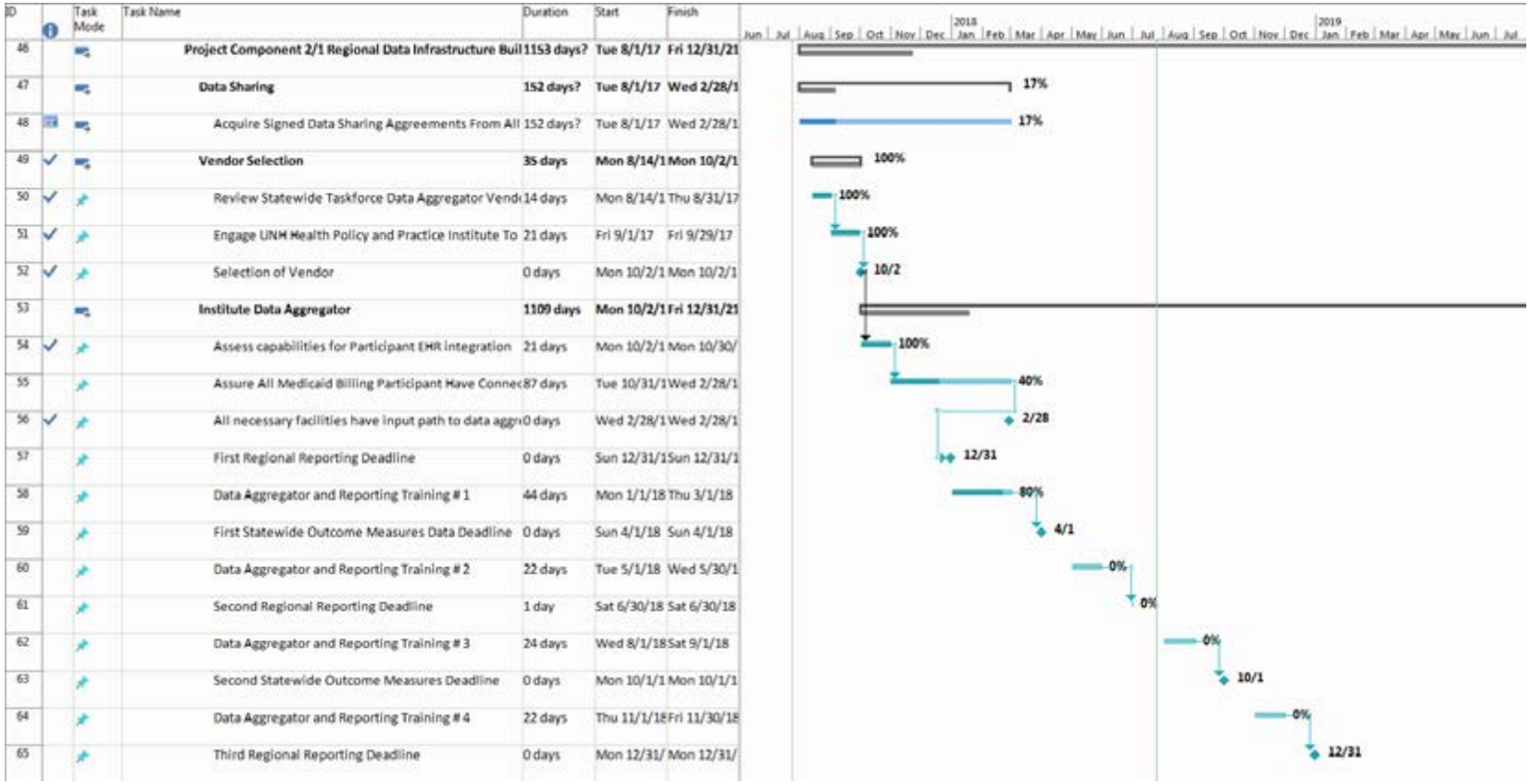
Saco River Medical Group engaged late in the reporting process (February) and, combined with staffing concerns in the area of IT and reporting, meant that they were not able to report in time for the first reporting period. They continue to engage and have covered staffing shortfalls with a "Training and Technology Request" of funds from the IDN to support their reporting process. Region 7 IDN expects them to full report in the second and consecutive reporting periods.

White Mountain Community Health Center engaged with Region 7 on reporting early on in the process and successfully reported on both measures required for the first reporting period, holding out only those data points deemed to be covered by 42 CFR Part 2.

Other providers who were targeted for reporting but did not participate because of 42 CFR Part 2 concerns or internal issues consuming IT resources were: Friendship House; Littleton Regional Healthcare; White Horse Addiction Center; and Weeks Medical Center.

Of these Friendship House and White Horse were not engaged for participation until the 42 CFR Part 2 situation could be resolved. Both sites also lack on-site EHRs and are reliant on the Bureau of Drug and Alcohol Services Web Interface Technology System (or WITS) and paper records to collect and store data. Region 7 is beginning to engage these providers over the summer with expected reporting for the current 07/01/2018-12/31/2018 reporting period.

Littleton Regional Healthcare and Weeks Medical Center were unable to provide IT or quality reporting resources during the reporting period, but IDN region 7 has met with leadership and they have committed to reporting for the period beginning 07/01/2018.



ID	Task Mode	Task Name	Duration	Start	Finish
46		**Project Component 2/1 Regional Data Infrastructure Buil**	**1153 days?**	**Tue 8/1/17**	**Fri 12/31/21**
47		**Data Sharing**	**152 days?**	**Tue 8/1/17**	**Wed 2/28/1**
48		Acquire Signed Data Sharing Aggreements From All	152 days?	Tue 8/1/17	Wed 2/28/1
49		**Vendor Selection**	**35 days**	**Mon 8/14/1**	**Mon 10/2/1**
50		Review Statewide Taskforce Data Aggregator Vend	14 days	Mon 8/14/1	Thu 8/31/17
51		Engage UNH Health Policy and Practice Institute To	21 days	Fri 9/1/17	Fri 9/29/17
52		Selection of Vendor	0 days	Mon 10/2/1	Mon 10/2/1
53		**Institute Data Aggregator**	**1109 days**	**Mon 10/2/1**	**Fri 12/31/21**
54		Assess capabilities for Participant EHR integration	21 days	Mon 10/2/1	Mon 10/30/
55		Assure All Medicaid Billing Participant Have Connec	87 days	Tue 10/31/1	Wed 2/28/1
56		All necessary facilities have input path to data aggr	0 days	Wed 2/28/1	Wed 2/28/1
57		First Regional Reporting Deadline	0 days	Sun 12/31/1	Sun 12/31/1
58		Data Aggregator and Reporting Training # 1	44 days	Mon 1/1/18	Thu 3/1/18
59		First Statewide Outcome Measures Data Deadline	0 days	Sun 4/1/18	Sun 4/1/18
60		Data Aggregator and Reporting Training # 2	22 days	Tue 5/1/18	Wed 5/30/1
61		Second Regional Reporting Deadline	1 day	Sat 6/30/18	Sat 6/30/18
62		Data Aggregator and Reporting Training # 3	24 days	Wed 8/1/18	Sat 9/1/18
63		Second Statewide Outcome Measures Deadline	0 days	Mon 10/1/1	Mon 10/1/1
64		Data Aggregator and Reporting Training # 4	22 days	Thu 11/1/18	Fri 11/30/18
65		Third Regional Reporting Deadline	0 days	Mon 12/31/	Mon 12/31/

(A2 Project Component 2-1)

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. Since all three community driven projects and the core competency will require some examination of population health, either for the purposes of quality improvement above and beyond the regional and statewide outcome measures or for tracking of individual high-risk patients for purpose of implementation, IDN Region 7 commits to a trial period of population health analytics.

This began an exploration of the selected tools capabilities in this area, a process targeted for completion by 06/30/2018. IDN Region 7 can report that this process has begun but is still ongoing.

On the Use of MAeHC as a Population Health Tool:

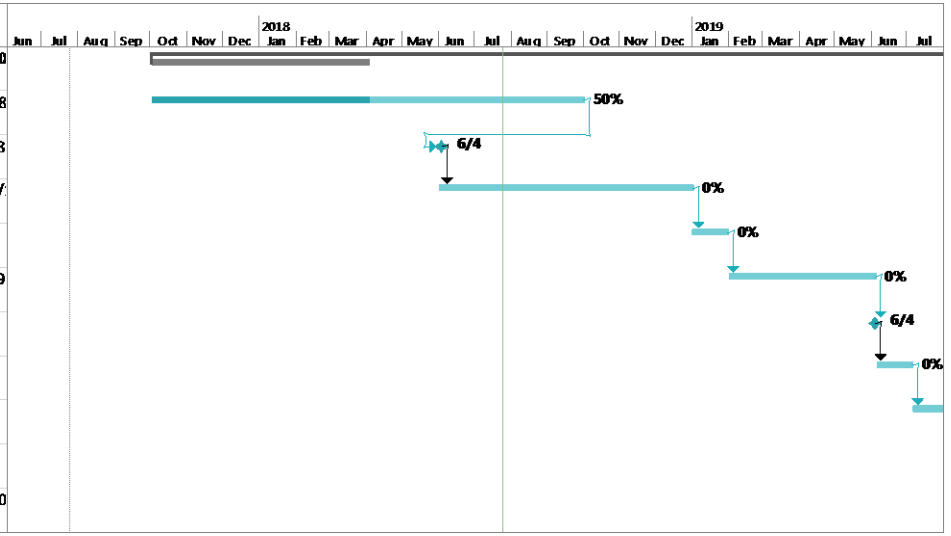
One of the desired uses of the MAeHC reporting system, in the view of the IDN Region 7 HIT/Data Committee and others, was for care coordination and population health. The web-based platform, drill-down patient view and reporting capabilities of the reporting system would be ideal for supporting a coordinated a multi-agency approach to this issue.

However, because any such utilization would require sharing for purposes other than 42 CFR Part 2-allowed audit and evaluation, MAeHC and the state have informed Region 7 in no uncertain terms that such a use would not be advisable or allowable. Because of this, any notions of using MAeHC for this purpose was abandoned by early spring.

Starting in the new year, the IDN engaged with ANALYSTS Inc, a health analytics reporting firm specializing in assisting in large multi-agency efforts similar to the IDN. An on-site scoping session was held in early winter to go over data needs both internal and external that they could support. Population Health Management was one of the desired capabilities that Region 7 wanted to see come out of this partnership. ANALYSTS gave a quote inclusive initially of internal reporting support, but which could be theoretically leveraged to support population health initiatives in the future. IDN Region 7 considered this quote but in the end decided not to pursue it.

Going forward, IDN Region 7 will continue to seek out population health solutions that can help support the processes of the E5 project and beyond. Region 7 is now targeting implementation of such a tool at one partner agency by 12/31/2018. Region 7 hopes to leverage relationships with the hospital affiliation and others who have existing ACO commitments to find and leverage population health analytics.

ID	Task Mode	Task Name	Duration	Start	Finish
220		**Project Component 2/2 Population Health Analytics**	**716 days**	**Mon 10/2/1**	**Tue 6/30/20**
221		Explore vendor capabilities for population health analytics	261 days	Mon 10/2/1	Sun 9/30/18
222		Determine if more capabilities needed for project population health goals	0 days	Mon 6/4/18	Mon 6/4/18
223		Develop population health reports supportive of E5 projec	152 days	Fri 6/1/18	Mon 12/31/
224		Solicit 3 providers engaged in E5 Project to test drive population health service	23 days	Mon 12/31/18	Wed 1/30/19
225		Population Health Trial Period	87 days	Fri 2/1/19	Mon 6/3/19
226		Presentation to network on trial program	0 days	Tue 6/4/19	Tue 6/4/19
227		Select 3 providers for second phase rollout	22 days	Wed 6/5/19	Thu 7/4/19
228		Second phase rollout providers begin implementation	240 days	Fri 7/5/19	Thu 6/4/20
229		Interim status report presentation on second phase providers to steering committee	0 days	Fri 11/15/19	Fri 11/15/19
230		Final report from second phase providers	0 days	Tue 6/30/20	Tue 6/30/20



(A2 Project Component 2-2)

Project Component 3: Support HIT Improvement Throughout the Region Through RFP 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 s 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.

The project is also supported by the utilization of limited "Training and Technology Requests" which are fast tracked for review but are limited to one per agency per calendar year and a maximum budget of $5000. These fast-tracked requests have been very well-received, especially by our smaller and newer providers, many of whom need assistance with the basics of capturing and storing data electronically. For HIT Project funding, preference will be given to participant organizations seeking funding to do the following (from highest priority to lowest)

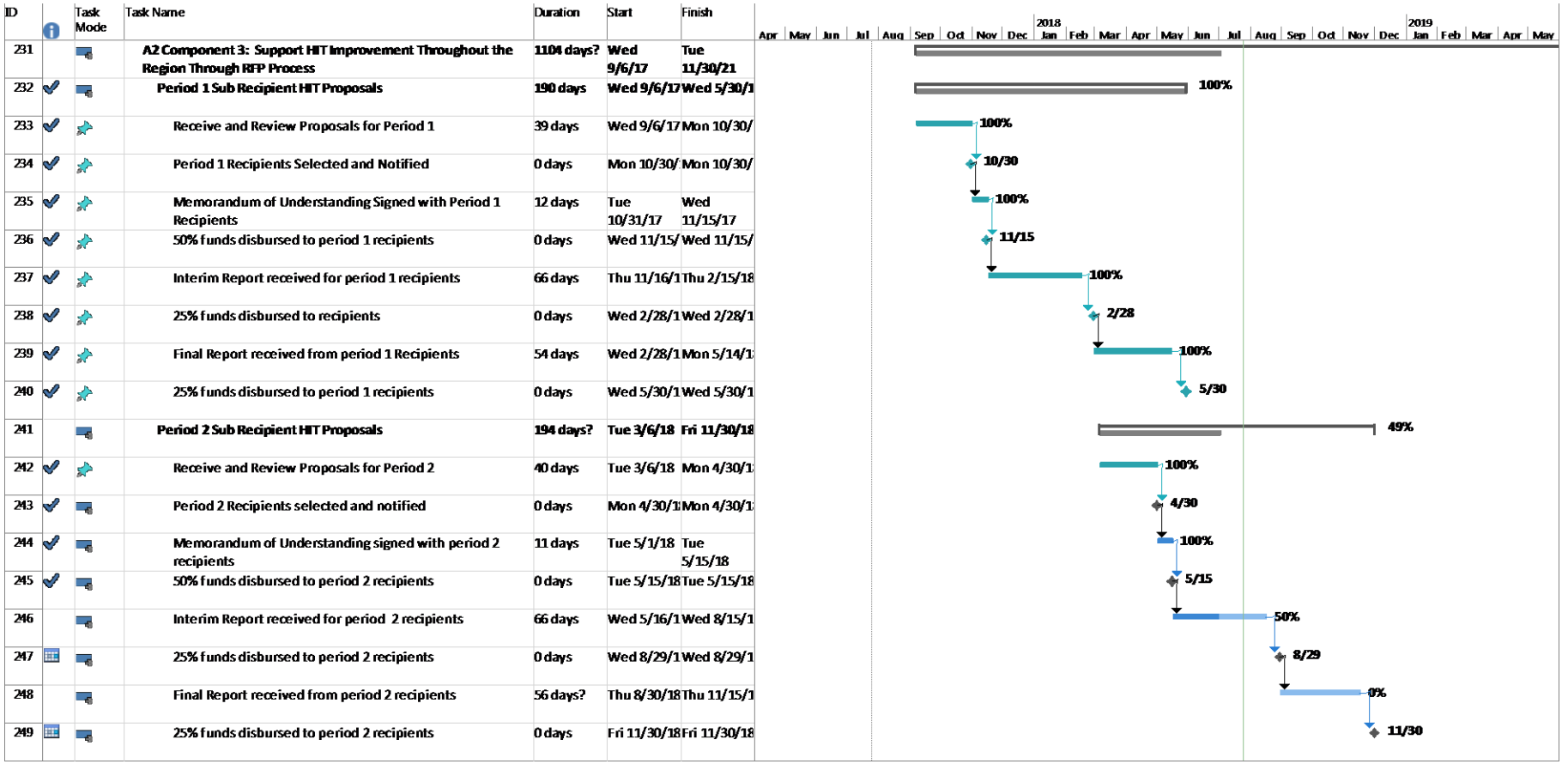
Create, improve or expand current health information exchange (HIE) infrastructure
Create or improve their ability to store or transmit patient data in a secure manner
Assure stable and secure internet connectivity
Create or enhance ability to capture and transmit patient consents electronically
Offer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

HIT Proposals funded in the reporting period 01/01/2018-06/30/2018 which fall into the general IT categories include:

Partner Organization	Funding Allocated	Project Description	HIT Component
Huggins Hospital	$5000	Budgeted funds will be used to install and implement the Zoom platform for training webinars, and for EMR and other IT modifications to support tracking and follow up of MAT service delivery, patient care, and outcomes tracking and reporting.	Discrete Electronic Data Capture Patient Engagement Technology
Carroll County Corrections Department	$1500	Power Point Projector LCD television Speaker system DVD player This will allow us to provide for both training for staff as well as additional support for clients I in phase I of the time intervention Model	Patient Engagement Technology
Mount Washington Valley Supports Recovery	$500	Laptop for tracking recovery visits and resident statistics	Electronic Data Capture Secured Data Storage Discrete Electronic Data Capture
ServiceLink Resource Center of Carroll County	$300	License for use of Kno2 Direct Secure Messaging Software	Secured Data Storage
North Country Serenity Center	$2650	Cell phone, Desktop computer, Laptop to enable tracking and communication from the recovery center.	Electronic Data Capture Secured Data Storage Discrete Electronic Data Capture
North County Healthcare	$50000	For continued use of software communication platform and provider directory to ensure that patients accessing an online call center are directed appropriately	Patient Engagement Technology/ Capacity Management Tools

		to providers across the physical health/behavioral health continuum.	
Total	$59950		

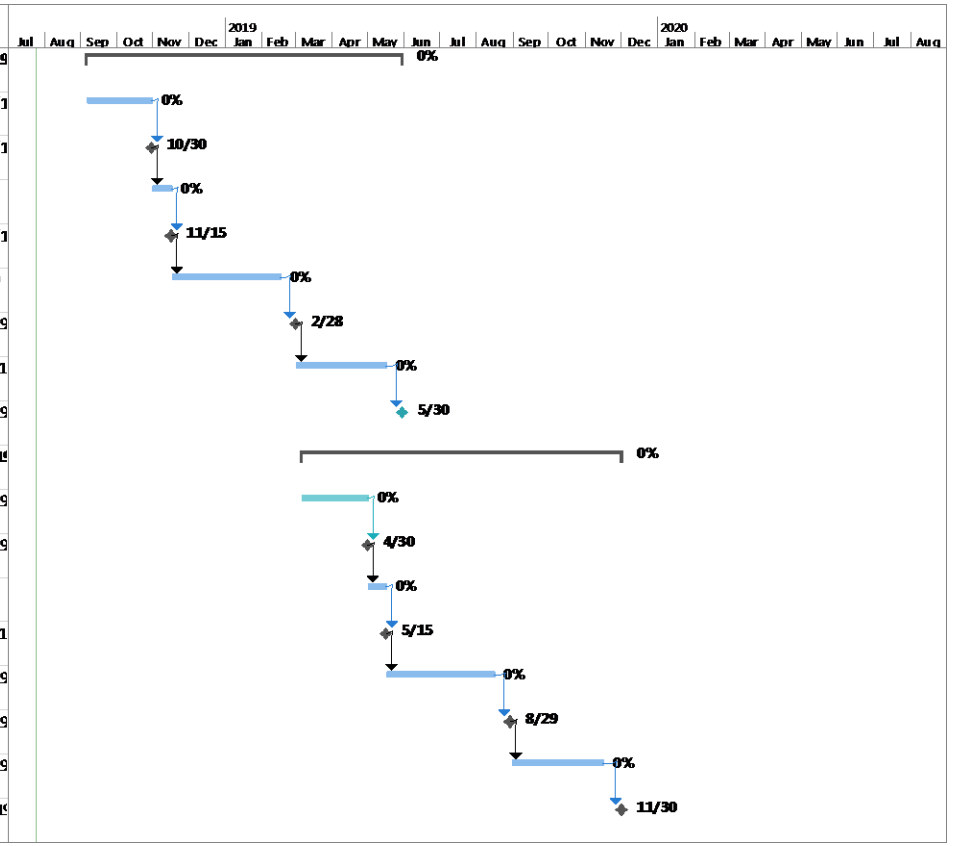
In future reporting periods, the IDN will be moving to a different structure for supporting these ongoing IT projects. It is likely that this will be tied directly to outcomes or to progress towards outcomes. This structure will be decided upon by the IDN Steering Committee in coming months.



ID	Task Mode	Task Name	Duration	Start	Finish
231		**A2 Component 3: Support HIT Improvement Throughout the Region Through RFP Process**	**1104 days?**	**Wed 9/6/17**	**Tue 11/30/21**
232		**Period 1 Sub Recipient HIT Proposals**	**190 days**	**Wed 9/6/17**	**Wed 5/30/1**
233		Receive and Review Proposals for Period 1	39 days	Wed 9/6/17	Mon 10/30/
234		Period 1 Recipients Selected and Notified	0 days	Mon 10/30/	Mon 10/30/
235		Memorandum of Understanding Signed with Period 1 Recipients	12 days	Tue 10/31/17	Wed 11/15/17
236		50% funds disbursed to period 1 recipients	0 days	Wed 11/15/	Wed 11/15/
237		Interim Report received for period 1 recipients	66 days	Thu 11/16/1	Thu 2/15/18
238		25% funds disbursed to recipients	0 days	Wed 2/28/1	Wed 2/28/1
239		Final Report received from period 1 Recipients	54 days	Wed 2/28/1	Mon 5/14/1
240		25% funds disbursed to period 1 recipients	0 days	Wed 5/30/1	Wed 5/30/1
241		**Period 2 Sub Recipient HIT Proposals**	**194 days?**	**Tue 3/6/18**	**Fri 11/30/18**
242		Receive and Review Proposals for Period 2	40 days	Tue 3/6/18	Mon 4/30/1
243		Period 2 Recipients selected and notified	0 days	Mon 4/30/1	Mon 4/30/1
244		Memorandum of Understanding signed with period 2 recipients	11 days	Tue 5/1/18	Tue 5/15/18
245		50% funds disbursed to period 2 recipients	0 days	Tue 5/15/18	Tue 5/15/18
246		Interim Report received for period 2 recipients	66 days	Wed 5/16/1	Wed 8/15/1
247		25% funds disbursed to period 2 recipients	0 days	Wed 8/29/1	Wed 8/29/1
248		Final Report received from period 2 recipients	56 days?	Thu 8/30/18	Thu 11/15/1
249		25% funds disbursed to period 2 recipients	0 days	Fri 11/30/18	Fri 11/30/18

(A2 Project Component 3-1 Part 1: Current and Past Cycles)

ID	Task Mode	Task Name	Duration	Start	Finish
250		**Period 3 Sub Recipient HIT Proposals**	190 days	Thu 9/6/18	Thu 5/30/19
251		Receive and review proposals for period 3	39 days	Thu 9/6/18	Tue 10/30/1
252		Period 3 recipients selected and notified	0 days	Tue 10/30/1	Tue 10/30/1
253		Memorandum of Understanding signed with period 3 recipients	12 days	Wed 10/31/18	Thu 11/15/18
254		50% funds disbursed to period 3 recipients	0 days	Thu 11/15/1	Thu 11/15/1
255		Interim Report received for period 3 recipients	66 days	Fri 11/16/18	Fri 2/15/19
256		25% funds disbursed to period 3 recipients	0 days	Thu 2/28/19	Thu 2/28/19
257		Final Report received from period 3 recipients	54 days	Fri 3/1/19	Wed 5/15/1
258		25% funds disbursed to period 3 recipients	0 days	Thu 5/30/19	Thu 5/30/19
259		**Period 4 Sub Recipient HIT Proposals**	193 days?	Wed 3/6/19	Sat 11/30/19
260		Receive and Review Proposals for Period 4	40 days	Wed 3/6/19	Tue 4/30/19
261		Period 4 Recipients Selected and Notified	0 days	Tue 4/30/19	Tue 4/30/19
262		Memorandum of Understanding Signed with Period 4 Recipients	11 days	Wed 5/1/19	Wed 5/15/19
263		50% funds disbursed to period 4 recipients	0 days	Wed 5/15/1	Wed 5/15/1
264		Interim Report received for period 4 recipients	66 days	Thu 5/16/19	Thu 8/15/19
265		25% funds disbursed to period 4 recipients	0 days	Thu 8/29/19	Thu 8/29/19
266		Final Report received from period 4 recipients	56 days?	Fri 8/30/19	Fri 11/15/19
267		25% funds disbursed to period 4 recipients	0 days	Sat 11/30/1	Sat 11/30/19



(A2 Project Component 3-1 Part 2: Next Two Cycles)

A2-4. IDN HIT: Evaluation Project Targets

From the IDN HIT Implementation Plan, use the format below to identify the progress toward targets, or goals, that the plan has achieved.

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	13	0	1	
Number of Participants Exchanging Information Via Shared Care Plan Tool	13	0	0	
Hospitals Sending Event Notifications To PreManage ED	7	1	4	
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	15 (presence of capabilities only)	16 (presence of capabilities only)	
Reporting Periods Successfully Completed (By 2020)	20	0	1	
Pilot Participants Using Population Health Tool (By 2020)	5	0	0	
Region 7 Patient Lives In PreManage Primary (By 2020)	19601	0	0	
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	0	5 (11 funded)	

Region 7 IDN has changed the target for the number of participant sites with at least one member trained in use of PreManage Primary and number of participants exchanging info via a shared care plan to be 13 agencies by 2018 to match with our B1 project. When Region 7 IDN staff first saw this measure it was thought that all sites needed to use a CCSA and shared care plan, but now it is known that it is only required for the behavioral health and primary care organizations in the region.

A2-5. IDN HIT: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing 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	1	1	
HIT Integration Coach	1	0	0	1	
Data Specialist at NCHC	1	0	0	0	
Data Aggregator specialists in the community through the RFP process	Up to 3	0	0	0	

A2-6. IDN HIT: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the IDN HIT project which must include financial reporting.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2020	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	HIT Actual Funds Spent	HIT Actual Expense (6 months)	HIT Budget Projection	HIT Budget Projection	HIT Budget Projection	HIT Budget Projection
HIT	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to December Projected	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0.00	$0
5. Supplies:			$0	$0	$0.00	$0
Educational			$0	$0	$0.00	$0
Office	$1,612	$138	$6,127	$12,254	$12,253.78	$6,127
6. Travel	$1,235	$613	$10,107	$20,213	$20,213.33	$10,107
7. Occupancy			$0	$0	$0.00	$0
8. Current Expenses			$0	$0	$0.00	$0
Telephone			$0	$0	$0.00	$0
Postage			$0	$0	$0.00	$0
Subscriptions		$150,322	$74,991	$149,983	$149,982.89	$74,991
Audit and Legal			$0	$0	$0.00	$0
Insurance			$0	$0	$0.00	$0
Board Expenses			$0	$0	$0.00	$0
9. Software		$738	$421	$842	$842.22	$421
10. Marketing/Communications	$1,809	$1,509	$506	$1,012	$1,012.44	$506
11. Staff Education and Training		$862	$12,633	$25,267	$25,266.67	$12,633
12. Subcontracts/Agreements			$0	$0	$0.00	$0
13. Other (specific details mandatory):			$0	$0	$0.00	$0
Current Expenses: Administrative Lead Organizational Support	$2,722	$1,541	$1,989	$3,979	$3,978.67	$1,989
Support Payments to Partners	$109,551	$99,342	$16,111	$32,222	$32,222.22	$16,111
TOTAL	**$153,205**	**$332,433**	**$166,218**	**$332,436**	**$332,436**	**$166,218**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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

Use the format below to provide an updated list of key organizations and providers participating in the IDN HIT project in the reporting period.

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
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services
Family Resource Center	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

Organization Name	Organization Type
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
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

Organization Name	Organization Type
White Horse Addiction Center	Substance Use Disorder Provider, Therapy for co-occurring disorders (mental health and substance use disorders); Recovery Resources, Advocacy and Support.
White Mountain Community Health Center	Non-FQHC Community Health Partner
North Country Serenity Center	Peer Recovery

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	Y
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	Y
Cottage Hospital	Y
Crotched Mountain Foundation	N
Family Resource Center	N
Grafton County Department of Corrections	N
Grafton County Nursing Home	N
Granite State Independent Living	N
Hope for NH Recovery	N
Huggins Hospital	Y
Indian Stream Health Center	Y

Life Coping, Inc.	N
Littleton Regional Healthcare	N
Memorial Hospital	Y
MWV Supports Recovery	N
National Alliance on Mental Illness	N
North Country Healthcare	N
Northern Human Services	Y
Rowe Health Center	N
Saco River Medical Group	Y
ServiceLink Resource Center of Carroll County and Grafton County	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	Y
North Country Serenity Center	N

Project Scoring: IDN HIT Process Milestones

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

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

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

Each IDN was required to complete a separate implementation plan for the completion of Coordinated Care and, if indicated, Integrated Care designations.

Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. Using Microsoft Project or similar platform update your project timeline 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. The narrative should relate to tables B1-3 through B1-10 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

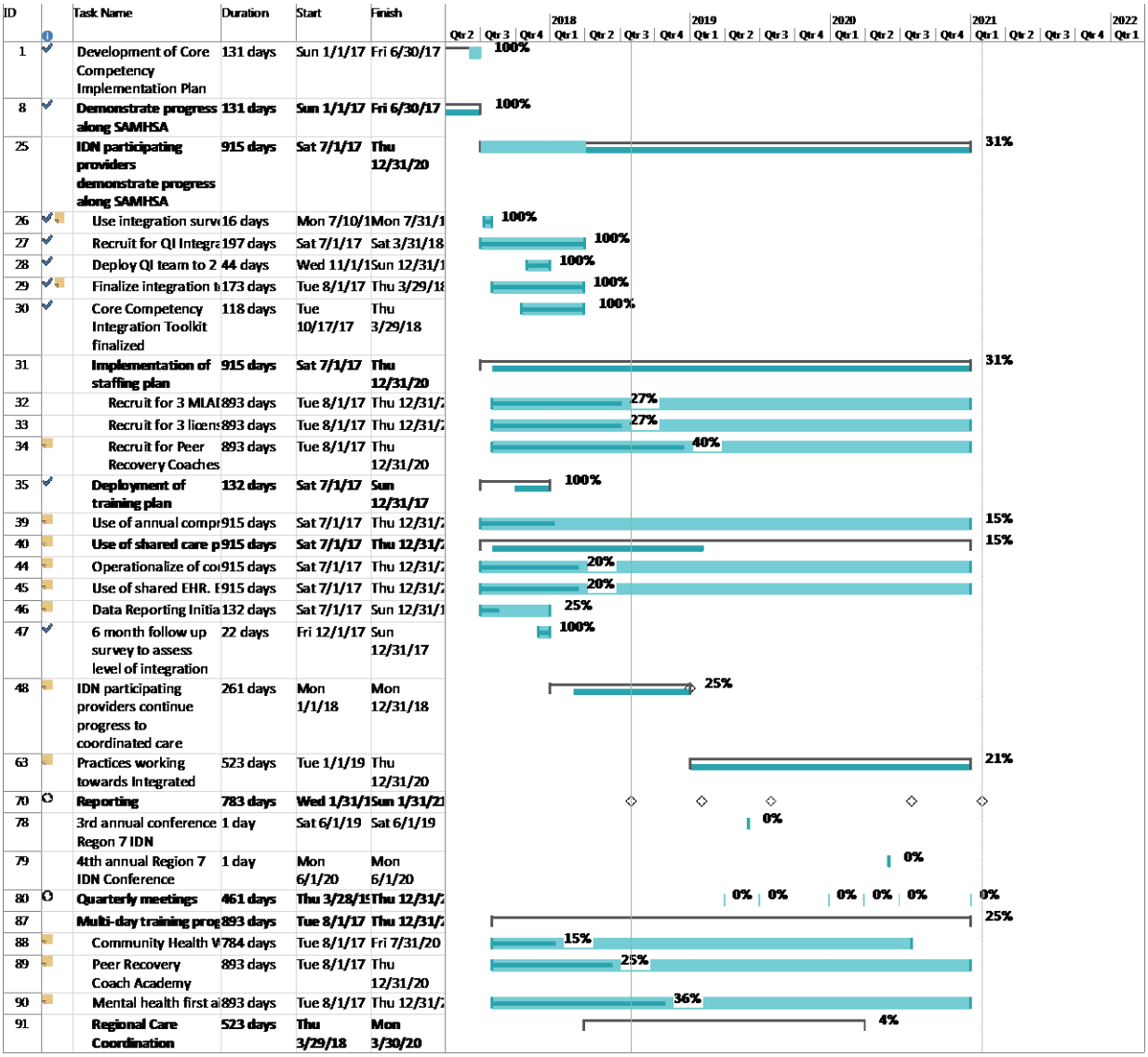
The *Coordinated Care Practice* must include:

- 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

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners.



Attachment_B1_2

During the reporting period of 1/1/2018-6/30/2018 Region 7 IDN had one new partner join the network, the Family Resource Center based in Gorham, NH. No partners left the network.

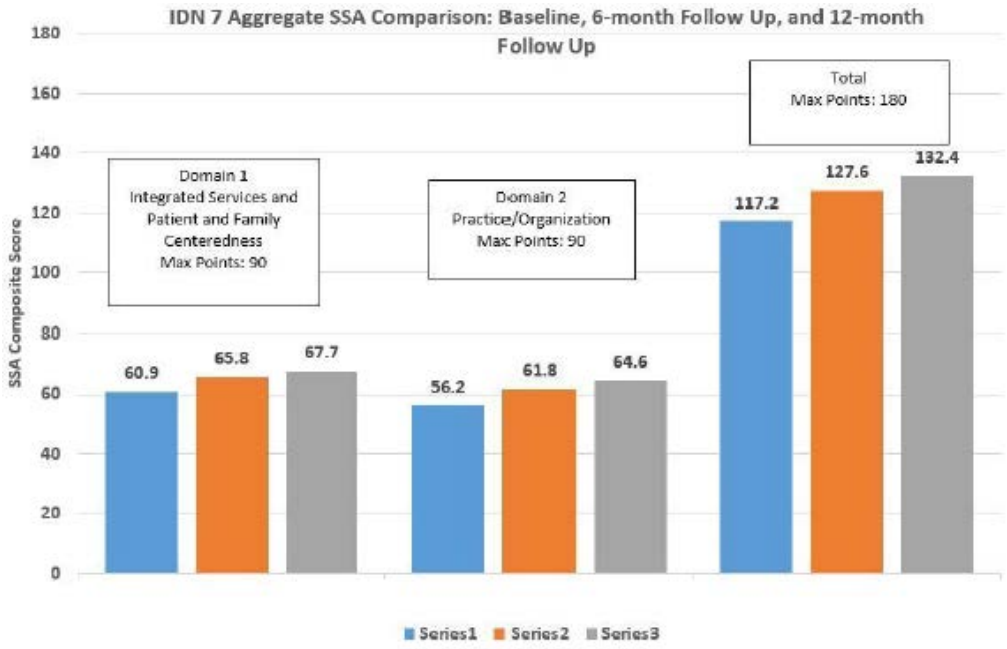
To assist IDN partners as they move along the continuum of integrated healthcare, NCHC continues to follow the region's implementation plan as follows:

- Utilize the Maine Health Access Foundation Site Self-Assessment (MeHAF SSA) to assess the level of behavioral health integration existing in participating behavioral health and primary care practices, and to demonstrate progress over time.
- Use of a quality improvement team
- Use a three-pronged approach to help transform the delivery of behavioral health care in the region:
    - adequately train the workforce utilizing a comprehensive training plan;
    - follow a continuum of care model which addresses prevention, early intervention, treatment, and recovery support services;
    - focus on transitional services

- Provide 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.
- Develop a Region 7 Core Competency Integration Toolkit to help practices advance along the continuum of integrated healthcare
- Assist participating behavioral health and primary care practices as they work to implement the 5 following components required to reach a level of coordinated care by December 31, 2018:
    - Comprehensive Core Standardized Assessment
    - Multi-Disciplinary Core Team
    - Standardized Workflows and Protocols
    - Information Sharing: Care Plans, Treatment Plans, Case Conferences

Maine Health Access Foundation Site Self-Assessment:

Region 7 IDN staff worked with staff from Citizens Health Initiative to deploy the Maine Health Access Foundation Site Self-Assessment again in June of 2018. This was the third time the survey was administered to behavioral health and primary care organizations in the region. Region 7 IDN had 14 practices complete the survey, versus the baseline of 19 practices. Despite this drop, when CHI met with the Region 7 IDN team they said this was a good result, because often follow up survey response rate drops below 50%. In addition, since the surveys were analyzed, both Littleton Regional Healthcare and Cottage Hospital have completed the survey. Their scores will not be included in the region' s aggregate results until the next survey round in December 2018, but their composite scores are included in the table below. NCHC will partner with CHI to administer this survey again in December of 2018. Below are the composite scores from the last 3 surveys to help visualize how partners are performing in the region:



note: Series 1: Baseline; Series 2: Follow-up 1; Series 3: Follow-up 2

IDN Region: 7

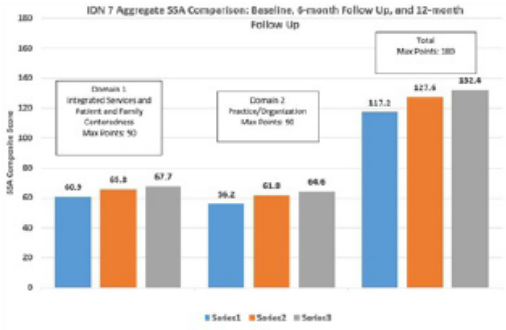
Site Self-Assessment (SSA) Roll-Up Report

Average Scores: Domain One
Integrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2
1. Level of integration: primary care and mental/behavioral health care	5.7	6.2	6.4
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	7.6	8.2	8.6
3. Treatment plan(s) for primary care and behavioral/mental health care	6.1	7.1	7.3
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	7.2	7.9	8.0
5. Patient/family involvement in care plan	7.1	7.9	7.5
6. Communication with patients about integrated care	6.5	6.7	7.1
7. Follow-Up of assessments, tests, treatment, referrals and other services	7.5	7.9	7.9
8. Social support (for patients to implement recommended treatment)	6.6	6.8	7.3
9. Linking to community resources	6.7	6.9	7.8

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1	F/U 2
1. Organizational leadership for integrated care	7.7	8.1	8.3
2. Patient care team for implementing integrated care	5.6	6.6	7.0
3. Providers' engagement with integrated care ("buy-in")	6.4	7.1	7.1
4. Continuity of care between primary care and behavioral/mental health	6.0	6.4	6.5
5. Coordination of referrals and specialists	6.6	7.1	7.6
6. Data systems/patient records	6.8	7.1	7.1
7. Patient/family input to integration management	4.7	5.6	6.0
8. Physician, team and staff education and training for integrated care	5.5	6.3	7.3
9. Funding sources/resources	6.8	7.7	7.6



Note: BL - Baseline Assessment; F/U 1 - First Follow-Up Assessment; F/U 2 - Second Follow-Up Assessment

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*

Below is a chart reflecting composite scores by practice site for both the June 2017 baseline assessment, December 2017 follow-up 1 survey, and June 2018 follow-up 2 survey.

Composite scores by Practice			
Practice Site	**June 2017 Baseline Results**	**December 2017 Follow – Up Results**	**June 2018 Follow- Up Results**
	153	153	N/A
	124	120	126
	103	115	N/A
	91	125	135
	145	150	152
	109	123	143
	132	127	113
	154	174	169
	86	105	117
	116	136	121
	118	127	140
	121	121	126
	121	121	126
	117	119	122
	117	119	122
	124	120	126
	N/A	86	N/A

The chart below shows areas for improvement in ascending order for all the site self-assessment surveys to date.

Domain One Improvement Opportunities (Average Scores by Question Shown in Ascending Order)

SSA No.	1. Level of integration: primary care and mental/ behavioral health care	6. Communication with pati e..	3. Treatment plan(s) for primary care and behavioral/ mental health care	8. Social support (for patients to implement recommended treatment)	5. Patient/family involvement in care plan	9. Linking to community resources	7. Follow-Up of assessments, tests, treatment, referrals and other services	4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	2. Screening and assessment for emotional/ behavioral health needs (e.g. stress, depression, anxiety, substance ab..
F/U 2	6.4	7.1	7.3	7.3	7.5	7.8	7.9	8.0	8.6
F/U 1	6.2	6.7	7.1	6.8	7.9	6.9	7.9	7.9	8.2
BL	5.7	6.5	6.1	6.6	7.1	6.7	7.5	7.2	7.6

Domain Two Improvement Opportunities (Average Scores by Question Shown in Ascending Order)

SSA No.	7. Patient/family input to integration management	4. Continuity of care between primary care and behavior..	2. Patient care team for implementing integrated care	3. Providers' engagement with integrated care ("buy-in")	6. Data systems/ patient records	8. Physician, team and staff education and training for integrated ca..	9. Funding sources/ resources	5. Coordination of referrals and specialists	1. Organizational leadership for integrated care
F/U 2	6.0	6.5	7.0	7.1	7.1	7.3	7.6	7.6	8.3
F/U 1	5.6	6.4	6.6	7.1	7.1	6.3	7.7	7.1	8.1
BL	4.7	6.0	5.6	6.4	6.8	5.5	6.8	6.6	7.7

Region 7 IDN used the baseline survey results to identify four areas that were in the greatest need of improvement and will continue to prioritize improvement efforts in these areas: level of integration - primary care and mental/behavioral health care; patient care team for implementing integrated care; patient/family input to integration management; and physician, team and staff education and training for integrated care. It is encouraging to see steady improvement in all these areas over the past year and shows the commitment of partner agencies as they work to improve integration. When CHI looked at the survey results this time they identified that one practice completed the survey last time, and although it was captured as a follow-up, it really was a baseline, and as such this made a slight adjustment on the region's scores for last time. Moving forward, if an agency completes a survey after the analysis period is over, their composite score will be release, but it will be aggregated with the region's scores in the next survey cycle, which may cause minor fluctuations in scores. An example of this is that in December 2017 the region reported an overall score of 125 which is in the high end of a level 4 along SAMHSA's framework. When these adjustments were made in the scores during this reporting cycle it now shows that the region actually scored a 127.6 which is a level 5 within the SAMSHA framework. This reporting cycle the region went up to a 132.4 which is wonderful progress.

Maine Health Access Foundation Site Self-Assessment categories	Baseline survey results June 2017	6 month follow up survey results December 2017	6-month follow up survey results June 2018
level of integration - primary care and mental/behavioral health care	5.8	6.0	6.4

patient/family input to integration management;	4.9	5.4	6.0
physician, team and staff education and training for integrated care	5.6	6.1	7.3
patient care team for implementing integrated care	5.5	6.6	7.0

The Region 7 IDN team met with the team from Citizen's Health Initiative (CHI) to review the results of the survey and discuss improvement opportunities in detail. CHI commented that the 2-week window for survey deployment that Region 7 IDN utilizes is working because IDN partners are taking time to complete the assessment which shows engagement and is a best practice to gather reliable data. Region 7 IDN team follows up with partners within the 2-week window a few times to encourage completion of the survey. The region did have a few partners who did not complete the survey in time, and CHI encouraged them to still complete a paper survey which will be included in the December roll-up scores.

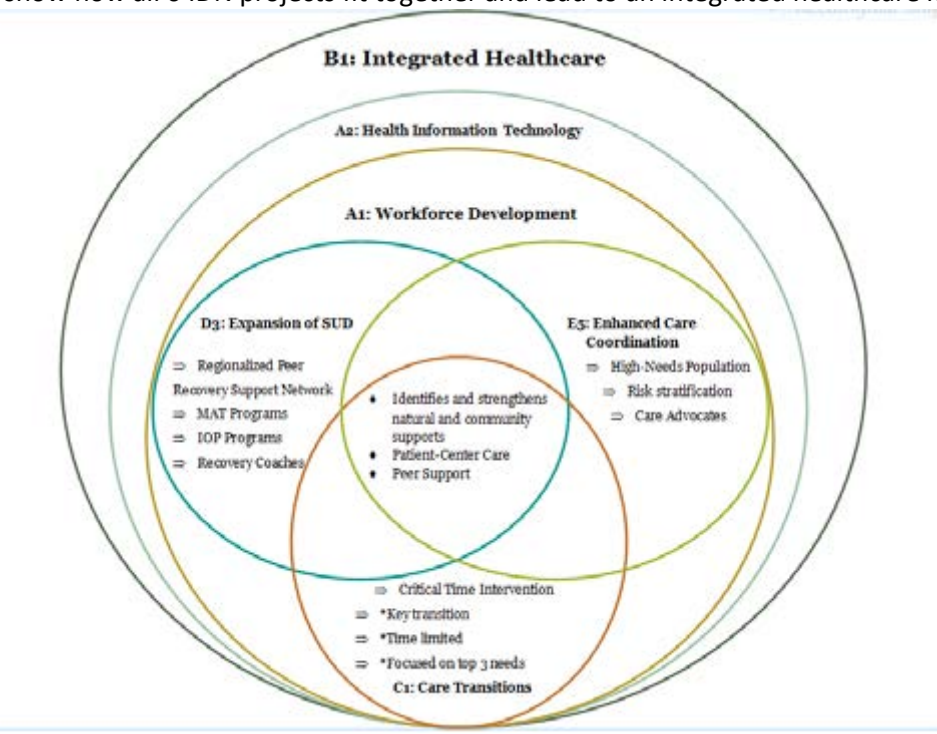
The four categories above are key areas Region 7 has decided to focus on for improvement. CHI provided valuable feedback and suggestions on strategies to use to help survey scores increase for the next report. Citizen's Health Initiative explain that to increase the level of integration scores practices will need to assess current workflows and protocols for any gaps related to integrated care. This could involve enhancing collaboration between internal departments which will lead to greater collaboration with external agencies across the region. It will be important for partners to refer to the SAMHSA levels of integration to ensure all workflows, policies and procedures align with the goal of integration the region to trying to reach. CHI suggested that Region 7 IDN explore using Tanya Lord's skills to increase patient/family input to integration management. Ms. Lord is a patient and family engagement professional who specializes in coaching practices on how to capture input from patients and families. She is available to practices virtually and in-person to consult on strategies to improve this category. Region 7 continues to be dedicated to improving physician, team and staff education and training for integrated care, which also goes hand in hand with developing patient care teams for implementing integrated care. IDN staff have been researching potential integrated care webinars and trainings to bring to the region. To ensure that appropriate trainings are selected a training needs survey was distributed at the June 14th Annual Conference with multiple training options to choose from. The region will continue to work with partners to establish more patient care teams around the region by contracting with Northern Human Services for psychiatric time.

Quality Improvement Team:

NCHC has shifted the IDN staffing model slightly based on infrastructure needs and anticipated partner needs. The current staffing model includes a part-time Quality Improvement Coach, and a part-time HIT Integration Coach. NCHC has opted to continue leveraging the work of one of the organization's Practice Transformation Network (PTN) Practice Facilitator, and bill some of her time to the IDN as she works with a few agencies in the region. The IDN Quality Improvement Coach recently became a Certified Professional in Healthcare Quality which is a great asset for the IDN. She will mentor and guide IDN staff as they work to assist additional partners in the region and be available for training and technical assistance as needed. The region's HIT Integration Coach started in January 2018 and is working with IDN partners as the primary point of contact and resource for the shared care plan. He has experience working

in direct care services within social service and mental health organizations, as well as working with a leading behavioral health electronic records company. His expertise with software implementation and insight into behavioral health operations and marketing makes him a strong resource for Region 7 IDN. Additional staffing changes during this reporting period include the hiring of a full time IDN Program Specialist who is responsible for much of the daily infrastructure logistics of Region 7 IDN, and due to staffing turnover, the region employed a new program coordinator in February 2018 who is actively involved in program coordination activities. Region 7 IDN had planned to contract with a company o help with data analytics and tracking of reporting metrics, but due to the cost of the proposal, and the amount of time it took for the contract to undergo legal review, NCHC decided not to pursue the contract at this time. However, additional conversations may continue with this data analytics contractor to determine if they can be helpful as the DSRIP project moves along.

As IDN staff work together to help the region meet DSRIP deliverables the following diagram will be used as a visual to show how all 6 IDN projects fit together and lead to an integrated healthcare model:



Region 7 IDN designed the graphic above to show the interconnectedness and overlap of the six IDN projects. Partner agencies are doing great work as they move along the continuum of integrated healthcare, and it is not always easy to categorize that work into only one project. As seen in the image, the 6 projects are based on; patient-centered care, peer support, closed-loop referrals, and community support. These strategies lend themselves well to a Community Care Team (CCT) model. Community care teams are multi-disciplinary teams that manage patients' complex needs across providers and systems of care. CCTs emphasize in-person contact with patients and support the delivery of quality-driven, cost-effective, and culturally appropriate patient-centered care by coordinating patients' medical and social service needs. The existing care transition teams at Memorial Hospital and Littleton Regional Healthcare are positioned well to explore this model, and potentially use it as a pilot to ensure clients are getting the best care possible.

Three-pronged approach to help transform the delivery of behavioral health care in the region:
Region 7 IDN has continued with a three-prong approach to help the region advance along the continuum of integrated healthcare: utilize a continuum of care model which includes prevention, early intervention, treatment, and recovery support services; improve coordination across providers to reduce gaps in care during transitions across care settings; and offer a comprehensive training plan to support the workforce in this approach. Despite partial funding cuts for the region's 2 Continuum of Care Facilitators, the region has still seen progress as partners work to incorporates a continuum of care model which addresses prevention, early intervention, treatment, and recovery support services. IDN partners have successfully used the Critical Time Intervention model, Community Health Workers, and improved risk stratification to address gaps in care the region. Additional details about both approaches can be found under the community projects.

A comprehensive training plan is the third approach the region is using to transform the delivery of behavioral health care in the region. Below is the master training plan which was submitted with the implementation plan in July 2017. 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	B1

	behaviors toward persons with mental health problems, and become comfortable addressing 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 experiencing a mental health or substance use challenge. The training helps identify, understand and	B1

	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,	C1

	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.	
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 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 health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC)	B1

	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 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 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,	E5

	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

Region 7 IDN held numerous trainings during the reporting period of 01/01/2018-06/30/18 based on the suggested trainings in the region's master training list. There were two quarterly meetings scheduled during this period however the March 2018 quarterly meeting was canceled due to weather. Approximately 50 people attended the June 2018 quarterly meeting, which doubled as the regions 1st Annual Conference, to learn about the region's progress and to discuss barriers and next steps as the region moves along the continuum of integrated healthcare. The meeting was as follows:

- *Impact of the Critical Time Intervention (CTI) Model* - Daniel Herman, MSW, PhD, Professor, Silberman School of Social Work; Director, Center for the Advancement of Critical Time Intervention, Hunter College
- Effective Use of Regional Access Point Services (RAPS) - Kim Haney, CRSW, RAPS Supervisor, Regional Access Point Services, Granite Pathways
- *Getting Connected and Getting Answers with 2-1-1* - Cary Gladstone, Senior Director, Asset Building Strategies Granite United Way
- *Regional Peer Recovery Support Services* - Kristy Letendre, Continuum of Care Facilitator, North Country Health Consortium
- *IDN Funding Update* - Commissioner Jeffrey Meyers, NH Department of Health and Human Services
- *Multi-Agency Perspectives on Care Coordination, a care coordinator panel discussion*- Ammonoosuc Community Health Services, Northern Human Services, Memorial Hospital, Littleton Regional Healthcare, and NCHC Community Health Worker

Other Trainings for Region 7 IDN during the reporting period 1/1/18-6/30/18:

- Community Health Worker Training (10/17-1/18) trained 11
- February 13, 2018 - Be the Change: Approaches and Tools to Successfully Manage Change All-Partner Statewide Learning Collaborative meeting. Concord, NH
- Drug Recognition Training on 3/19/18 trained about 20 at NCHC
- Drug Recognition Training in May 2018 trained about 20 in Coos County
- Recovery Coach Academy on 03/19-24 was brought to the region by NHADACA
- CTI Worker Training on 3/19-3/20 trained 12
- Privacy training related to information sharing, shared care plan and 42CFR Part 2 - 3/20 and 3/27
- Regional Care Coordination on 3/29-3/30 trained 6 in Carroll County (other 2 delayed)
- Motivational Interviewing on 5/1-5/2 trained 22
- Mental Health First Aid on 5/9/2018 trained 29 at Memorial Hospital (postponed from March 2018)
- Introduction to Management of Aggressive Behavior on 5/14/2018 trained 28 at Littleton Regional Healthcare
- Shared Care Plan Webinar - 5/30/2018 for 9 Region 7 IDN partner agencies
- Introduction to Managing Physical Confrontation on 6/4/2018 trained 11 at Ammonoosuc Community Health Services
- Mental Health First Aid on 6/8/2018 trained 24 at Huggins Hospital
- Mental Health First Aid on 6/22/2018 trained 20 at Huggins Hospital
- HIV/AIDS was brought to NCHC by NH Recovery Coach Academy on 7/25/18; trained 25 individuals of our region.
- Other RCA and 6/14 trainings

The region held five open community Narcan events and dispensed 43 kits during the reporting period.

NCHC continues to assess the training needs and interests of the region. Region 7 IDN staff are still exploring webinar opportunities for the delivery of chronic illness trainings and scheduling live training sessions on topics related to integration and team-based care. As previously mentioned in the January Semi-Annual Report, a survey was sent to the main clinical contact person at the behavioral health and primary care organizations in the region based from the region's master training table. In addition, NCHC staff have engaged in conversation with the New England Addiction Technology Transfer Center at Brown University to learn about training opportunities through this agency. IDN staff identified specific Brown University trainings which would count towards the trainings outlined in the regions' master training plan above and used the June annual conference/quarterly meeting as an opportunity to assess partner interest by embedding a training needs survey into the meeting evaluation. The results of these 2 surveys will be used to prioritize trainings for the remainder of 2018 and into 2019.

Training Schedule for the remainder of 2018 into 2019:

- Ethical Considerations for Peer Recovery Coaches: July 25-27, 2018
- Law Enforcement Against Drugs (LEAD) Training beginning at the end of July 2018.
- HIV/AIDS: August 9, 2018
- Suicide Prevention for Peer Recovery Coaches: August 23, 2018
- August 23-24, 2018 – Critical Time Intervention Train-the-Trainer
- August 25, 2018- Drug Recognition Training – train 95 bus drivers of Berry Transportation
- Fall 2018 – Motivational Interviewing training.
- Fall 2018 – Upper Grafton & Coos County Regional Care Coordination Training
- September 2018 - NAMI Connect Suicide Prevention training - Littleton Regional Healthcare
- September 27, 2018 - Co-Occurring Medical Conditions within Behavioral Health
- September 28, 2018- Co-Occurring Psychological Conditions within Primary Care
- September 13th, 2018- IDN Regional Quarterly Meeting: Trauma Informed Care - participants will understand the effects of childhood trauma as it relates that could trigger patients in their own health care setting and describe three interventions or skills that can be used to decrease the trauma response in patients. AMC Highland Center, Crawford Notch
- September 20th, 2018: Initial Training on Addiction & Recovery
- October – December 2018 –Community Health Worker Training
- October 19, 2018 – Behavioral and Medical Professionals Working Together to Address Co-Occurring Conditions,
- CTI worker training late fall 2018
- CTI supervisor training late fall 2018
- Peer Recovery Coach Academy: September 13-14 & 27-28, 2018
- Train the trainer for Peer Recovery Coach Academy: October 11-12, 2018
- Ethics & Train the Trainer: November 5-7, 2018
- Suicide Prevention for Peer Recovery Coaches: November 29, 2018
- HIV/AIDS: December 14, 2018
- Peer Recovery Coach Academy: April 2019
- Peer Recovery Coach Academy: September 2019
- Suicide Prevention: October 17, 2019
- Ethics: November 2019
- HIV/AIDS: December 5, 2019

In addition to the training planning above IDN staff have engaged in conversation with Institute for Health Policy and Practice through the NH Citizens Health Initiative and the Health Law and Policy Program, to potentially deliver additional trainings to the region using a model like the Project Echo training model. Subject matter experts will use Zoom technology to remotely deliver specialized trainings to IDN partner sites within the region in a process which resembles virtual grand round. Current discussions around trainings include 42CFR Part 2; core comprehensive standardized assessment, including workflow/follow up for screening for depression; social determinants of health and social supports; patient, consumer and family engagement; and other topics based on identified needs.

IDN staff are also promoting *Project ECHO Medication Assisted Treatment: Building Competency and Capacity for Primary Care Teams in Northern New England* which will start in August 2018. This training program will create a virtual learning community to support prescribing providers and behavioral health providers as they work to increase access to MAT in local communities.

Region 7 IDN staff used the following survey results to help prioritize the trainings for the region. Additional information for these results was captured in an evaluation given at the region's annual conference in June 2018. The trainings in italics were from the surveys distributed during the region's annual conference.

Region 7 Priorities (Based on Survey) in order of priority by percentage of those answering the question	June 2018
Topic	*Percentage rating
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.	62%
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	60%
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	59%
TeamSTEPS: 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. Goals of the session are to understand how communication affects team processes and outcomes; define effective communication and communication challenges; and the tools and strategies that will improve a teams' communication	56%
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.	54%
Street Recognition Drugs: Recognize common street drugs, their symptoms and effects on the body and how to best treat patients' using them.	51%
Ethical Communications & Decision Making in an Integrated Care Environment: Understand the roles of all partners in the integrated care environment and how they	51%

relate to each other. Addresses how varied communication and confidentiality requirements impact one another and our patients and identify strategies to reduce those barriers in order to provide the best care possible.	
Crisis Management of Co-Occurring Patients: Strategies to use with persons with mental illness and emotional disorders, and or are experiencing a crisis, including techniques for defusing potential volatile interactions, and identifying resources to assist in making a disposition.	49%
De-escalation Best Practices for Severe Mental Health: Ensure the safety of the patient, staff, and others in the area; help the patient manage their emotions and distress to maintain or regain control of their behavior; avoid the use of restraint when possible; and avoid coercive interventions that escalate agitation.	49%
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)	47%
Change Management: Understand how to get both organizational and employee buy-in with culture change, how to implement new processes as efficiently and effectively as possible, and how to identify risks and systems to mitigate those risks and monitor progress	44%
Suicide Prevention Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	41%
Cultural Competency: - Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	40%
Understanding Adverse Childhood Experiences & Working with Complex Trauma:- Trauma informed practice implies a working knowledge of not only what signs and symptoms exist with trauma but also, how trauma impacts brain function, coping, and client well-being. This session will cover the basics of trauma definition and symptomology, with special focus the impact of multiple adverse childhood experiences (ACES) on brain process and its impact on coping and substance use. Special attention will be given to the exploration of a variety of prevention strategies in working with individuals, families and communities.	39%
MH 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.	34%
Competent Caring: When Mental Illness Becomes A Traumatic Event: NAMI and the Hospital Corporation of America have collaborated to create Competent Caring: When Mental Illness Becomes a Traumatic Event, a DVD for continuing education training for health care staff. The DVD highlights the experience of an individual living with a mental	32%

illness, as well as the staff response when he seeks treatment for a mental health crisis in an emergency room setting. collaborated to create Competent Caring: When Mental Illness Becomes a Traumatic Event, a DVD for continuing education training for health care staff. The DVD highlights the experience of an individual living with a mental illness, as well as the staff response when he seeks treatment for a mental health crisis in an emergency room setting.	
Screening, Brief Intervention, and Referral to Treatment (SBIRT): Short brief interventions and referral to treatment for alcohol and substance abuse is an evidenced base practice that can be integrated into a primary care or other health setting. Validated screening tools, design flows for clinical settings and motivational interviewing techniques are taught in this session	32%
MAT Best Practice America Society of Addiction Medicine	32%
Critical Time Intervention: 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.	31%
Team STEPPS Series for Hypertension Management: The purpose of this training 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 identify communication challenges; and the TeamSTEPPS Tools and Strategies that can improve a teams' communication.	24%
Learning Collaborative of Behavioral Health and Primary Care: Best -practice and evidence-based integration recommendations and supports for those seeking more integration. Peer support, sharing of strategies and networking cross clinical and behavioral health staff.	29%
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	29%
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: 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	27%

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.	
Best Practices for Severe Mental Health Beyond the Scope of the Primary Care Practice	24%
Expanding Tobacco Treatment Among High Risk Populations for Value-Based Integrated Care: Describe the short and long- term consequences of tobacco use for individuals who have a mental health issue or substance use disorder. Describe strategies to help those individuals quit and how to make a referral to the NH Tobacco Helpline.	20%
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.	22%
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.	20%
Home Visitor Safety	18%
New Lipid Guidelines: Understand the components of the new lipid guideline recommendations and the current evidence to support the transition. Understand the methodology upon which the new lipid guidelines were based. Identify the new components of the lipid guidelines in comparison to the Adult Treatment Panel (ATP) III revised guidelines. Discuss common misconceptions and recall current expert consensus guidelines for non-statin medication.	16%
Social Determinants of Health	43.75%
Natural Supports and Strength-Based Approaches	56.25%
Interpersonal Communications	37.50%
Reflective Listening, Sensitivity & Stigma	43.75%
Understanding Adverse Childhood Experiences and Working with Complex Trauma	68.75%
The Connection between Substance Misuse and Suicide	56.25%
Best Practices in Care transitions	43.75%
Managing Chronic Disease in Behavioral Health Patients	50%
Behavioral Health Workforce Recruitment & Retention Strategies	37.50%
Transgender Health	50%
Bullying	43.75%
Autism in Behavioral Health Patients	18.75%

Recovery Oriented Systems of Care	25%
Advocacy	12.50%
Legal and Ethical Issues	37.50%
Referral Processes	31.25%
Family Systems	25%
Ongoing Treatment Planning	18.75%
Documentation	18.75%
Conflict Resolution	43.75%

The following trainings were identified as opportunities for the partners in the region and are available through The New England Addiction Technology Transfer Center at Brown University. Seventeen partners expressed interest according to the Likert scale below. These trainings were also included on the evaluation at the June 2018 annual conference.

Interest Level:	**Not at all**	**Slightly**	**Moderately**	**Very**	**Extremely**
Screening, Brief Interventions, Referral to Treatment (SBIRT)- 3 hours	5.88%	11.76%	41.18%	29.41%	11.76%
Screening, Brief Interventions, Referral to Treatment (SBIRT) - 5 hours	5.88%	17.65%	47.06%	17.65%	11.76%
Opiate Addiction and Treatment Options - 5 hours	0	11.76%	11.76%	29.41%	47.06%
Foundations of Clinical Supervision in Substance Use Disorder Treatment and Recovery Settings – 30 hours (combination of online & face-to-face)	11.76%	17.65%	35.29%	23.53%	11.76%
Compassion Fatigue - 5 hours	0	0	17.65%	35.29%	47.06%

Breaking the Stigma of Substance Use Disorders	0	5.88%	11.76%	35.29%	47.06%

Support and financial incentives for the primary care and behavioral health providers in the region to process along the continuum of integrated care:

Rowe Health Center was awarded funds to hire a consultant to help analyze current practice to determine how to most effectively integrate behavioral health into primary care. The agency will focus on enhancing capacity, improving community support services, and providing comprehensive care to their patients. The consultant will help build an integrated medical home type model, design training modules and deliver training to relevant staff.

Northern Human Services was awarded IDN funding to help support CrossRoads Clinic, a co-located primary care office within their Berlin, NH agency. Coos County Family Health Services will have a medical exam room with the community mental health center. The project is almost complete, and they anticipate a ribbon cutting ceremony on July 10, 2018. The Berlin Clinic will be open one day a week and will offer the following services: Chronic Disease Management, Illness and minor treatments, Woman's health, Preventive Health Care, and Health Promotion and Education. The site will be staffed by a Physician Assistant and an RN.

Region 7 IDN Core Competency Integration Toolkit:

The region has sent the Core Competency Toolkit out to numerous partners in the region and have had a positive feedback about the toolkit. It will go through revisions on an on-going basis, which currently already includes revisions to the 42CFR Part 2 guidelines. Some of the tools are shared amongst the various toolkits within the region. For example, there is a case conference template, and case conference agenda which was instrumental to White Mountain Community Health Center as they worked to hold their first case conference, including a psychiatrist in June of 2018.

Region 7 IDN made significant progress on Project B1, Integrated Healthcare, during the period of January 1, 2018-June 30, 2018. Region 7 IDN Steering Committee suggested that IDN staff set up time to meet in person with IDN partners to learn about barriers and challenges related to implementation of the B1 project. Feedback from these meetings, along with other partner input, states the biggest challenges of this project include the implementation of the Core Comprehensive Standardized Assessment (CCSA), the implementation of the shared care plan, and the need for a psychiatrist to be part of the monthly case conferences of the multi-disciplinary core team.

CCSA implementation: IDN partners have identified numerous barriers regarding CCSA implementation. Some partner agencies have expected the IDN to develop a CCSA tool. Other partners have questions on how to formulate the CCSA so they will be able to pull out the required MAeHC reporting information which asks if a CCSA has been completed for a patient. Partners have expressed concerns about the

maximum 30- day window for the completion of the CCSA, and concerns about finding out that a patient needs services, but then have those services not be available. Another challenge has been that IDN partners may capture the required domain information for some Medicaid patients, but not all Medicaid patients. An example of this is the legal domain only being assessed if a patient receives medication assisted treatment services. Additionally, partner organizations have expressed concerns about adding additional domains into existing assessment processes due to time constraints, and the financial burden of adding additional screening questions into an EHR

IDN staff have worked diligently from numerous angles to address these barriers and challenges. IDN staff have had to consistently explain that the region is not using a standardized assessment form, and that the CCSA is a process, not a tool. The region is taking the approach that IDN partners can continue to use their current assessment process and add new screening questions or tools if they are not currently capturing specific information related to one of the 12 CCSA domains. Region 7 IDN staff pulled together a list of questions that cover each of the required domains and has shared this list with IDN partners as a resource.

The CCSA guidance released from NH DHHS has been a good resource as the region works to implement the comprehensive core standardized assessment. Region 7 IDN IT Lead has focused on the CCSA during many of the IT/data workgroup calls to help partners involved in reporting to have a better understanding of the CCSA. The region hosted a couple combined IT/data and clinical workgroup meetings during this time to discuss both the CCSA and shared care plan to get different perspectives involved in the conversation. These meetings provided an opportunity for both groups to get a better understanding of what was needed from each other for a successful implementation of the CCSA. This includes covering the correct domains for all patients, as well as reporting that the assessment was completed on a yearly basis and transmitting this information to MAeHC for the purposes of statewide outcome reporting in line with the ASSESS_SCREEN_01 measure.

The Region 7 IDN Quality Improvement Coach used her clinical and quality improvement expertise to develop a CCSA protocol to serve as a draft document for IDN partners to enable them to visualize what is needed in a CCSA protocol. IDN staff explain that the protocol is just a template and can be adapted to meet the needs of participating agencies. The CCSA guidance from NH DHHS and the region's model CCSA protocol have both been instrumental in working through the CCSA requirement with IDN partners. As conversations evolve, IDN staff continue to assess CCSA implementation challenges for B1 partners in the region and attempt to find solutions to address the challenges. One solution includes offering IDN partners funds to help incorporate additional screening questions into EHR platforms or provide partners with additional funds to help them build internal data reporting infrastructure, so they can report out to MAeHC if a CCSA was completed for a patient in a reporting period. Below is the CCSA protocol developed:

Sample Protocol and Questions for Comprehensive Core Standardized Assessment

For the Medicaid Population

The Comprehensive Core Standardized Assessment (CCSA) process will be conducted, at a minimum, annually. The assessment will be used as the basis for an individualized care plan for patients identified

as high risk through risk stratification process implemented by primary provider. The CCSA is intended to be a standardized screening process that integrates Medical, Behavioral and Social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. The process is the basis for an individualized care plan, used by the care team to guide the treatment and management of the target sub-population. The assessment will include the following domains:

Demographic Domain

Patient Registration is the process of checking-in a person **to initiate the episode of care** which takes place in various healthcare settings and at the various functions of the episode of care. The main function of registration is to collect information on required demographics (such as age, gender, race and ethnicity) as well as payment information. The Registration Department, Patient Access, Admitting Departments, Call Centers, or Online Scheduling Services, are responsible for management of patient registration activities. In some cases, pre-registration may take place prior to the actual registration process at the healthcare organization.

During the patient registration, insurance verification and pre-authorization may take place. In this case, the insurance verifier is involved in verifying payment information as a part of the patient registration process. Patient registration information is provided by the patient and/or by the designated representative (guardian, parent, caregiver, etc.) to the registration staff. Information may also be received/uploaded from various data sources, e.g., Electronic Health Record (EHR) systems, Payor systems, Health Information Exchanges (HIE).

The patient registration information can be provided verbally, via facility registration portal/kiosk, or phone interview. Information collected at the registration initiates the creation of a new episode of care record. This information will be further used at the next functions of the episode of care (triage/assessment, testing, treatment, medication management and discharge/transfer).

Out-patient setting visit:

1. Registration for walk-in/patient presentation
2. Registration/Scheduling for planned visit
3. Registration/Scheduling for diagnostic testing (during the visit, and after the visit)
4. Registration/Scheduling for treatment (during the visit, and after the visit)
5. Registration for medication administration
6. Registration for post-visit follow-up

Medical Domain

Benefits of Routine Health Assessment (Fernald, D.H. et.al 2013)

- Improve relationships with patients by using the data to stimulate dialogue.
- Help clinicians identify and prioritize patient health issues and health goals.

- Help pinpoint focused messages when talking with patients about what matters to their health.
- Help patients understand their current health status and act to improve their health.
- Consistently remind patients to increase their awareness about specific behaviors and habits that affect their health or chronic conditions.
- Track patient health behaviors over time (e.g., physical activity, smoking, stress, or quality of life), which can also help with patient follow-up.
- Measure and monitor patient data at the practice/population level for proactive, planned care.
- Identify issues requiring patient referral to additional resources.
- Fulfill requirements for and generate revenue from incentive programs and national guidelines.

A full medical health history is taken and documented when a patient establishes care and updated at least annually. It is best practice to ask patients, at every visit, if they have been seen by another medical provider since their last visit and if there are any medical/health history changes that have taken place since their last visit. All updates will be documented in the patient's medical record.

Substance Use Domain (SBIRT) (SAMHSA-HRSA Integrated Health Solutions)

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. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

SBIRT CONSISTS OF THREE MAJOR COMPONENTS:

- Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting
- Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
- Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

This screening process will take place at least annually, during the annual comprehensive visit. Please see separate policy and procedure for specific screening tools, scoring, and recommendations for brief intervention and referrals for treatment. Sample screening tools that are recommended for use are:

- AUDIT-Alcohol Use Disorders Identification Test
- CAGE-an assessment instrument used by primary care givers to identify people with alcohol-related problems
- DAST- Drug Abuse Screening Test
- CRAFFT-a behavioral health screening tool designed for children under age 21

Housing Domain

The impacts of unmet health-related social needs, such as homelessness, inconsistent access to food, and exposure to violence on health and health care utilization, are well-established. Growing evidence indicates that addressing these and other needs may help reverse their damaging health effects.

Unmet housing needs may include homelessness, poor housing quality, or inability to pay a mortgage or rent. The following two screening questions have been validated by the Center for Medicaid and Medicare Services (CMS) for assessment of housing stability:

1. What is your housing situation today?

    - ❑ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park).
    - ❑ I have housing today but I'm worried about losing housing in the future.
    - ❑ I have housing.
    - ❑ Other

2. In your housing situation, do you have problems with any of the following? Check all that apply:

    - ❑ Bug infestation
    - ❑ Mold
    - ❑ Lead paint of pipes
    - ❑ Inadequate heat or hot water
    - ❑ Oven off: stove not working
    - ❑ No smoker detectors or not working smoke detectors
    - ❑ Water leaks
    - ❑ None of the above

It is recommended that these screening questions be asked at least annually, however updating this information at each encounter provides a safety net for patients experiencing housing issues where a referral to care coordination may be beneficial.

Family and Support Services Domain (Person and Family Engagement)

While the majority of adults prefer to manage their own care, some decide **to make health care decisions through co-management or delegation of health care decisions to family members or close friends.** Societal factors such as age, socio-economic factors, education level, cultural beliefs and

traditions and health characteristics all impact the way that a person may choose to manage their health care. Due to the subtle nuances of how these unique factors impact the way that individuals make health care decisions, it is imperative that **discussions about health care include an open dialogue of the parties who should be included in health care conversations**. The co-creation of health care goals should provide the opportunity for family members, close friends or caregivers to participate in these important conversations about health. It is essential for health care providers to create meaningful partnerships with persons, families and caregivers to bring their preferences into the care discussion.

Assessment annually may include some of the following questions: (Access Health Spartanburg)

1. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? **Check all that apply.**

Food
- ❑ Yes
- ❑ No

Clothing
- ❑ Yes
- ❑ No

Utilities
- ❑ Yes
- ❑ No

Child Care
- ❑ Yes
- ❑ No

Medicine or any health care (medical, dental, mental, vision)
- ❑ Yes
- ❑ No

Phone
- ❑ Yes
- ❑ No

- ❑ **I choose not to answer**

2. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

3. Would you have someone to help you if you were sick and needed to be in bed?
- ❑ Yes
- ❑ No
- ❑ N/A

4. Do you have someone to take you to a clinic or doctor's office if you needed a ride?

5. Are you married or living together with someone in partnership?

- ❑ Married
- ❑ I am living with a partner in a committed relationship.
- ❑ I am in a serious and committed relationship but not living together.
- ❑ Single
- ❑ Separated
- ❑ Divorced
- ❑ Widowed

6. Do you rely on a family member or friend to assist you with your healthcare needs? If yes, please indicate name and relationship: _____

- ❑ Yes
- ❑ No
- ❑ N/A

7. In a typical week, how often do you:

Talk with family, friends or neighbors by phone call or video chat (e.g. Skype, FaceTime)?

- ❑ Never
- ❑ Once a week
- ❑ Two days a week
- ❑ 3 – 5 days per week
- ❑ Nearly every day

Get together with family, friend or neighbors?

- ❑ Never
- ❑ Once a week
- ❑ Two days a week
- ❑ 3 – 5 days per week
- ❑ Nearly every day

Use email, text messaging or internet (e.g. Facebook) to communicate with family, friends or neighbors?

- ❑ Never
- ❑ Once a week
- ❑ Two days a week
- ❑ 3 – 5 days per week
- ❑ Nearly every day

8. How often do you:

Attend church or religious service?

- ❑ Once per year
- ❑ 2 – 3 times per year
- ❑ 4 or more times per year

- ❑ At least once per month
- ❑ At least once per week

9. How often do you attend meetings of the clubs or organizations that you belong to?

- ❑ Once per year
- ❑ 2 – 3 times per year
- ❑ 4 or more times per year
- ❑ At least once per month
- ❑ At least once per week

Education Domain

Beginning as early as the 1900s, there has been the recognition of a patient's right to protect the integrity of one's own body and the need for patient consent or knowledge regarding what shall be done. The basic elements of informed consent, as outlined in this groundbreaking case, served as the cornerstone of patient participation to the extent that it initiated the practice of disclosing information to patients about their care and medical services rendered. Over the past few decades, this one-way street of informing the patient has evolved into a two-way street of communicating with patients. As the concept of patient engagement has evolved, so too has the expectation of many persons to be educated about their diagnosis, treatment options, care and outcome.

Education is focused on the specific knowledge and skills the patient and family will need to make care decisions, participate in their care, and continue care at home. To identify and understand those needs for education, there is an assessment process. Knowledge and skills deficits are identified and used to plan the education. The assessment process also includes those patient variables that determine if the patient is ready and capable to learn.

These variables include:

- the patient's and family's beliefs and values;
- their literacy, educational level, and language;
- emotional barriers and motivations;
- physical and cognitive limitations; and
- the patient's willingness to receive information.

Once the educational needs are identified, they are recorded in the patient's record. This facilitates the participation of all the patient's caregivers in the education process. Each organization decides the location and format for educational assessment, planning, and delivery of information in the patient's record.

1. **What is the last grade you completed in school?** _____
2. **If you have a college degree, what in?** _____
3. **How would you rate your ability to read?**

❑ Good ❑ Average ❑ Poor

4. **Do you ever need help reading health related materials?** [ ]Yes [ ]No

5. **How often do you need to have someone help you when you read instructions, pamphlets, or other written materials?**

- ❑ Always
- ❑ Sometimes
- ❑ Never

6. **I know what each of my prescribed medications do**

- ❑ Disagree Strongly
- ❑ Disagree
- ❑ Agree
- ❑ Agree Strongly
- ❑ N/A

7. **I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself**

- ❑ Disagree Strongly
- ❑ Disagree
- ❑ Agree
- ❑ Agree Strongly
- ❑ N/A

8. **I am confident that I can tell a doctor concerns I have even when he or she does not ask**

- ❑ Disagree Strongly
- ❑ Disagree
- ❑ Agree
- ❑ Agree Strongly
- ❑ N/A

9. **I am confident that I can follow through on medical treatments I may need to do at home**

- ❑ Disagree Strongly
- ❑ Disagree
- ❑ Agree
- ❑ Agree Strongly
- ❑ N/A

Employment and Entitlement Domain

1. **What is your current work situation?**

   - ❑ Full time work
   - ❑ Part time or temporary work
   - ❑ Unemployed and seeking work
   - ❑ Unemployed but not seeking work
   - ❑ I choose not to answer

2. **Have you applied for: If yes, what is the status of your application?**_____

   - ❑ Social Security
   - ❑ Disability
   - ❑ SSI
   - ❑ Unemployment
   - ❑ None

Legal Domain

1. **In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?**

   - ❑ Yes
   - ❑ No
   - ❑ I choose not to answer

   If yes, what was your release date? _____

2. **Are you a refugee?**

   - ❑ Yes
   - ❑ No
   - ❑ I choose not to answer

3. **Do you feel physically and emotionally safe where you currently live?**

   - ❑ Yes
   - ❑ No
   - ❑ I choose not to answer

4. **In the past year, have you been afraid of your partner or ex-partner?**

   - ❑ Yes
   - ❑ No
   - ❑ Unsure
   - ❑ I have not had a partner
   - ❑ I choose not to answer

<u>Depression Screening Domain</u> (use depression screening protocols)

Depression is a chronic and recurring disease. Effective communication and patient education are necessary to enhance adherence to treatment and prevent relapse. Long-term patient care is essential to manage any chronic disease, including depression. The delivery of patient care requires not only determining what care is needed but clarifying roles and tasks to ensure that patients get the highest quality of care and follow-up.

Depression has been associated with poorer outcomes in patients with a variety of medical conditions, such as coronary artery disease, diabetes mellitus, and stroke. Treatment of depression may reduce mortality from these conditions, as well as help prevent suicide. Therefore, accurately identifying patients who have depression is important so that appropriate treatment can be initiated. (Maurer, D. 2012. P. 139)

Procedures:

1. The U.S. Preventive Services Task Force recommends screening in adolescents and adults in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up.

2. Patients aged 12 and older, without a current diagnosis of depression, will be screened for depression using the PHQ-2 tool when being roomed, if they have not had a screening completed within the preceding 12 months.

3. **If score of the PHQ-2 is 3 or greater, then the PHQ-9 is administered**.

   a. The treating clinician is notified by the clinical support staff of **any positive results** from depression screening and the PHQ-9 score PRIOR to the clinician entering the examination room.

   b. **A suicide risk assessment** is performed by the provider.

4. If diagnosis of depression is confirmed, the clinician educates the patient about depression and the care process, engage the patient and determine patient preference for treatment.

5. The clinician and patient will select an appropriate management approach for treatment of depression:

   a. Watchful waiting, with supportive counseling

   b. Antidepressant medication

   c. Mental health referral for psychological counseling

   d. Combination of antidepressant medication and psychological counseling

   e. Rarely, refer to emergency services if indicated, to reduce risk of harm

<u>Risk Assessment Domain</u> (including Suicide Risk when depression screening positive)

Risk Stratification for Care Coordination: (low, medium, high risk scoring)
An example of risk stratification assessment completed by provider at least annually:

1. Is the patient healthy, with no chronic disease or significant risk factors?

Yes or No

If yes, patient is at a **Level 1 Primary Prevention** plan of care that included preventive screenings and immunizations; patient education; annual health risk assessment; appropriate monitoring for warning signs.

2. Is the patient healthy, but at risk for chronic disease, or has other significant risk factors?

Yes or No

If yes, patient is at a **Level 1 Primary Prevention**, but with increased interventions for unhealthy lifestyle/habits; needs to be linked to community resources to enhance patient education and self-management skills.

3. Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals?

Yes or No

If yes, patient is at a **Level 2 Secondary Prevention** to treat disease and avoid serious complications.

4. Does the patient have one or more chronic disease, with significant risk factors, and is unstable or not at desired treatment goals?

Yes or No

If yes, patient is at a **Level 2 Secondary Prevention** to treat disease and avoid serious complications but may need a health coach or referral to specialty services.

5. Does the patient have multiple chronic diseases, significant risk factors, complications, and/or complex treatments?

Yes or No

If yes, patient is a **Level 3 Tertiary Prevention** to treat the late or final stages of disease and minimize disability.

6. Does the patient have a catastrophic or complex condition in which his/her health may or may not be restored?

Yes or No

If yes, patient is a **Level 3 Tertiary Prevention** which may range from restoring health to only providing comfort care

Patient's primary care provider will select the risk level at annual visits or with changes in patient status that requires an increase in care coordination and resources.

- **Level 1 Primary Prevention:** Low resource use with goal to prevent onset of disease
- **Level 2 Secondary Prevention:** Moderate resource use with goal to treat disease and avoid serious complications.

- **Level 3 Tertiary/Catastrophic:** High to extremely high resource use with goal ranging from restoring health to only providing comfort care

Suicide Risk Assessment: (see separate procedure and tool)

Up to 45% of individuals who die by suicide have visited their primary care physician within a month of their death; additional research suggests that up to 67% of those who attempt suicide receive medical attention as a result of their attempt. Given these statistics, primary care has enormous potential to prevent suicides and connect people to needed specialty care — especially when they collaborate or formally partner with behavioral healthcare providers. While there is no way to predict with complete certainty who will attempt suicide, understanding certain imminent warning signs as well as statistically related risk factors will help providers know when to actively intervene and further assess for imminent suicide risk. Key components of a suicide risk assessment: (suicide risk assessments will take place when there is a positive depression screening and if there is clinical suspicion of suicide risk)

1. Assess warning signs and risk factors

2. Assess protective factors

3. Suicide Inquiry: thoughts/plan/intent/access to means

4. Clinical judgment

Functional Status Domain

The Functional Status Questionnaire can be used as a self-administered functional assessment for a patient seen in any healthcare setting. It provides information on the patient's physical, psychological, social and role functions. It can be used both to screen initially for problems and to monitor the patient over time. This questionnaire will be administered at least annually.

Pediatric Developmental Screening: 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.

References:

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Fernald, D.H., Tsai, A.G.,et.al.(Sept. 2013). Health assessments in primary care: a how to guide for clinicians and staff. AHRQ publication no. 13-0061-EF.

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Integrating the Healthcare Enterprise Patient Care Coordination White Paper (June 16, 2017. 6 Rev. 1.0). Patient registration demographic data capture and exchange: IHE International, Inc.

Maurer, D.(2012). Screening for depression; American Academy of Family Physicians.pgs.139-145.

Thomas-Henkel, C and Schulman, M.(Oct. 2017).Advancing innovations in healthcare delivery for low-income americans. Center for Health Care Strategies. Retrieved May 7, 2018 from https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf

Person & Family Engagement: Achieving person and family engagement (PFE): Using the adoption of PFE metrics as a lever for change. (2017) Transforming Clinical Practice Initiative.

SAMHSA-HRSA Integrated Health Solutions. SBIRT https://www.integration.samhsa.gov/clinical-practice/sbirt

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

From the IDN HIT Infrastructure Project Plan, use the format below to identify the progress toward process targets, or goals, that the project has achieved.

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	13 as of 2018	0	0	
# of partner agencies using shared care plan	13 as of 2018	0	0	
# of partner agencies using multi-disciplinary core team	5 as of 2018	0	0	
# of partner agencies using standardized workflow and protocols	13 as of 2018	0	0	
# of partner organizations which have implemented MAT services	5 as of 2018	2	6	
# of psychiatric nurse practitioners	3 as of 2018	2	5	
# of MLDACs	16 as of 2018	16	19	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Licensed Mental Health Professionals	23 as of 2018	18	16	
# of Peer Recovery Coaches	6 as of 2018	22	59	
# of Community Health Workers	4 as of 2018	11	13	
# CTI Workers	15 as of 2018	11	24	
# CTI Supervisors	3 as of 2018	3	3	
# Care Advocates	15 as of 2018	0	7	
# Care Advocate Supervisors	1 as of 2018	0	0	
# Community based clinicians (staffing from first round of capacity)	1 as of 2018	1	1	
# Physician assistant clinicians (staffing from first round of capacity)	1 as of 2018	1	3	
Community nurse coordinator clinicians (staffing from first round of capacity)	1 as of 2018	1	1	
Behavioral health assistant clinicians (staffing from first round of capacity)	1 as of 2018	1	2	
Behavioral health case managers clinicians (staffing from first round of capacity)	5 as of 2018	4	5	
LICSW clinicians (staffing from first round of capacity)	3 as of 2018	2	2	
IDN QI Coach	1 as of 2018	0	1	
HIT Integration Coach	1 as of 2018	1	1	
IDN Data Specialist (NCHC)	1 as of 2018	0	0	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Data Specialists for IDN partners	Up to 3 as of 2018	0	0	

Region 7 IDN does not believe that all B1 partner agencies will be connected to a multi-disciplinary core team. Because the region has shifted away from the regional core team model, it will be difficult to get full participation with this component, so now the region would like to stand up 5 teams by the end of 2018.

B1-4. IDN Integrated Healthcare: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, provide the current number of full-time equivalent (FTE) staff 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	16	18	
Licensed Mental Health Professionals	23 by 2018	14	18	16	
Peer Recovery Coaches	6 by 2018	2	22	59	
CTI Workers	15 by 2018	0	11	27	
CTI Supervisors	3 by 2018	0	3	3	
Community Health Workers	4 by 2018	0	13	13	
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2	5	
Care Advocates	15 by 2018	0	0	7	
Other Front Line Provider	1 by 2018	0	10	16	
Care Advocate Supervisors	1 by 2018	0	0	0	
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	
Physician assistant (round 1 funds)	1	1	1	3	

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 nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	
IDN QI Coach	1	0	0	1	
HIT Integration Coach	1	0	1	1	
IDN Data Specialist (NCHC)	1	0	0	0	
Data Specialists for IDN partners	Up to 3	0	0	0	

B1-5. IDN Integrated Healthcare: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/19	01/01/2020-12/31/2020	01/01/2021-12/31/2021
	Core Competency Actual Funds Spent	Core Competency Actual Expense (6 months)	Core Competency Budget Projection	Core Competency Projection	Core Competency Projection	Core Competency Projection
Core Competency	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to December Projected	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
			(6 months)	(12 Months)	(12 Months)	(6 Months)
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$4,650	$341	$6,127	$12,254	$12,254	$6,127
6. Travel	$3,560	$1,767	$12,633	$25,267	$25,267	$12,633
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$2,127	$421	$842	$842	$421
10. Marketing/Communications	$5,218	$4,351	$10,613	$21,226	$21,226	$10,613
11. Staff Education and Training		$2,487	$12,002	$24,003	$24,003	$12,002
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific detail mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$7,851	$4,469	$1,989	$3,979	$3,979	$1,989
Support Payments to Partners	$315,939	$290,152	$389,952	$779,903	$779,903	$389,952
TOTAL	**$444,143**	**$367,152**	**$479,365**	**$958,730**	**$958,730**	**$479,365**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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

(at the practice or independent practitioner level during this reporting period)

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	Y
White Horse Addiction Center	Y
Saco River Medical Group	Y
North Country Health Consortium	Y

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

If all IDN Governance sign-offs were YES in a prior submission and there are no changes, then a resubmission of this section is not required. If any sign-offs were NO or Governance Leadership has changed, then a full resubmission of this information is required with the signatures noted as received.

Name	Title	Organization	Sign Off Received (Y/N)
Jebb Curelop	Financial Manager	Life Coping	Y
Susan Houghton	Senior phal Community Health Officer	Huggins Hospital	N
Mary Reed	Senior Direct of Public Health for Granite United Way	Carroll County Coalition for Public Health	N
Rona Glines	Director of Physician Services	Weeks Medical Center	Y

Name	Title	Organization	Sign Off Received (Y/N)
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
Vacant	Vacant	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
Kevin Kelly	Chief Executive Officer	Indian Stream Health Center	N

Due to staffing transitions we have been recruiting to fill vacant positions, we will be following up with new members to have charters resigned moving forward.

B1-8. Additional Documentation as Requested in B1-8a-8h

a. All of the following domains must be included in the CCSA:
- Demographic information
- Physical Health Review
- Substance Use Review
- Housing Assessment
- Family and Support Services
- Educational Attainment
- Employment or entitlement
- Access to Legal Services
- Suicide Risk Assessment
- Functional Status Assessment
- Universal screening using depression screening (PHQ 2 & 9)
- Universal screening using SBIRT

For pediatric providers, the CCSA must also include:
- Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits
- Developmental screening using Bright Futures or other American Academy of Pediatrics recognized screening.

b. List of multi-disciplinary core team members that includes, at minimum:
- PCPs
- Behavioral Health Providers (including a psychiatrist)
- Assigned care managers or community health worker.

c. Multi-disciplinary core team training for service providers on topics that includes, at minimum:
- Diabetes hyperglycemia
- Dyslipidemia
- Hypertension
- Mental health topics (multiple)
- SUD topics (multiple).

d. Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management.

e. Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions.

f. Secure Messaging

g. Closed Loop Referrals

h. Documented workflows and/or protocols that include, at minimum:
- Interactions between providers and community based organizations
- Timely communication
- Privacy, including limitations on information for communications with treating provider and community based organizations
- Coordination among case managers (internal and external to IDN)
- Safe transitions from institutional settings back to primary care, behavioral health and social support service providers
- Adherence to NH Board of Medicine guidelines on opioid prescribing.

As mentioned in the January semi-annual report, NCHC developed a core comprehensive assessment checklist for B1 partners to gather information on which of the required B1 domains a partner currently assesses. Eleven out of the thirteen B1 partners in the region completed the survey during this reporting period. The remaining two agencies, which are SUD providers, will be assessed during the July – December reporting period now that NH DHHS has released guidance on the CCSA for SUD providers. Many partners in the region reported they assess all required domains, but conversations have shown that even though an agency may have the ability to assess a domain, they do not have protocols in place to do so consistently for the Medicaid population. The survey results will serve as an engagement tool to work with providers and help with protocol development to ensure processes are in place to assess these domains as required by the DSRIP project. Results of the January-June 2018 CCSA survey are as follows:

Site	Demographic	Physical Health	Substance Use	Housing	Family & Support	Educational attainment	Employment	Access to legal services	Suicide Risk	Functional Status	Universal Screening	SBIRT
Saco River Medical Group	Y	Y	Limited	N	N	N	N	N	Y	N	Y	N
Littleton Regional Healthcare	Y	Y	Y	N	N	N	N	N	N	N	N	N
Memorial Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	No answer
Huggins Hospital Behavioral Health	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Huggins Primary Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
White Mountain Community Health Center	Y	Y	Y	Y	N	Y	Y	N	Y	N	Y	Y
Weeks Medical Center	Y	Y	Y	N	N	N	N	N	Y	Y	Y	Y
Coos County Family Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rowe Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Northern Human Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Ammonoosuc Community Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Indian Stream Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

When White Mountain Community Health Center completed the survey earlier in 2018 they were not assessing family and support, legal, or functional status domains. Since completing this survey and working closely with the IDN Quality Improvement Coach they now have a complete CCSA process which meets DSRIP requirements, along with an accompanying CCSA protocol. Other significant progress to report since the January 2018 submission includes the implementation of SBIRT at Huggins Hospital, along with the identified need for an SBIRT training. IDN staff will be addressing that need in the next

reporting period, as well as working closely with other IDN partner agencies to increase the number of agencies utilizing the SBIRT model. Saco River Medical Group plans to start using SB1-2 over the summer, and plans to add family and support services, education, employment and entitlement, and the legal soon. Memorial Hospital has started to look at adding the housing domain to their current assessment process.

Many Region 7 IDN agencies reported that they assess a domain, but often that is inconsistent, and IDN staff will use this information to engage with partners in the region as they work to develop a CCSA protocol to ensure good practices as the CCSA is implemented in the region.

The table below reflects what NCHC currently knows regarding comprehensive core standardized assessments for pediatric providers for the reporting period 01/01/18-06/30/18.

Site	Validated developmental screening for all children, ASQ:3, and/or ASQ SE at 9, 18, 24/30 months	Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized screening	Other tool
Ammonoosuc Community Health Services	N	N	Y Developmental Milestones and M-CHAT-R
Coos County Family Health Services	Y ASQ:SE	Y	N
Weeks Medical Center	Y ASQ:3	Y	Y (MCHAT)
White Mountain Community Health Center	N	N	Y (MCHAT)
Huggins Hospital	Y	Y	Y (Teen screen)
Memorial Hospital	Y	N	Hoping to integrate ACEC
Littleton Regional Healthcare	Y ASQ:3	N	N
Saco River Medical Group	Y ASQ:3	Y	Y (MCHAT)
Indian Stream Health Center	Y ASQ:3	N	N

Additional information regarding what specific tools are used to capture domains was assessed during the January – June 2018 reporting period. The table below showcases the results:

Partner	What validated screening tool(s) do you currently use for depression screenings?	What validated screening tool(s) do you currently use for substance use disorder screenings?	What validated assessment tool do you currently use for depression assessment?	What validated assessment tool do you currently use for substance us disorder assessment?
Saco River Medical Group	PHQ-2	CAGE=adult-Plan SB12	PHQ-9	CRAFT (Teens)
Littleton Regional Healthcare	PHQ2	EMR has a built-in screening tool for tobacco, alcohol and recreational drugs	PHQ9 (if PHQ2 is positive)	Nothing as a standard across the practices at this time
Memorial Hospital	PHQ-9, Adult wellbeing MDQ, GAD	AC-OIC?	PHQ-9	SOAPP
Huggins Hospital Behavioral Health	PHQ-9	AUDIT, DAST, CRAFFT for Teens	PHQ-9 with clarifying questions	Assess age of first use for each substance, current use, frequency and amount
Huggins Primary Care	PHQ-2 and PHQ-9	AUDIT, DAST	PHQ-9	AUDIT, DAST or CRAFFT for teens
White Mountain Community Health Center	PHQ-2, PHQ-9	AUDIT, DAST, S2BI	PHQ-9	N/A
Weeks Medical Center	PHQ-2	DAST, AUDIT, CRAFFT	PHQ-9	DAST, AUDIT, CRAFFT
Coos County Family Health Services	PHQ-2, PHQ-3and PHQ-9	CAGE/CRAAFT	PHQ-9	ORT-Opioid Risk Tool, SBIRT
Rowe Health Center	PHQ2, Mini Mental, Suicide Assessment	AUDIT	PHQ9, GAD7, Geriatric Depression Scale	SCREEN ONLY
Northern Human Services	PHQ-9, ANSA, and CANS	CANS and ANSA-Also use AUDIT, DAST, and ASI	CANS, ANSA and PHQ	AUDIT, DAST, and ASI
Ammonoosuc Community Health Services	PHQ-2	2 question screen: 10 in the last 3 months have you had more than 5 (male)/ 3 (female) drinks on any single occasion? 2) How many times in the past year have you	PHQ-9 and PHQ-A	CRAFFT and UNCOPE

Partner	What validated screening tool(s) do you currently use for depression screenings?	What validated screening tool(s) do you currently use for substance use disorder screenings?	What validated assessment tool do you currently use for depression assessment?	What validated assessment tool do you currently use for substance us disorder assessment?
		used an illegal drug or taken a prescription medication for nonmedical reasons?		
Indian Stream Health Center	PHQ2, and PHQ9. We also use the GAD7 for anxiety, and PCL for PTSD.	CRAFFT, the ORT (Opioid Risk Tool), SBIRT, and separate alcohol and recreational drug use screenings.	Assessment and treatment protocols based on MacArthur Foundation depression management tools.	Assessment and treatment protocols based on SBIRT

White Mountain Community Health Center (WMCHC) has made significant progress in the implementation of the CCSA during the period of January – June 2018. They have been working closely with the IDN Quality Improvement Coach to get a CCSA process in place, and they used this new process for the first-time s in June 2018 with positive feedback from both the patient and staff. The agency is using a portion of their IDN funds to incorporate ASQ-3 tools into their CCSA process by the end of 2018. Below is the CCSA form which will be used at WMCHC:

WHITE MOUNTAIN COMMUNITY HEALTH CENTER
Whole Person. Whole Family. Whole Valley.

Functional Assessment for Adults

Name:_____ Date:_____

In an effort to provide comprehensive care and support that better meets you and /or your family needs we ask you complete the following questionnaire.

Demographics

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park).
   - ☐ I have housing today, but I'm worried about losing housing in the future
   - ☐ I have housing
   - ☐ Other:_____

2. In your housing situation, do you have problems with any of the following? Check all that apply.
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat or hot water
   - ☐ Oven or stove not working
   - ☐ No smoke detectors or no working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

3. In the past year, have you been able to access:

Food
- ☐ Yes
- ☐ No

Child Care
- ☐ Yes
- ☐ No

Clothing
- ☐ Yes
- ☐ No

Medicine or any healthcare (medical, dental, vision)
- ☐ Yes
- ☐ No

Utilities
- ☐ Yes
- ☐ No

Phone
- ☐ Yes
- ☐ No

Activities of Daily Living

1. Do you need help with the following? Check all that apply.

☐ Bathing	☐ Dressing	☐ Meal prep/cooking
☐ Mobility	☐ Shopping	☐ Money management
☐ Transfers	☐ Telephone	
☐ Toileting	☐ Housework/Laundry	
☐ Eating	☐ Transportation/Driving	

Transportation

1. Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer

Family Support Services

1. Would you have someone to help you if you were sick and needed to be in bed?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer

2. Do you have someone to take you to a clinic or doctor's office if you needed a ride?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer

3. Are you married or living with someone in partnership?
   - ☐ I am Married
   - ☐ I am living with a partner in a committed relationship
   - ☐ I am in a serious and committed relationship, but not living together
   - ☐ I am single
   - ☐ I am separated
   - ☐ I am divorced
   - ☐ I am widowed

4. Do you rely on a family member or friend to assist you with your healthcare needs?
   - ☐ Yes Name: _____ Relationship: _____
   - ☐ No
   - ☐ I choose not to answer

5. In a typical week, how often do you...
   a. talk with family, friends or neighbors by phone call or video chat (Skype, Facetime)?
      - ☐ Never
      - ☐ Once a week
      - ☐ 3-5 days per week
      - ☐ Two days a week
      - ☐ Nearly everyday

   b. get together with family, friends or neighbors?
      - ☐ Never
      - ☐ Once a week
      - ☐ Two days a week
      - ☐ 3-5 days per week
      - ☐ Nearly everyday

   c. use email, text messaging or internet (e.g. Facebook) to communicate with family, friends or neighbors?
      - ☐ Never
      - ☐ Once a week
      - ☐ Two days a week
      - ☐ 3-5 days per week
      - ☐ Nearly everyday

6. How often do you attend...
   a. church or religious services?
      - ☐ Once per year
      - ☐ 2-3 times per year
      - ☐ 4 or more times per year
      - ☐ At least once per month
      - ☐ At least once per week

   b. meetings of the clubs or organizations that you belong to?
      - ☐ Once per year
      - ☐ 2-3 times per year
      - ☐ 4 or more times per year
      - ☐ At least once per month
      - ☐ At least once per week

Education

1. What was the highest grade you completed in school? _____
2. If you have a college degree, what in? _____
3. Do you ever need help reading?
   - ☐ Yes
   - ☐ No

4. How often do you need to have someone help you when you read instructions, pamphlets, or other written material?
   - ☐ Always
   - ☐ Sometimes
   - ☐ Never

Medical

1. I know what each of my prescribed medication do.
   - ☐ Disagree Strongly
   - ☐ Disagree
   - ☐ Agree
   - ☐ Agree Strongly
   - ☐ N/A

2. I am confident that I can tell a doctor my concerns even when he or she does not ask.
   - ☐ Disagree Strongly
   - ☐ Disagree
   - ☐ Agree
   - ☐ Agree Strongly
   - ☐ N/A

3. I am confident that I can tell whether I need to go to the doctor or if I can take care of a health problem myself.
   - ☐ Disagree Strongly
   - ☐ Disagree
   - ☐ Agree
   - ☐ Agree Strongly
   - ☐ N/A

4. I am confident that I can follow through on medical treatments I may need to do at home.
   - ☐ Disagree Strongly
   - ☐ Disagree
   - ☐ Agree
   - ☐ Agree Strongly
   - ☐ N/A

Employment & Entitlement

1. What is your current work situation?
   - ☐ Full-time work
   - ☐ Part-time or temporary work
   - ☐ Unemployed and seeking work
   - ☐ Unemployed and not seeking work
   - ☐ I choose not to answer

2. Have you applied for?
   - ☐ Social Security? Status of application_____
   - ☐ Disability? Status of application _____
   - ☐ SSI? Status of application _____
   - ☐ Unemployment? Status of application _____
   - ☐ None

Legal

1. In the past year have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correction?
   - ☐ Yes. What was your release date _____
   - ☐ No
   - ☐ I choose not to answer

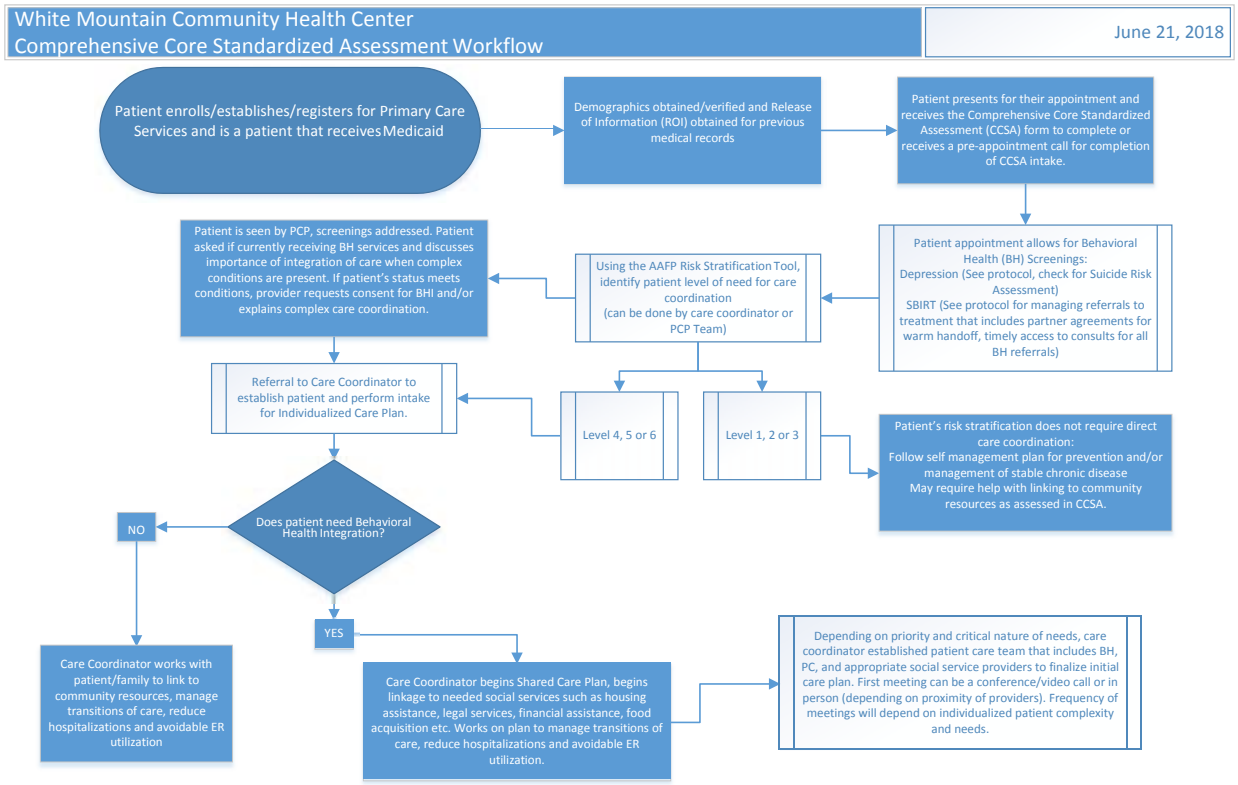
Cultural

1. Are you a refugee?
   - ☐ Yes
   - ☐ No

Risk Assessment

1. Do you feel physically and emotionally safe where you currently live?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer
2. In the past year, have you been afraid of your partner or ex-partner?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer
   - ☐ Unsure
   - ☐ I have not had a partner

Patients will either complete the CCSA form during their medical visit or they may be scheduled for a phone intake, depending on the availability of care coordination staff. WMCHC anticipates hiring an additional CHW in July of 2018 to assist with this process. After the CCSA is completed for a patient it will then be evaluated by either care coordination staff or primary care team staff, and a risk level will be applied using the American Academy of Family Physicians (AAFP) Risk Stratification Tool for Care Management and Coordination. WMCHC will be deploying the CCSA to all Medicaid patients using the following workflow:



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Huggins Hospital staff have been working closely with the IDN Quality Improvement Coach to ensure they have a CCSA and a CCSA protocol which meets DSRIP requirements by the end of 2018. Huggins Hospital plans to roll out the CCSA for their entire patient population, not just the Medicaid population. Huggins Hospital staff have had internal discussion on how social determinant domains could be assessed utilizing Phreesia tablets. In addition, Huggins Hospital will be using Allscripts as an EHR, and staff are looking at how to incorporate CCSA domains into this platform and how this information will be able to be extracted for reporting needs. Huggins Hospital staff are working together to look at each domain and determine the best way to move forward with the development of the CCSA protocol.

Ammonoosuc Community Health Services has started to create a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets. They intend to program the tablets in a way that the form only appears for Medicaid patients on an annual basis. When a patient registers the form will pop up, and once it is complete is will not reappear until the next year. ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed. The agency plans to finalize their CCSA protocol and protocol once they have finished embedding a form into their tablets and anticipate they will have this completed before the end of 2018.

Weeks Medical Center plans to move forward to implement a CCSA during the period of July-December 2018 and use lessons learned to work with Littleton Regional Healthcare to do the same. IDN staff will follow up with these agencies regarding CCSA workflow and protocol development.

IDN staff will continue to work with other B1 partner agencies in the region to offer resources to assist with CCSA implementation, including workflow and protocol development.

B1 8b List of multi-disciplinary core team members that includes, at minimum: PCP, Behavioral Health Providers (including a psychiatrist), Assigned care managers or CHW

Region 7 IDN planned to form 3 regional multi-disciplinary core teams using the same phased roll out approach as the shared care plan: Carroll County first, Coos County next, and then focusing on northern Grafton towards the end of 2018. This regional model was selected to foster inter-agency discussions on high risk patients in the region, and to efficiently utilize the time of those involved with the multi-disciplinary core team, including the psychiatrist. After numerous conversations within the region it become apparent that a regional multi-disciplinary core team wouldn't work mainly because agencies didn't find value in this model and were very concerned about privacy related issues. As mentioned in the January 2018 Semi-Annual Report, IDN staff spoke with the Region 7 IDN Steering Committee about incentivizing these teams to meet DSRIP requirements. Since this project is a demonstration, the region has pivoted away from regional multi-disciplinary core teams, and instead IDN staff will work with individual partner agencies to address specific needs related to the formation of a multi-disciplinary core team. Because of the phased roll out approach, and targeted work by IDN staff, 2 agencies in Carroll County have a defined multi-disciplinary core team in place: Huggins Hospital and White Mountain Community Health Center.

Huggins Hospital

Provider Type	Position
Primary Care Provider	Dr. Jamison Costello, Huggins Primary Care Provider
Behavioral Health Provider	Wendy Allen, LICSW, Huggins Hospital
Care Manager or Community Health Worker	Amy Leroux, RN Care Coordinator, Huggins Hospital
Psychiatrist	Northern Human Services

NCHC, on behalf of Region 7 IDN is working to finalize a contract with Northern Human Services to support the needs of the multi-disciplinary core team at Huggins Hospital.

White Mountain Community Health Center

Provider Type	Position
Primary Care Provider	Primary Care Provider staff, WMCHC
Behavioral Health Provider	Social Worker, WMCHC
Care Manager or Community Health Worker	Community Health Worker, WMCHC
Psychiatrist	Northern Human Services

WMCHC is already contracting with Northern Human Services to provide psychiatric consulting services but plans to use IDN funds to offset lost revenue associated with staff participation on the multi-disciplinary core team. As the state looks at alternative payment models which focus on value versus fee-for-service, it is the hope that this team approach will have demonstrated value, and there can be a way for these teams to be reimbursed for the time involved.

Ammonoosuc Community Health Services

Provider Type	Position
Primary Care Provider	Primary Care Provider, ACHS
Behavioral Health Provider	LICSW, ACHS
Care Manager or Community Health Worker	Behavioral Health/SUD Case Manager, ACHS
Psychiatrist	Pathways Psychiatric Consulting, Dr Erinn Fellner & Dr Stacey Charron

As IDN staff conducted partner meetings over the last few months they learned that Ammonoosuc Community Health Services is in the process of contracting for psychiatric services to support the needs of ACHS. Region 7 IDN has leveraged this existing relationship and will provide ACHS will some IDN funds to support the formation of a multi-disciplinary core team as outlined by DSRIP requirements. IDN staff will also work with Weeks Medical Center and Indian Stream Health Center who also contract with psychiatrists to meet the needs of their agencies, to see if the agencies are willing to use these existing services to form a multi-disciplinary core team. Memorial Hospital is undergoing conversations with Maine Behavioral Health about telepsychiatry, and additional conversations will continue with the remaining B1 partners in the region to assess next steps in the development of multi-disciplinary core teams. IDN staff will remind provider agencies to invite social service providers to multi-disciplinary core team meetings as needed to address patient needs.

B1-8c Multi-disciplinary core team training

Master Tracking Table of Regional Trainings						
Reporting Period: January 1, 2018-June 30, 2018			**# of Individuals trained**			
Date	**Training Title**	**Training Category**	**Core Team Disciplines**	**Non-Direct Staff**	**Other Staff**	**Total**
3/29/18	Regional Care Coordination Training	*Team-based Care Trainings*	5	1	0	6
03/30/18	42 CFR Part 2 (Regional Care Coordination Training)	*Substance Use Disorder Recognition, Treatment, Management, and Specialty Referral*	5	1	0	6
05/01-02/2018	Motivational Interviewing	*Team-based Care Trainings*	13	9	0	22
05/09/18 06/08/18 06/22/18	Mental Health First Aid	*Mental Health Recognition, Treatment, Management, and Specialty Referral*	16 13 9	8 5 9	5 5 2 Total:	29 23 20 72
5/14/18	Management of Aggressive Behavior Part 1	*Team-based Care Trainings*	14	6	8	28
6/04/18	Managing Physical Confrontation (MOAB Part 2)	*Team-based Care Trainings*	5	6	0	11
6/14/18	211 & RAPS Resources	*Team-based Care Trainings (IDN Quarterly Meeting)*	26	8	17	51
6/14/18	Peer Recovery Support Network	*Team-based Care Trainings (IDN Quarterly Meeting)*	26	8	17	51
6/14/18	The Impact of Critical Time Intervention	*Team-based Care Trainings (IDN Quarterly Meeting)*	26	8	17	51
6/14/18	Multi-Agency Perspectives on Care Coordination	*Team-based Care Trainings (IDN Quarterly Meeting)*	26	8	17	51

During the January-July 2018 reporting period IDN Region 7 held three Mental Health First Aid trainings, one Motivational Interviewing training, a 2-part Management of Aggressive Behavior Training, and the First Annual Conference/Quarterly Meeting. The Annual Conference/Quarterly Meeting consisted of a variety of presentations that educated partners on team-based care specific to existing resources, critical time intervention, and care coordination. The table below represents the quantity of participants trained during the period divided by discipline.

The June 14th Annual Conference/Quarterly Meeting provided multiple presentation in the AM session including 211 & RAPS resources, Peer Recovery Support Network Development, and the Impact of Critical Time Intervention. The meeting trained 51 people across all three disciplines and gave the region a better understanding of these aspects of the project. The PM session of the meeting trained 51 people in Multi-Agency Perspective on Care Coordination to help improve their understanding about the impact, barriers, and progress the region is facing regarding Care Coordination.

Multiple Region 7 IDN partners were trained over the January-June reporting period in the main 8 IDN sponsored trainings of this period. The table below showcases the number of individuals trained by organization for each training across all disciplines.

	CTI Worker Training	Regional Care Coordination	Motivational Interviewing	Mental Health First Aid	Introduction to Management of Aggressive Behavior	Introduction to Managing Physical Confrontation
Ammonoosuc Community Health Services					19	8
Northern Human Services		1		2	2	2
Family Resource Center	6		5		7	1
Huggins Hospital		3	1	43		
Saco River Medical Group		1				
White Mountain Community Health Center		1		2		
Carroll County Department of Corrections	1	1	3			
Tri-County Community Action Program	3		3			
Crotched Mountain	4					

Whitehorse Addiction Center	2		3			
North Country Health Consortium	1		2			
NCHC Friendship House			2			
Memorial Hospital			3	16		
Carroll County Coalition for Public Health				2		
Granite State Independent Living				1		

The IDN team has been working to capture the separate disciplines being trained throughout the region as described in the table below.

Core Team Disciplines		**Non-Direct Staff**	**Other Staff**
MD/DO	MSW	Patient Service Reps.	Any other staff member that does not directly relate to the defined disciplines or a staff member with unreported credentials/job title.
PA	MLADC	Registrar	
APRN	LADC	Medical Secretary	
RN	CRSW	Front Desk Personnel	
LPN	Care Coordinator	Any staff member who is indirectly involved with a patient's care.	
MA			
Psy.D.			
LICSW			

A comprehensive process was developed to ensure all credentials and job titles are reported for all trainings and meetings throughout this period. The team worked to create registration links that had the capability to capture Name, email, organization, job title, and credentials; this helped the team assess the distribution of disciplines trained and the ability to divide by organization. The Master Tracking Table of Regional Trainings above shows the progress the team has made in capturing all disciplines as each training shows the distribution of disciplines across the three categories.

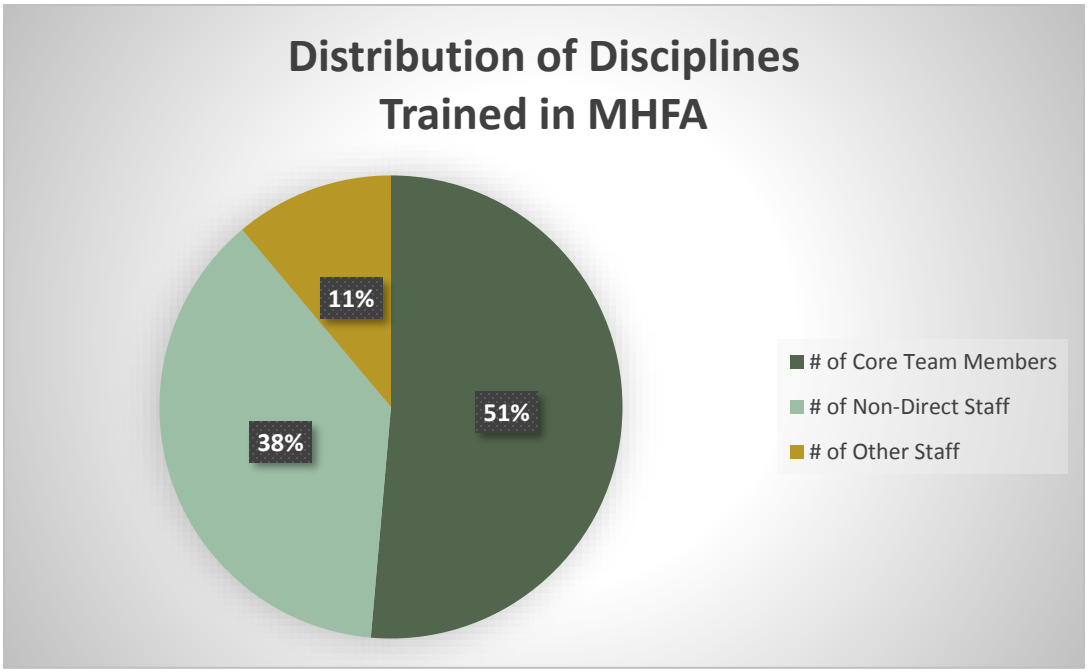
B1-8d: Training for non-direct staff:

NCHC had a staff member participate in the Mental Health First Aid Train-the-Trainer class in April of 2018, and this newly trained staff person joined another NCHC staff member already trained in the model to teach 3 Mental Health First Aid trainings during the January – June 2018. The first training was at Memorial Hospital on May 9th for 29 participants, and the other 2 were at Huggins Hospital, the first on June 8th for 23 participants, and the second on June 22nd for 20 participants. Region 7 IDN staff will work to coordinate at least one more Mental Health First Aid training before the end of 2018 so the region will meet its deliverable of having 4 Mental Health First Aid trainings offered in each year 2018-2020.

Below is a table reflecting what was reported in the region's implementation plan regarding number of front-line staff who needed to be trained in Mental Health First Aid. Mental Health First aid training was determined to 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 training is also open to the Core Team Disciplines and other staff. During this reporting period, trainings were offered on 5/9/18, 6/8/18, & 6/22/18. A variety of IDN Region 7 partners participated in these three trainings, reaching a wide range of disciplines. Below is a table reflecting the regions progress regarding number of front-line staff trained in Mental Health First Aid.

Mental Health First Aid Training Plan	Target based on need	Trained as of 06/30/18
Saco River Medical Group	3 (reception, phone support, medical records)	0
Littleton Regional Healthcare	35 (medical secretaries and hospital registrars)	1
Memorial Hospital	8 (front desk, medical records, registration)	3
Huggins Hospital	19 (front desk, PATH, billing, medical records)	21
White Mountain Community Health Center	5 (front desk, billing, medical records)	0
Weeks Medical Center	8 (front desk)	0
Northern Human Services	20 (front desk, medical records, billing)	2
Coos County Family Health Services	12 (front desk staff)	0
Rowe Health Center	10 (patient service representatives, certified medical assistants)	3

Ammonoosuc Community Health Services	38 (front desk, medical records, scheduling, billing, facilities, human resources, finance, administration	0



The pie chart above shows the distribution of disciplines that have been trained in Mental Health First Aid out of a total of 49 individuals, as of January 30, 2018. The "Core Team" and "Other" categories consist of a variety of disciplines that are in the Mental Health First Aid Training table above.

B1-8e Monthly Core Team Case Conferences

As previously mentioned in this Semi-Annual Report, Region 7 IDN decided they would not pursue 3 regional multi-disciplinary core teams because this model didn't meet the needs of the partners in the region. Instead, IDN staff are working with partners to support their needs as they form multi-disciplinary core teams and set up systems for monthly case conferences. White Mountain Community Health Center has used the tools from the region's B1 toolkit to prepare for monthly case conferences, and due to an established psychiatric consulting relationship with Northern Human Services, was able to hold their first IDN case conference in June of 2018. The agencies care coordinator selected a patient to discuss during the meeting and used a paper shared care plan template as a document to incorporate information into from the case conference and from the complete CCSA. The care coordinator felt this was a great process and reported that the provider team has already identified patients for the next monthly case conference. WMCHC is using IDN funds to offset provider time to participate in monthly case conferences.

Huggins Hospital anticipates they will have their first monthly case conference in August 2018 once Northern Human Services executes a memorandum of agreement for a psychiatrist to participate in the monthly case conference. Region 7 IDN funds are helping to support this arrangement. Ammonoosuc Community Health Services will also be using IDN funds to help support psychiatric consulting services for the two monthly case conferences, with an anticipated start date of last summer 2018.

IDN staff will continue to engage with B1 partners to address barriers related to the implementation of monthly case conferences and support the needs of these agencies as they work to include monthly case conferences within practice workflows. In addition, the region 7 IDN team will work with these agencies as they create written roles and responsibilities for these meetings.

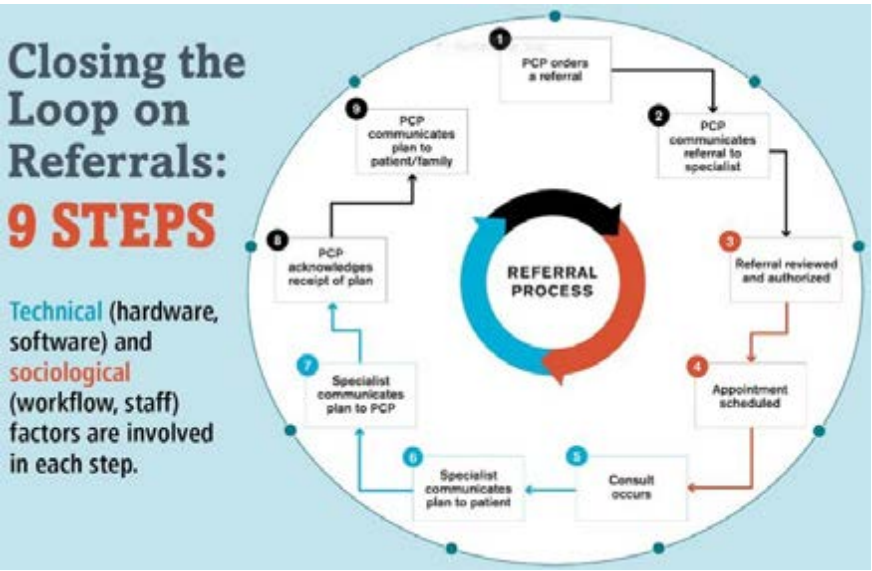
B1-8f - Secure Messaging

As mentioned in the region's January 2018 Semi-Annual Report, 15 of the region's 24 direct service providers have access to direct secure messaging. Region 7 IDN staff remind agencies that would like to incorporate direct secure messaging that they can apply for IDN funds using the region's Training and Technology Form, which provides agencies up to $5000 to address training or technology needs not already provided by the region. ServiceLink Resource Center of Carroll County used this form in May of 2018 to request funds to purchase one Kno2 license, so they can send and receive secure referrals and information to and from community partners to streamline care coordination and integration of care.

Region 7 IDN staff will use July-December 2018 reporting period to engage with agencies who do not have direct secure messaging in place to discuss next steps for possible implementation of a direct secure messaging platform.

B1-8g - Closed Loop Referrals

Region 7 IDN staff have been working with IDN partners to address the need for closed loop referrals, either electronic, or non-electronic. IDN staff used the region's care coordinator panel discussion during the IDN Annual Conference in June 2018 as an opportunity to have a conversation on referral processes, including closed loop referrals. The region's Quality Improvement Coach shared the Institute for Healthcare Improvement (IHI) "9-Step Closed-Loop Referral Process guidelines, which were created to standardize how primary care practitioners refer patients to specialists and keep track of referral-related information over time.



Region 7 IDN does have some agencies with closed loop referral processes in place, but many of these agencies do not have written protocols for this process, which is a DSRIP requirement, and a recommended step according to the Institute for Healthcare Improvement. Written protocols for closed loop referrals will create a stronger system with less chance of patients "falling through the system" due to things like: ambiguous roles and responsibilities for the PCP, the specialist, and their staff (e.g., who should gather specific information for patient assessment); insufficient resources (e.g., staff to monitor referral process); lack of clear policies and detailed instructions (e.g., how to address no-shows); and lack of standard protocols for electronic referrals.

As IDN staff continue to engage with IDN partners across the region they will use the following 9 steps to guide conversations related to closed loop referral processes:

- Interoperability between systems of referring PCP and specialists.
- Assess electronic communication related to the referral process.
- Create and use collaborative care agreements to delineate expectations for PCPs and specialists, including roles in co-management and communicating with patients and families; agreements should also include expectations regarding scheduling, etiquette, and timeliness of communication.
- Improve and standardize handoffs during the referral process, similar to recent advances in handoffs at transitions of care.
- Use a process map to delineate current workflow and address workflow-related problems before implementing an electronic referral process.
- Develop processes to ensure clear accountability of patient follow-up (i.e., ownership and coordination at each step).
- Develop a user-friendly, reliable method to track referral status at the patient level until it is closed and to ensure routing to correct specialist.
- Apply evidence-based communication techniques when communicating with patients and families.
- Monitor progress in improving the EHR referral process.

The IDN clinical workgroup will provide guidance as partners in the region work on closed loop referral processes to ensure SUD providers and social service agencies are included in the closed loop referral process as necessary. IDN staff will include information related to closed loop referral processes in the region's toolkits and address the need to use PDSA to ensure the processes in place are efficient and meet the needs of both the IDN partner agency and the patient. Ways to measure effectiveness include:

- % 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

B1-8h Documented workflows: Region 7 IDN partners are in various stages of creating documented workflows. Northern Human Services had done considerable amount with this during the last reporting period, but then suspended their efforts until they incorporated Collective Medical Technology into their systems. Feeling that other partners were in similar situations, the Region 7 IDN team hasn't pursued this as much until CMT implementation occurs.

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: • Demographic information • Physical health review • Substance use review	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	• Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT					
	For pediatric providers, the CCSA must also include: • Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; • Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental	Table listing all providers by domain indicating Y/N on progress for each process detail				
B1-8b	List of multi-disciplinary core team members that includes, at minimum: • PCPs • Behavioral health providers	Table listing names of individuals or positions within each provider				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	(including a psychiatrist) • Assigned care managers or community health worker	practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple)	Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that	Training schedule and table listing all staff indicating progress on				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	can aid in recognition and management	each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	Documented work flows and/or protocols that include, at minimum: • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support service providers • Intake procedures that include	Work flows and/or Protocols (submit all in use)				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	systematically soliciting patient consent to confidentially share information among providers • Adherence to NH Board of Medicine guidelines on opioid prescribing					

B1-9. Additional Documentation as Requested in B1-9a - 9d

Achievement of all the requirements of a Coordinated Care Practice:

B1- 9a Progress towards Coordinated Care

The current status of IDN partners most likely to adopt the Shared Care Plan is outlined below:

Huggins Hospital and Outpatient Clinic: Huggins Hospital has done the most work to adopt the SCP in the region. They have completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process. Huggins works closely with the IDN Quality Improvement Coach to address the CCSA protocol, and has created a multi-disciplinary core team, supported by a psychiatrist as previously mentioned, and will be having their first monthly case conference in August 2018. Huggins Hospital will also be working on depression protocols.

Memorial Hospital: Memorial is not currently engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. The organization was recently integrated in to the MaineHealth system and they are engaged in an Epic electronic health record implementation. IDN staff have had on going communications and one meeting with their team including a demo of the shared care plan, and will continue to engage with the staff at Memorial Hospital to discuss next steps, As this hospital is near the Maine border and they are a MaineHealth affiliate, staff have shared that not having Maine patient data in the CMT network is a barrier to using the SCP that is unique for this organization. Memorial Hospital has really focused on their behavioral health integration, and MAT expansion. They have a total of 6 staff divided within 2 departments who can prescribe for MAT services. They use the following for assessments, all provided by MaineHealth to ensure there is a standard protocol across the MaineHealth system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment. This assumes the person is opioid dependent; Addiction Severity Index Lite-CF; PHQ-9; Adverse Childhood Events; MaineHealth Mental Health Assessment : Scoring and Care PlanningGAD-7 Anxiety rating scale; and MDQ- mood disorder questionnaire. So far every patient they have seen has been a patient within primary care there is the shared electronic record that enables us to capture and share patient

information. This closes the loop. Moving forward, they are going to begin accepting transfers of patients from outside providers so the closed looped referral process will become an active goal as they work on the care coordination of newly entering patients. The agency holds monthly IMAT meetings with everyone involved in IMAT including senior leadership at the hospital.

North Country Health Care: NCH is comprised of Weeks Hospital, Androscoggin Valley Hospital, Littleton Regional Healthcare and Upper Connecticut Valley Hospital. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives. In this period, Androscoggin, Upper Connecticut Valley and Weeks were able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. Recently, we have initiated a project to establish ADT connections for Littleton Hospital and we hope that can be completed quickly.

NCH has also agreed to begin implementing the shared care plan. This will occur first at the Weeks hospital emergency department. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. While no specific time line has been established yet, it is hoped that we will see active use by the end of the next reporting cycle. Weeks Medical Center has been looking at the CCSA domains and explore how to capture all of these domains. They will work closely with Littleton Regional Healthcare throughout this process to share information and lessons learned.

Cottage Hospital: Cottage Hospital is not currently engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. IDN staff continue to engage this partner on how the tool can help the organization and other IDN partners. Cottage Hospital has received funding to hire a behavioral health integration consultant as previously mentioned.

White Mountain Community Health Center: This organization has done significant work in developing a process to deliver integrated care including hiring a care coordinator, developing an assessment process and establishing a multidisciplinary team process. They have worked closely with a North Country Health Consortium Practice Transformation facilitator in this regard. They are actively working on a shared care plan install. IT resources are currently developing the census file upload and leadership is defining parameters for SCP users, cohorts and notifications. WMCHC has been working on risk stratification models, and a CCSA protocol. They held their first monthly case conference in June of 2018, supported by a psychiatrist. Staff at the agency feel this meeting was helpful and are looking forward to the next meeting.

Indian Stream Health Center: Indian Stream is not currently engaged in active work on the SCP at this time. IDN Staff have met with their team and while they are supporters of the SCP initiative, resources to implement are a challenge due to a significant EHR upgrade at this time. ISHC is looking at assessments and protocols and has said they will work closely with IDN staff to help include the CCSA domains as this work continues. ISHC already contracts with a psychiatrist, and has medical/behavioral health provider meetings, so Region 7 IDN team will continue to have conversations with the agency to address their needs related to share care plan, and implementation of monthly case conferences.

Coos County Family Health Services: IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking. We are scheduling an initial project call now with Collective Medical Technologies and the organization will be moving forward with an installation of the shared care plan in the coming weeks. CCFHS provides MAT services and is working with NHS on a co-located behavioral health/primary care site. They are currently assessing some of the CCSA domains, but not consistently. As the agency continues exploration of the shared care plan, the additional DSRIP deliverables will be discussed.

Northern Human Services: NHS is not engaged in active work on the SCP at this time. IDN staff have had a several meetings with the group. They have been doing due diligence on consent requirements and related processes. It is hoped that the organization will adopt the SCP in the coming months, particularly in light of the work being done by primary care organizations in the region. Northern Human Services started to develop communication workflows but has put that on hold until additional conversations occur with CMT. They are trying to reach out to providers in the area to make sure all agencies are aware of their scope of services. These conversations could help with referral processes.

Saco River Medical Group: Saco River and IDN staff have met twice to discuss the SCP. Resources to install and provider workflow and productivity impact have been concerns. Additionally, SRMG's primary hospital partner, Memorial Hospital, is not yet submitting ADT information and the SCP is viewed as less valuable without that information. Saco River is engaged, and willing to work with IDN staff to put systems in place to meet DSRIP deliverables, including looking at risk stratification models.

The current status of IDN partners working to capture all 12 domains of the Comprehensive Core Standardized Assessment is outlined below:

White Mountain Community Health Center: White Mountain Community Health Center (WMCHC) has made significant progress in the implementation of the CCSA during the period of January – June 2018. They have been working closely with the IDN Quality Improvement Coach to get a CCSA process in place, and they used this new process for the first-time s in June 2018 with positive feedback from both the patient and staff. The agency is using a portion of their IDN funds to incorporate ASQ-3 tools into their CCSA process by the end of 2018.

Huggins Hospital: Staff have been working closely with the IDN Quality Improvement Coach to ensure they have a CCSA and a CCSA protocol which meets DSRIP requirements by the end of 2018. Huggins Hospital plans to roll out the CCSA for their entire patient population, not just the Medicaid population. Huggins Hospital staff have had internal discussion on how social determinant domains could be assessed utilizing Phreesia tablets. In addition, Huggins Hospital will be using Allscripts as an EHR, and staff are looking at how to incorporate CCSA domains into this platform and how this information will be able to be extracted for reporting needs. Huggins Hospital staff are working together to look at each domain and determine the best way to move forward with the development of the CCSA protocol.

Ammonoosuc Community Health Services: has started to create a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets. They intend to program the tablets in a way that the form only appears for Medicaid patients on an annual basis. When a patient registers the form will pop up, and once it is complete is will not reappear until the next year. ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed. The agency plans to finalize their CCSA protocol and protocol once they have finished embedding a form into their tablets and anticipate they will have this completed before the end of 2018.

Weeks Medical Center: plans to move forward to implement a CCSA during the period of July-December 2018 and use lessons learned to work with Littleton Regional Healthcare to do the same. IDN staff will follow up with these agencies regarding CCSA workflow and protocol development.

The current status of IDN partners working with a Multidisciplinary Core Team is outlined below:

White Mountain Community Health Center: WMCHC had their first case conference with their established MDCT in June 2018. The team explained that the meeting was very beneficial in caring for the patient and developing a care plan for moving forward. They found the toolkit forms exceptionally

valuable for during the planning process and execution of the meeting. The health center already contracts with Northern Human Services for psychiatric services, allowing them to use this as the psychiatric component on the MDCT.

Huggins Hospital: Huggins has identified all team members for their MDCT as shown previously in B1. They plan to schedule their first case conference and develop a care plan for one of their high needs patients.

Northern Human Services: NHS has been working the IDN administrative lead, NCHC, to finalize a contract to provide Region 7 with psychiatric services for developing MDCT's across the region. Teams will be developed of the next 6-months and case conferences will begin.

B1-9B Adoption of both of the following evidence-based interventions:

- Medication Assisted Treatment
- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through the use of IMPACT or other evidence-supported models

Region 7 IDN has a number of B1 partners who deliver MAT, including: Weeks Medical Center, Coos County Family Health Services, Ammonoosuc Community Health Services, Memorial Hospital, White Mountain Community Health Center, and Saco River Medical Group. Huggins Hospital will be starting to develop a MAT program during the next 6 months, and Friendship House recently contracted with a nurse practitioner who has a waiver to deliver MAT services. Additional information is needed to be collected on evidence-based treatment for mild-moderate depression. Both Huggins Hospital and WMCHC are working on the development of depression protocols.

B1-9C Use of Technology to identify, at a minimum:

- At Risk Patients
- Plan Care
- Monitor/Manage Patient progress toward goals
- Ensure Closed Loop Referral

ACHS uses technology to Identify at-risk patients in various ways. ACHS maintains an Electronic Health Record (EHR) that contains information from all ACHS providers. This includes primary care, dental, vision, mental health, substance misuse, patient navigators, and case managers. ACHS is able to run queries for patients that are at risk for various chronic illnesses, treat, and track all using the same shared chart. The Primary care manages and coordinates the various services that each patient receives through the chart and an HER flagging system. This ensures the treatment team has all pertinent and relevant data to make appropriate decisions for the patient's care. ACHS also obtains intakes and discharges from local area hospitals electronically. Primary care will conduct follow up calls to ensure patients are receiving the needed care. ACHS also screens emergency department intakes and discharges for behavioral health (mental health and/or substance use) diagnosis. These patients also receive a follow up call to offer expanded behavioral health services.

ACHS also conducts monthly Chronic Care Management (CCM) team meetings for the purpose of offering or referring patients for expanded care to meet their unique needs. The CCM will use the ACHS EHR to identify and assess patient's needs. They will use the same HER to flag and coordinate care. The HER allows the CCM to track, and potentially adjust, treatment goals.

Weeks: MAT Program is based on the BDAS best practice model. They utilize an EMR system to document a patient's plan of care, monitor goals, and to close the referral loop. A tablet is used for SUD screening purposes and identifying at risk patients. A brief summary of the process is indicated below:

- Weeks' has incorporated the AUDIT questionnaire for adult SUD screening and the CRAFFT questionnaire for adolescents. Patients are provided with a tablet upon arrival. Screening results are uploaded to the patient's medical record and available for the provider to review with a patient during the visit. The tools used help the provider determine if the patient has a substance use issue.
- Patients who have a substance use disorder receive provider intervention and if deemed necessary, the provider will discuss Weeks' MAT program as an option. If the patient agrees with this option, the provider creates a referral to one of the behavioral health counselors who schedules an appointment to assess whether the patient is ready to commit to the program and if so, a referral is then made to the North Country Recovery Center for intake.
- The behavioral health counselor also creates a referral to the behavioral health case manager who meets with the patient to determine what other services are needed which will help the patient as they work through the recovery process.
- The behavioral health team leader oversees North Country Recovery Center's operations, monitors patient compliance with the program (i.e., tox screens, urine screens, appointments, etc.), and provides guidance to the Behavioral Health Case Manager.
- The patient has regularly scheduled appointments with the prescriber and counselor; and can schedule appointments with the behavioral health case manager or behavioral health team leader as needed

Saco River Medical Group uses their EHR to track at-risk patients as identified by screenings or provider referrals. They are building a system to track closed loop referrals.

Huggins Hospital has limited in ability to use technology to implement population health management functions such as population stratification, targeting and monitoring care, and managing closed loop referrals because they are in the middle of a resource-intensive electronic medical record (EMR) upgrade. The old system does not provide this technology and cannot efficiently be retrofitted to do so. Technology-based population health management is pended until completion of our EMR implementation project. They are able to use CPSI, our EMR, to segment diabetes patients and monitor lab values to follow up and target interventions.

B1-9D Documented Workflows including at a minimum: Joint service protocols and Communication channels

Region 7 IDN staff will continue to work with partner agencies to develop joint service protocols and communication channels. Currently partners are not providing documented information related to protocols with social service providers.

Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of *Integrated Care Practice* Designation Requirements

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirement	Adoption of both of the following evidence-based interventions: • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	Protocols (Submit all in use)				
• B1-9c		• Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	• Table listing all providers indicating progress on each process detail				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9d		Documented work flows with community based social support service providers including, at minimum: • Joint service protocols • Communication channels	Work flows (Submit all in use)				

B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

Use the format below to identify the total number of practices/providers who have **achieved** 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.

Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	13	0	0	**0**	
Integrated Care Practice	9	0	0	**0**	

None are considered coordinated care designation because none currently have a complete CCSA in place which captures all 12 domains and used on a routine basis. See below for narrative on progress towards coordinated care.

Use the format below to identify the **progress** each practice made toward Coordinated Care Practice or Integrated Care Practice designation during this reporting period.

Progress Toward Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/2017	6/30/18	12/31/18
	Northern Human Services		• **They have been working on consent requirements and related processes relating to the shared care plan;** • **Finalizing a contract with NCHC to provide psychiatric services for developing MDCT's across the region;** • **Finalizing CrossRoads clinic: a co-located site with CCFHS supplying primary care providers;** • **Staff member attended Regional Care Coordinator training;**	

			• **Part of a multi-disciplinary core team meeting with WMCHC and soon to be with Huggins Hospital;** • **Actively engaged in shared care plan conversations**	
	White Mountain Community Health Center		• **Hired a care coordinator;** • **Developed a CCSA assessment process;** • **Held first case conference June 2018, and establish a MDCT process;** • **Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes;** • **Actively working to install shared care plan;** • **Has a MAT program in place, has held a case conference with a full MDCT and have taken a pilot patient through the CCSA process;** • **Staff member attended Regional Care Coordination Training;**	
	Memorial Hospital		• **Met with key staff to discuss IDN deliverables. Their affiliation with MaineHealth and time being spent on an EHR upgrade has played into the timing of meeting IDN deliverables;** • **The have had new nurse practitioners receive certification in MAT and have a robust behavioral health integration project underway through MaineHealth;** • **They are looking into connecting to psychiatric services through MaineHealth;** • **Memorial has taken the lead on a 4 agency collaborative proposal in Region 7 IDN to improve care coordination in the North Conway area;** • **Staff attended a Mental Health First Aid training;**	

	Huggins Hospital		• **They have completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process;** • **Staff have been working closely with the IDN Quality Improvement Coach to ensure they have a CCSA and a CCSA protocol which meets DSRIP requirements by the end of 2018;** • **Huggins Hospital plans to roll out the CCSA for their entire patient population, not just the Medicaid population;** • **They have received funds to stand up a MAT program during this period and have been shaping a MDCT to use in the upcoming reporting period;** • **Hosted 2 Mental Health First Aid trainings;** • **Staff attended Regional Care Coordinator training**	
	Saco River Medical Group		• **Saco River and IDN staff have met twice to discuss the SCP. Resources to install and provider workflow and productivity impact have been concerns;** • **Saco River Medical Group has a MAT program in place;** • **Staff attended Regional Care Coordinator training;** • **Saco River Medical Group is looking at the CCSA process and is working to address the IDN domains;** • **Staff are working on care coordination processes**	
	Coos County Family Health Services		• **IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking;** • **CCFHS addresses most of the domains in the CCSA and**	

			conversations continue about the CCSA process and shared care plan; • **Coos County Family Health Service has a MAT program in place;** • **Providing staff to CrossRoads clinic, a co-located site with Northern Human Services**	
	Weeks Medical Center		• **Weeks is an affiliate of North Country Health Care. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint.** • **Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network.** • **Weeks plans to move forward to implement a CCSA during the next 6 months and use lessons learned to share with Littleton Regional Healthcare as they implement the CCSA. Weeks has a robust MAT program;** • **As part of the affiliation Weeks has been addressing regional care coordination which includes working with Community Health Workers from the North Country Health Consortium**	
	Indian Stream Health Center		• **ISHC is engaged in conversations related to CCSA and are currently making revisions to their assessment process;** • **Staff is interested in shared care plan and IDN staff will engage them in additional conversations in the next 6 months** • **They do have a contract with a psychiatrist, and do have provider meetings, just not a formal case conference process in place – IDN staff will continue discussions about this**	

	Ammonoosuc Community Health Services		• **Creating a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets;** • **ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed. The agency plans to finalize their CCSA protocol and protocol once they have finished embedding a form into their tablets and anticipate they will have this completed before the end of 2018;** • **Working on development of various protocols required**	
	Littleton Regional Healthcare		• **LRH is an affiliate of North Country Health Care. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan – Weeks will start this process and then work with other affiliates;** • **LRH will work to capture domains required in IDN CCSA and will work closely with Weeks Medical Center to help with this process;** • **ADT feeds should be live in next reporting period**	
	Rowe Health Center		• **The health center continues to build capacity to implement integrated healthcare. They received IDN funding to hire a consultant to help them work toward this goal. Conversations continue around the CCSA and shared care plan**	
	White Horse Addiction Center		• **Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints – IDN staff will engage with White Horse about the shared care plan in the next reporting period;** • **Working with a consultant to build capacity and implement processes to work toward coordinated care.**	

	North Country Health Consortium Clinical Services /Friendship House		• **Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints – IDN staff will engage with staff at Friendship House about the shared care plan in the next reporting period;** • **Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders.**	
Progress Toward Integrated Care Practice	**List of providers identified to make progress toward Integrated Care Practice designation**	**12/31/2017**	**6/30/18**	**12/31/18**
	ACHS		• **ACHS is able to run queries for patients that are at risk for various chronic illnesses, treat, and track all using the same shared chart;** • **ACHS also obtains intakes and discharges from local area hospitals electronically.** • **ACHS also screens emergency department intakes and discharges for behavioral health (mental health and/or substance use) diagnosis. These patients also receive a follow up call to offer expanded behavioral health services;** • **AHCS has a new MAT program ready to start at its Littleton location, modeled after a pilot program at their Woodsville site;** • **Working to develop formalized protocols including evidence-based treatment**	
	Memorial		• **Expanded MAT services – have a total of 6 MAT prescribers.** • **Will continue conversations related to use of technology to identify high risk patients, and evidence based treatment of depression.**	

	Weeks Medical Center		• **MAT Program is based on the BDAS best practice model. They utilize an EMR system to document a patient's plan of care, monitor goals, and to close the referral loop. A tablet is used for SUD screening purposes and identifying at risk patients;** • **Patients who have a substance use disorder receive provider intervention and if deemed necessary, the provider will discuss Weeks' MAT program as an option. If the patient agrees with this option, the provider creates a referral to one of the behavioral health counselors who schedules an appointment to assess whether the patient is ready to commit to the program and if so, a referral is then made to the North Country Recovery Center for intake;** • **The behavioral health counselor also creates a referral to the behavioral health case manager who meets with the patient to determine what other services are needed which will help the patient as they work through the recovery process;** • **IDN staff will continue conversations related to evidence based treatment of depression**	
	Coos County Family Health Services		• **On-going conversations related to electronic closed loop referral, using technology to identify at risk patients, and evidence based treatment of depression;** • **MAT program in place**	
	Friendship House/NCHC Clinical Services		• **Exploring MAT program** • **IDN team will be working with them regarding formalized protocol development**	
	White Mountain Community Health Center		• **MAT program in place;** • **Working on risk stratification model to help identify high risk patients;**	

			• **Working on protocol related to evidence-based treatment of depression**	
	Huggins Hospital		• **Currently has limited in ability to use technology to implement population health management functions such as population stratification, targeting and monitoring care, and managing closed loop referrals because they are in the middle of a resource-intensive electronic medical record (EMR) upgrade** • **IDN Quality Improvement Coach working with them closely to develop protocols and risk stratification model;**	
	Saco River Medical Group		• **use EHR to track at-risk patients as identified by screenings or provider referrals. They are building a system to track closed loop referrals;** • **MAT program in place;**	
	Northern Human Services		• **On-going conversations related to electronic closed loop referral, using technology to identify at risk patients, evidence-based treatment of depression, and providing MAT services;** • **Will be working on communication workflows with primary care providers during next reporting period;** • **Slated to open CrossRoads clinic in July 2018**	

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 were required to complete an IDN Community Project Implementation Plan including design and development of clinical services infrastructure plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

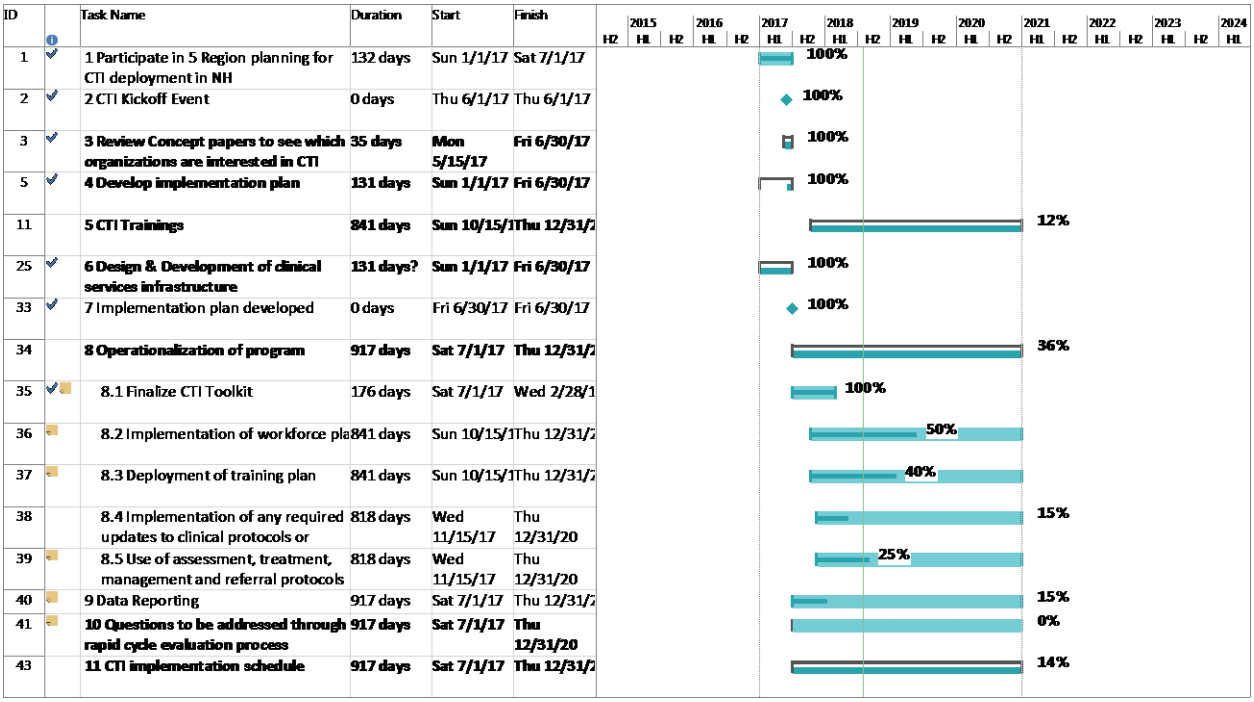
Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Provide an update to the training plan, curricula, and schedule that identifies 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 update to the evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The update will, at a 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.

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables C-2 through C-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.



ID	Task Name	Duration	Start	Finish
1	1 Participate in 5 Region planning for CTI deployment in NH	132 days	Sun 1/1/17	Sat 7/1/17
2	2 CTI Kickoff Event	0 days	Thu 6/1/17	Thu 6/1/17
3	**3 Review Concept papers to see which organizations are interested in CTI**	**35 days**	**Mon 5/15/17**	**Fri 6/30/17**
5	**4 Develop implementation plan**	**131 days**	**Sun 1/1/17**	**Fri 6/30/17**
11	**5 CTI Trainings**	**841 days**	**Sun 10/15/1**	**Thu 12/31/2**
25	**6 Design & Development of clinical services infrastructure**	**131 days?**	**Sun 1/1/17**	**Fri 6/30/17**
33	7 Implementation plan developed	0 days	Fri 6/30/17	Fri 6/30/17
34	**8 Operationalization of program**	**917 days**	**Sat 7/1/17**	**Thu 12/31/2**
35	8.1 Finalize CTI Toolkit	176 days	Sat 7/1/17	Wed 2/28/1
36	8.2 Implementation of workforce pla	841 days	Sun 10/15/1	Thu 12/31/2
37	8.3 Deployment of training plan	841 days	Sun 10/15/1	Thu 12/31/2
38	8.4 Implementation of any required updates to clinical protocols or	818 days	Wed 11/15/17	Thu 12/31/20
39	8.5 Use of assessment, treatment, management and referral protocols	818 days	Wed 11/15/17	Thu 12/31/20
40	9 Data Reporting	917 days	Sat 7/1/17	Thu 12/31/2
41	**10 Questions to be addressed through rapid cycle evaluation process**	**917 days**	**Sat 7/1/17**	**Thu 12/31/20**
43	**11 CTI implementation schedule**	**917 days**	**Sat 7/1/17**	**Thu 12/31/2**

Attachment_C1_1

During the reporting period of 1/01/2018 -6/30/2018 Region 7 IDN had 1 new member agency, The Family Resource Center at Gorham, join the network, and no members leave.

Due to staffing turnover, NCHC hired a new project coordinator who joined the IDN team in February 2018. Since starting, she has spent a considerable amount of her time coordinating the region's C1 project, Critical Time Intervention. Region 7 IDN has made progress in the implementation of the CTI project during the January-June 2018 reporting period, which includes an expanded CTI workforce, a newly developed Region 7 Mini CTI Learning Collaborative, release of the region's CTI toolkit, and active involvement with statewide CTI Community of Practice meetings.

A CTI Worker training was held in Plymouth, NH on March 19-20, 2018 with 37 participants from all five regions and statewide partners, 12 of which were from Region 7 IDN and 4 of which were from Crotched Mountain, a statewide partner. The agencies in Region 7 sending staff were Carroll County Department of Corrections (CCDOC), North Country Health Consortium (NCHC), The Family Resource Center at Gorham (FRC), Tri-County Community Action Program (TCCAP), and Whitehorse Addiction.

IDN Regions 1, 3, 4, 6, 7 and statewide partners have continued to work together as the CTI-NH Community of Practice (CTI-NH CoP) with technical support from the Center of Advancement for Critical Time Intervention (CACTI) at Hunter College. Monthly conference calls were used to communicate updates from each region including successes and/or challenges allowing other regions to share questions, feedback, similar concerns and other shared experiences. These calls also allowed time for planning the quarterly, in-person CTI-NH CoP meetings as well as upcoming CTI trainings. The first in-person quarterly meeting for the CTI-NH Community of Practice (CoP) was held on March 21, 2018 in the Plymouth, NH. In addition to the updates from each region, a representative from New Hampshire Hospital (NHH) presented information about processes to encourage efficiency from statewide referrals to various regions. It was suggested that CTI teams connect with their regional mental health liaison(s) to share CTI referral criteria since it is difficult for the social workers at NHH to keep track of the locations and separate details of all the CTI teams, and NHH is required to contact these liaisons as part of the discharge process. There were 3 break-out sessions at the March 2018 CoP meeting providing participants with the opportunity to discuss external barriers to CTI implementation, creating effective community partnerships, and tools to assist with CTI implementation. Total attendance for this meeting was 21, 5 of those being from Region 7. The second quarterly, in-person CTI-NH CoP meeting was held in Concord, NH on June 27, 2018 with 25 participants, 5 of which were from Region 7. In addition to the updates from each region, participants discussed program successes, along with similarities and differences between the Critical Time Intervention model versus enhanced care coordination or traditional case management, because there seems to be a lot of confusion from clients and providers regarding the overlap of CTI with other services. This confusion also leads to questions pertaining to sustainability for the future via the possibility of CTI becoming a Medicaid billable service and avoiding duplication of services. Consent and redisclosure protocol involving 42 CFR Part 2 was tabled for a future conversation with the intent to invite Health Information Technology (HIT) specialists from each IDN for their added perspectives. Many regions shared concerns about reaching the evaluation project target of number of individuals served by CTI that are part of the implementation plans.

Region 7 IDN has continued to serve in a lead role as the 5 IDN regions work to implement CTI in NH. This lead role includes organizing logistics for trainings and meetings, managing the contract with CACTI, and dividing up shared financial expenses. This arrangement has been instrumental to ensure training plans

are carried out in a timely manner, and the CTI-NH Community of Practice meets monthly. Region 7 IDN staff also created a statewide CTI folder within Basecamp to serve as a document sharing platform. The CTI folder has training materials, implementation tools, research articles, a contact list, NH Mental Health Region designations and sample forms from other regions such as; brochures, referrals and assessments.

Plans are currently underway for a statewide CTI Train-the-Trainer event for August 2018. The regions anticipate having CTI trainers available in the state will help with sustainability of the model. This 2-day training will prepare experienced CTI workers and supervisors to deliver training in CTI. Training Objectives include:

- Describe three best practices for trainers
- Present a 5-7 minute overview of the basics of CTI
- Explain team members' roles and responsibilities in each CTI phase
- Facilitate discussion about challenges and opportunities in each CTI phase
- Demonstrate a "tell, show, do, apply" approach to training
- Enhance skillfulness as a trainer through practice with feedback

The five IDN regions have a meeting scheduled for August to discuss training plans after September 2018, since that is the end of the current contract with Hunter College who has provided the statewide CTI trainings thus far.

A few ideas related to referrals have surfaced during the monthly CTI-NH CoP conference calls that have informed Region 7's work moving forward with CTI implementation. The first is that many regions found the eligibility criteria of clients with "serious mental illness" to be too narrow which limited the number of referrals to CTI teams. Region 7 IDN made the choice to expand to a person who "experienced a behavioral health disorder or is at risk of experiencing a behavioral health disorder". This will also allow clients with undiagnosed mental illness to be considered. A referral form with updated eligibility requirements was added to the CTI Toolkit. The second is the need for educating potential partners on the CTI model to ensure referrals are made in a timely manner. Many suggested that face-to-face encounters work the best to explain when explaining the CTI model. Region 7 IDN is working to get one or more CTI teams in place that will address the transition of hospital to the community. Once that is available, outreach to care coordinators, transition teams and social workers can be enhanced. A CTI brochure is in development for that purpose.

A barrier to getting additional CTI teams established in the region has been getting the message out that CTI is its own evidence-based program that needs to be followed to fidelity. Once agencies understand the scope of implementing CTI and the need for fidelity, they are faced with questions about how to make that happen. One way to address this was to create a CTI-Region 7 IDN Mini Learning Collaborative (CTI-R7 MLC) for the people in Region 7 IDN who have been trained in CTI. A consultant from CACTI is also available during these meetings to provide support and even set up coaching sessions with individual agencies when needed. Three CTI-R7 MLC have occurred in April, May and June of 2018 with participants from five partner agencies. These have been beneficial for checking in and making connections among agencies as CTI teams are conceptualized across the region to reach more clients.

The Director of the Center for the Advancement of Critical Time Intervention at Hunter College gave a presentation at the Region 7 IDN Annual Conference in June focusing on the impact of the CTI model. This was planned in response to confusion from some providers and clients on the how CTI is different from

traditional case management. The presentation clarified that CTI engages clients during transitions with the aim of improving continuity of care and community integration by linking clients to networks of support. The three main distinctions that set it apart from other services are that CTI is time limited, focused, and decreased in intensity over three phases. Time limited means CTI Workers are preparing to let go from the first time they meet clients through to the end of the 9-month period when linkages and supports should be well established. A focused approach means one to three areas of prioritized need are chosen during each phase following the client's lead. It is not comprehensive case management. Phases with decreasing intensity means ideally there is a pre-CTI stage for building rapport with the client followed by 3 three-month phases that that go from heavy support to a try-out phase and finally the transfer of care. This decreasing intensity of support is transpiring while community supports are increasing. Having limited caseloads of up to 20 clients provides CTI Workers the opportunity to meet in the community or where the client lives.

Region 7 IDN staff will continue with efforts to educate the region regarding the CTI model and will follow up with partners who have employees trained in CTI but have not implemented a CTI team yet. Options for pulling teams together involving multiple agencies will also be explored. CTI teams must consist of at least two people including a CTI Supervisor/Fieldwork Coordinator and a CTI Worker. The number of CTI Supervisors in the region remains at 3 since there have not been any supervisor trainings during this reporting period. The plan is to offer another supervisor training near the end of 2018 or early 2019. There are currently 24 CTI workers positioned in Region 7. Three of the 11 from the last reporting period are no longer in the region. The 8 that remain added to the 16 newly trained workers during this reporting period brings the total to 24.

Carroll County Department of Corrections (CCDoC) has continued to build their CTI team by hiring a case manager in March 2018 who attended CTI Worker training and has been working with clients transitioning from incarceration to the community. CCDoC already had a CTI Supervisor on staff. A lot of pre-CTI work is done with correctional clients to build relationships, determine needs, and provide initial treatment services to improve their chances for successful transition to community services including substance use and mental health programs. The case manager has been working to strengthen connections with community-based treatment and health services by attending appointments with CTI clients. So often correctional clients enter the community without a solid transition plan and don't meet with providers until after release from the institution. This project works to ensure there is a coordinated care plan with referral to key agencies to reduce gaps in care during time of transition back to the community. Currently, they have 8 clients in pre-CTI, 1 client in Phase 1, 2 clients in Phase 2, and 1 client no longer participating for a total of 12 individuals served. Clients who choose to stop participating are kept open with agencies in the event they come back for services. If that happens, the client joins the phase that they would be in had they stayed active. CCDoC hopes to see more CTI teams available around the region to refer clients to as they leave the facility.

Carroll County has created a Criminal Justice Coordinating Committee to establish community goals for reduced recidivism and improved treatment services. The Critical Friends Committee is made up of key community providers, jail staff and probation. They have been meeting to improve the quality of transitional services. The CCDoC Superintendent has established a reentry program and the CTI model has helped them develop organizational capacity to link offenders to need services as they transition back to the community. For those incarcerated by court order, CCDoC continues to provide a full spectrum of transitional programs designed to prepare individuals currently in jail to successfully and productively

return to their community and reduce the potential for re-offending. The program is designed to provide treatment services for offenders with co-occurring disorders as they move back into the community. Right now, 85% of individuals evaluated in their program have an opioid problem. The next largest group of those evaluated (15%) has a methamphetamine problem and/or alcohol problem. This model offers stabilization and treatment for individuals that is not always possible in community-based settings due to lack of follow through or due to social determinants which inhibit individuals' ability to stay in community-based treatment. Many individuals going through the county jail have never had the length of sobriety that they are able to attain at the jail and are more likely to build on the in–house success in the community with this support.

Tri-County Community Action Program (TCCAP) is the only agency in Region 7 IDN that provides dedicated homeless intervention and outreach services across the whole region. TCCAP also operates two homeless shelters. They have added four new staff to work on the CTI project, but they have lost two others that were trained. One was a CTI worker and is now in a new role at TCCAP, while the other was a CTI Supervisor but left the agency. The current team of six has been trained as follows; one who has taken both the CTI Worker & Supervisor training, two Homeless Intervention & Prevention Specialists who have taken the CTI Worker training and Motivational Interviewing training, and three who have only had the chance to view a one-hour CTI training online. The positions for those three will be; CTI Worker, CTI Coordinator and CTI Supervisor. Turnover has slowed their implementation process, but the current staff are very enthusiastic and have been taking advantage of all the opportunities that are available, including; research, use of Basecamp, and participating in meetings. Since TCCAP covers three counties, these six people are spread out over three different offices. The benefit to this is that the staff can cover a larger geographic area; however, it makes working together a little more challenging. TCCAP has begun outreach by visiting partner agencies to set the stage for referrals. A letter, memorandum of understanding and brochure are also under development to get the word out. TCCAP plans to develop a referral form, intake form, and assessment form and create a universally accepted consent form. The creation of these forms will be with assistance from the CTI toolkit which was drafted by the IDN team at NCHC, to contain the documents necessary to implement the Critical Time Intervention model, including protocols for patient assessment, treatment, management, and referrals. Some pre-CTI work has been done at one of the agency's shelter since the transition they are addressing is homeless or at risk of homelessness to the community. The goal is to ensure that homeless individuals transitioning into permanent housing have all the supports they need in place to maintain that housing. The CTI team from TCCAP will meet with the Region 7 IDN team in July to discuss tracking and reporting outcomes, and the possible use of the region's shared care planning software.

Northern Human Services (NHS) has continued to express interest in developing a CTI team or partnering with other agencies to deliver CTI. They are still exploring possibilities, but they have concerns regarding workload and overlap with current services. The one employee who was trained as a CTI Supervisor and happens to be the Mental Health Liaison for the North Country, will be leaving the agency. NHS plans to have another employee identified to fill this role. Over the last few months NHS has expressed two major concerns about implementing CTI. The agency has concerns that the program seems to duplicate what their case managers already provide for services, and concerns related to loss of revenue due to staff participation in meetings and trainings related to CTI, instead of providing billable services. Along with these concerns additional administrative and documentation demands related to fidelity pose a barrier because the agency already has substantial documentation requirements. There will be future discussions with NHS to determine funding opportunities and CTI implementation.

The Family Resource Center (FRC) at Gorham became a new partner during this period and has six employees trained in CTI. FRC has been actively exploring the connections with CTI and current services. The Family Resource Center has been awarded a 12-month grant known as, Strength to Succeed, which will focus on parents and children involved with the Division of Children, Youth, and Families (DCYF) who have a Substance Use Disorder. FRC envisions piloting a CTI team as this grant is implemented to focus on the transition of client enrollment into SUD treatment with a goal to connect clients with treatment. The agency will work closely with the Region 7 IDN team to ensure the project follows CTI fidelity.

North County Healthcare has submitted a proposal addressing regional care coordination and has stated that care coordinators from Littleton Regional Healthcare and Weeks Medical Center will be responsible for establishing a CTI program to effectively transition patients from one setting to another. This CTI program will be responsible for providing support for the vulnerable patient population (i.e., mental health illnesses, substance use disorders, elderly, and the homeless), improving continuity of care, fostering positive patient outcomes; and promoting cost effectiveness methods of treatment. Weeks Medical Center currently has one employee trained in CTI.

White Mountain Community Health Services has one person trained as a CTI Worker and is still exploring how to get a CTI team implemented or connect with CTI teams in the region to make referrals. Memorial Hospital has also expressed interest in a CTI component.

Mount Washington Valley Supports Recovery has expressed interest in the CTI model, and White Horse Addiction center already has 2 staff trained in the model. Both agencies are working collaboratively with the other peer recovery agencies in the region, and upcoming conversations related to a regional peer recovery network will include conversations about potential utilization of the CTI model.

The region's CTI toolkit has been updated and will continue to be shared with agencies implementing the CTI program. The toolkit contains documentation forms provided by the Center for the Advancement of CTI (CACTI), guidelines for the project, and sample tools that can be adapted by individual agencies, including a referral form, abbreviated assessment, crisis prevention and intervention plan and job descriptions. The toolkit will be revised as feedback is received from the CTI workers.

C-2. IDN Community Project: Evaluation Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. 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 12/31/2018	0	12	
# of partner organizations implementing CTI	3 by 12/31/2018	2	2	
# of CTI workers positioned in Region 7 IDN	15 by 12/31/2018	11	24	

C-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing 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 12/31/2018	0	11	24	
CTI Field Work Coordinator/clinical supervisor	3 by 12/31/2018	0	3	3	

C-4. IDN Community Project: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2020	01/01/2019-12/31/19	01/01/2020-12/31/2020	01/01/2021-12/31/2021
	Care Transition Actual Funds Spent	Care Transition Actual Expense (6 months)	Care Transition Budget Projection	Care Transition Projection	Care Transition Projection	Care Transition Projection
Care Transition	**CY 2017 Actuals**	**CY 2018 January to June Actual**	**CY 2018 July to December Projected**	**CY 2019 Projected**	**CY 2020 Projected**	**CY 2021 Projected**
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$968	$71	$1,074	$2,147	$2,147	$1,074
6. Travel		$368	$0	$0	$0	$0
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$443	$421	$842	$842	$421
10. Marketing/Communications	$1,086	$572	$506	$1,012	$1,012	$506
11. Staff Education and Training		$522	$0	$0	$0	$0
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$930	$1,989	$3,979	$3,979	$1,989
Support Payments to Partners	$65,766	$59,987	$83,037	$166,074	$166,074	$83,037
TOTAL	**$91,231**	**$75,802**	**$99,784**	**$199,569**	**$199,569**	**$99,784**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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 in this reporting period using the format below.

Organization/Provider	Agreement Executed (Y/N)
Tri- County Community Action Program	y
Carroll County Department of Corrections	y
Northern Human Services	N
Memorial Hospital	N
White Mountain Community Health Center	N
North Country Healthcare	N
The Family Resource Center at Gorham	N
White Horse Addiction Center	N
Mount Washington Valley Supports Recovery	N
North Country Health Consortium	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	Is complete
Sequential Intercept Model	Illustrated flow chart of points of interception with potential clients	Is complete
Referral/Consent Form	Protocol for referring clients to the CTI program and obtaining client consent	Is complete
Phase Plan	Outlines Client goals, is created with client input	Is complete
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	Is complete
CTI Closing Note	Summary of interventions, impact on client, closing status, next steps and recommendations.	Complete

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 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.

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 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	B1

	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.	
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	B1, C1, D3, E5

	program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	
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	B1

	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 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	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 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	E5

	training will provide instruction 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

Project Scoring: IDN Community Project Process Milestones

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

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

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

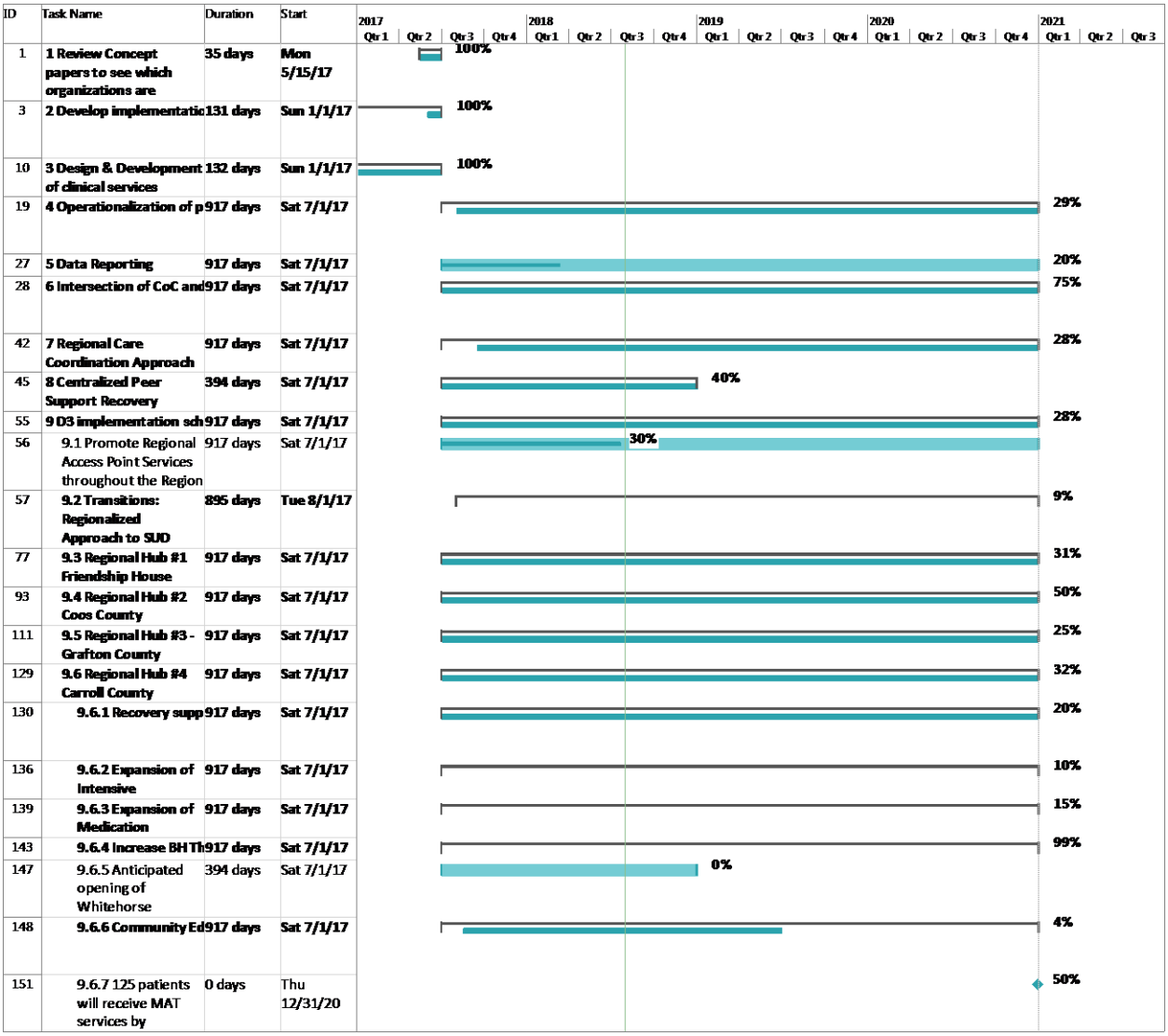
Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Provide an update to the 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 update to the 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.

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables D-2 through D-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.



Attachment_D3_1

During the reporting period of 1/01/2018 -6/30/2018 Region 7 IDN had 1 new member agency, The Family Resource Center at Gorham, join the network, and no members leave.

The information below speaks to the progress that Region 7 IDN has made on their D3 project, Expansion in Intensive Substance Use Disorder (SUD) Treatment Options during the period of January 1- June 30, 2018. IDN Partners involved with this project collaborated with each other to address comprehensive peer recovery services, SUD treatment, and enhanced treatment for Co-Occurring disorders.

Since NCHC assumed operations of Friendship House in October 2017, staff have worked to incorporate Friendship House (FH), outpatient services, peer recovery support services and the impaired driver care management program into NCHC's Clinical Services Program. The key component of this transition included building a new state of the art 18,500 square foot, highly energy-efficient facility, specifically designed to control operating costs with the intent on sustainability. The 32-bed facility will be made up of 14 rooms that could double in capacity with the addition of bunk beds and 4 single occupancy rooms with integral bathrooms to serve as detox units. The facility will meet all facilities licensing requirements and CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation requirements, allowing

for future expansion to serve additional populations and be reimbursed at rates approved through private commercial health coverage which is necessary to support–program sustainability. The new facility is currently in the final building phase, with an anticipated opening date of July 2018. When patients and staff are transitioned to the new facility, work will begin on tearing down the old building to make a new parking lot for Friendship House. AHEAD (Affordable Housing Education and Development) has maintained ownership and still plans to lease the facility to North Country Health Consortium.

Friendship House, the region's only residential treatment facility, continues to enhance its capabilities to treat addiction as a chronic disease with a medical model. This medical model includes opening a 4-bed medical detoxification unit at Friendship House within the next year, with a target date of Fall 2019. The detox wing will provide 24-hr nursing coverage, and a medical provider will see patients daily while they are in the detox unit. While work is being done to finalize this component at Friendship House, the agency is exploring their ability to provide ambulatory detox services delivered by a psychiatric nurse practitioner who has obtained a waiver from the Drug Enforcement Agency to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. This service is known as Medical Withdrawal Medication Management and will help SUD patients to withdraw from substance use in a managed approach until additional detox services are readily available in the North Country. The agency anticipates having a nurse practitioner waivered to provide MAT services over the next few months once they complete the MAT training.

The exploration of Partial Hospitalization at Friendship House has been discussed over the past 6 months. This model is similar to Intensive Outpatient Programs (IOP); however, it entails 4 hours 5 days a week to total 20 hours of treatment a week. This model also involves a psychiatric component to assist the agency's ability to provide co-occurring disorders treatment in the future. Currently, Friendship House can accept patients with co-occurring disorders yet can only treat the SUD aspect of their illness. Building capacity within the agency will help to alleviate this gap in service as Friendship House works towards offering a full array of services based on patient need. The last 6 months have been dedicated to researching improved criteria to treat patients with co-occurring disorders and integrating the new curriculum into treatment.

NCHC Clinical Services include IOP. This model is a 12-week program, designed to be 3-hour group sessions on 3 days per week, for a total of 9 hours per week, with an additional one-on-one counseling session once a week. NCHC's Clinical Services offer one-on-one counseling after completion of IOP and have successfully transferred clients to 3.5 level of care in cases of relapse, based on ASAM criteria. During the reporting period of January-June 2018, NCHC's Clinical Services were capped at 10 patients per program, but due to increased demand this cap has been removed. Currently, this program averages 8-10 clients at any given time. During this 6-month program NCHC's Clinical Services IOP served 23 patients. The IOP is anticipated to expand to Grafton County and increase its numbers as Friendship House works closely with the Grafton County Drug Court. NCHC will be taking over the Grafton County Drug Court contract with the state in mid-August. NCHC staff have been working to make contacts with referral agencies to expand IOP services.

In addition to Friendship House and IOP, NCHC's Clinical Services include the Impaired Driver Care Management Program (IDCMP) and other outpatient services such as individual counseling, group counseling, and family therapy. There are outpatient satellite sites in North Conway, Tamworth, Berlin, and Woodsville.

During the past 6 months, Friendship House has had limited capacity to offer peer recovery services, but they have focused on strengthening relationships with the region's recovery centers. They have begun working closely with North Country Serenity Center (NCSC) to share and refer patients while in treatment and during transition. NCSC has presented at multiple community meetings held at Friendship House to expose clients to their services and help enroll clients into NCSC's recovery support services before

transition. Friendship House staff are in conversations with staff from North Country Recovery Center at Weeks Medical Center regarding the need for clinical supervision for NCSC's Certified Recovery Support Workers.

Friendship House currently has 3 CRSWs with multiple staff working toward this status. The agency also has 2 Master Licensed Alcohol and Drug Counselors (MLADC), 1 Master Level LADC submitting for licensure, 1 master level LADC working towards MLADC, 1 associate level LADC, and 2 bachelors level staff working towards LADC. Friendship House envisions providing mobile LADC services to the IDN region once capacity is built. Current recovery support staff personnel at Friendship House are all working toward becoming Certified Recovery Support Workers.

Friendship House has seen the residential service reimbursement rate as a huge barrier during the reporting period. The rate does not match the expense of the services which results in agency funds being used from elsewhere to cover salaries. This is the same barrier that exists to standing up the 4-bed detox unit as the detox reimbursement rates do not come close to covering medical salary. As the state moves towards valued-based reimbursement, this barrier may have less of an impact on the agency.

Ammonoosuc Community Health Services (ACHS) has expanded its primary medical care, behavioral health, and substance abuse capability to Northern Grafton County and Southern Coos County by engaging in several activities throughout the region. ACHS works closely with Friendship House and is currently providing medical support to Friendship House for intake physicals, prescribing comfort medications for patients as necessary, prescribing for clients with dual diagnoses, and addressing screening and treatment needs for those with a chronic disease. The ACHS Behavioral Health Substance Use Disorder Case Manager is also working with Friendship House to arrange after care for clients upon discharge as needed.

ACHS has worked to expand mental health clinician support to provide substance use preventive and counseling services at Lafayette Regional School, Bethlehem Elementary School, Profile High School, Lisbon Elementary School, Littleton School district, and Blue Mountain Union School in Landaff. In addition to area schools, ACHS works closely with the Grafton County Department of Corrections to provide primary medical care and behavioral health services for the Grafton County Diversion Program and the Focused Intentional Re-Entry and Recovery Program (FIRRM). ACHS anticipates expansion of these services to include work with the Coos County Diversion Program soon.

ACHS's Woodsville MAT program is active and operating and has 2 prescribers who have become waivered to deliver MAT services. The Woodsville MAT program is serving as a pilot project for ACHS and has served 2 patients in the reporting period. Information learned during this pilot project will be used to help ACHS staff create internal policies and procedures as the ACHS MAT program expands to the Littleton location. Littleton MAT providers just finished training and are awaiting waivers. The intent is to start providing MAT services in Littleton location after 8/1/18. At that time ACHS will move forward with training additional staff for MAT support. ACHS staff have formalized a work flow to notify ACHS behavioral health staff when clients are seen in an Emergency Department (ED) for behavioral health or substance use reasons. Since the workflow was instituted on February 8, 2018 the feedback loop has identified 52 ACHS patients (3.5% of those seen) with a BH/SUD diagnosis from all area EDs. The patients' charts were flagged, PCPs and BH staff were notified and appropriate follow ups were conducted on 100% of these patients. This feedback loop has been a great improvement of their response time to patient's being seen at EDs and appropriate staff notification. ACHS will continue collecting data on this workflow to better understand these transitions and provide service for this community need.

ACHS and North County Serenity Center are working together to provide seamless peer recovery support and wrap-around medical, dental, and behavioral health services for SUD patients in the area. ACHS also works with patients at White Mountains Recovery Homes to provide similar services. ACHS has established relationships and is seeking to formalize procedures for enrolling patients into Weeks Medical

Center's and Little River Health Care's Medically-Assisted Treatment (MAT) programs while continuing to offer its own 6-week MAT program.

Coos County Family Health Services (CCFHS) has six providers with waivers to deliver MAT services. The focus of the MAT program to this point has been pregnant women and new mothers and their partners. Moving forward, CCFHS plans to expand services to include additional patients within the practice. During the reporting period of January 1, 2018- June 30, 2018, CCFHS staff provided MAT services to 8 patients. CCFHS also contracts with the Family Resource Center in Gorham to provide childcare for the parents enrolled in the MAT program.

Northern Human Services (NHS) is working with the Drug Court program in Coos and Carroll Counties. As the population of clients accepted to Drug Court increases, NHS hopes to initiate an IOP program in 2019, but the timeline is dependent on interest and referrals. NHS will explore the potential of offering a joint IOP program serving the needs of both Drug Court programs by using a HIPAA compliant Zoom program. There will be an MLADC at one site and a LADC or LADC-in-training at the other to help facilitate the IOP. NHS does not currently offer MAT services, but the agency is exploring the option of offering these services based on the need of dually-diagnosed patients the agency serves.

White Horse Addiction Center (WHAC) has expanded services to North Conway this reporting period. The agency purchased 2 office suites in North Conway to house the SUD Treatment and Recovery Resource Center. The SUD Treatment Center opened on June 18, 2018 to deliver outpatient treatment services including IOP, individual counseling, LADC evaluation, and DUI aftercare. The Recovery Resource Center is slated to open on July 1, 2018 and staff will provide 1-on-1 peer recovery meetings, transportation assistance, and volunteer opportunities. Additional services to be added will include life skills groups, AA and NA meetings, recovery support groups, parenting classes and more.

During the reporting period of January – June 2018, two staff members at White Horse Addiction Center became CRSWs and are currently providing case management as well as recovery support. two staff members at White Horse Addiction Center became CRSWs and are currently providing case management as well as recovery support. Since January 2018, WHAC has assisted clients with transportation needs and recovery support services and helped over 33 clients apply for and obtain Medicaid services. The agency has referred 15 clients to residential SUD treatment. From 11/13/17 to 5/25/18, WHAC had 89 new intakes, and 67 of these are still in treatment. During the January – June 2018 reporting period, the agency reported 43 clients who participated in one of the agencies 2 IOPs, one Christian program and one secular program. They reported 24 individuals receiving active peer recovery services, and up to 50 clients a week engaging in some level of peer recovery coaching, although these clients haven't been formally tracked. White Horse Addiction Center has a new tracking system which will be used moving forward to officially register clients when they come in for services. This system is also used by other recovery agencies in the region.

Three staff from White Horse Addiction Center were trained in Motivational Interviewing, and one staff member attended the Harvard Treatment of Addiction Conference. The agency purchased new DSM-V and ASAM criteria books for staff to utilize.

White Mountain Community Health Center (WMCHC) has made continued progress with their MAT program and had 2 APRNs receive their psychiatric nurse practitioner certification during this reporting period. These 2 APRNs have begun sharing their time between WMCHC and Northern Human Services, working part-time for both agencies. WMCHC also has one APRN with a waiver to prescribe for MAT services who can have a caseload of 30 patients. During the reporting period of January-June 2018, WMCHC served 36 patients with MAT services.

Saco River Medical Group currently has one provider integrating MAT services into primary care and anticipates a second provider starting in September 2018. The current MAT provider has 60 active MAT

patients and is capping enrollment there for now. Their MAT services were delivers to 78 individuals during this reporting period. The new family medicine physician starting in September is expected to see 60-80 MAT patients.

Memorial Hospital has a formal behavioral health division within primary care and has a PMHNP-BC to serve as the Director of Behavioral Health. The hospital currently has 3 APRNs in Primary Care delivering MAT services and 3 Nurse Midwives in Women's Health providing MAT services through the agency's New Life Program. Memorial Hospital served 64 patients with MAT services within their primary care practices during this reporting period and an additional 16 women enrolled in the New Life Program. The New Life Program focuses on prenatal women presenting with opioid use disorder.

Weeks Medical Center has doubled its capacity to treat behavioral health and substance use disorders and has an integrated physical and behavioral health facility. In 2017, Weeks opened the North Country Recovery Center (NCRC), a medication-assisted treatment program for opioid use. During the reporting period of January 1, 2018-June 30, 2018, Weeks expanded MAT services to Littleton Regional Healthcare and Ammonoosuc Community Health Services patient populations and plans to expand MAT services to Upper Connecticut Valley Hospital (UCVH) and Indian Stream Health Center (ISHC) patient population during the next reporting period. To meet the workforce needs of this expansion in MAT services, Weeks Medical Center hired 3 employees during this reporting period; a behavioral health case manager to replace the current behavioral health case manager who accepted a position as behavioral health team leader, a care coordination assistant who works with the behavioral health and physical health providers and care teams, and a LCMHC to provide counseling services. Weeks Medical Center has 2 prescribers with waivers to deliver MAT services and is in the process of obtaining a waiver for their PMHNP. The North Country Recovery Center had 22 active participants in their MAT program on January 1, 2018. As of the end of June 2018, there were 52 enrollments in the program; 13 participants dropped out of the program, two of which re-enrolled. One participant successfully completed the program within the first year.

NCRC has worked to ensure a streamlined referral process is in place as they work to expand services. The referral process is for primary care providers to create a referral to one of Weeks' three behavioral health specialists (Psychiatric NP, M-LADC, and LCMHC) who will screen for enrollment in the North Country Recovery Center (NCRC) program. The behavioral health counselor determines if a patient is a good candidate for the MAT program and specifies the treatment plan (Vivitrol or Suboxone). The counselor refers the patient to NCRC for treatment and notifies the patient's primary care provider that the patient is accepted into the program. Treatment plans for opioid use disorders are patient-specific and created with input from the patient, the prescriber, and other members of the health care team. Medication treatment and psychosocial therapy is detailed in a patient's medical record based upon best practices and established procedures. Records are faxed to the patient's primary care provider for inclusion in the patient's health record. Interdisciplinary team meetings are held to include topics of discussion around patient progress, outcomes; and may include reviewing reports, best practices, general successes, improvement plans and any other areas of focus.

Patients who are referred to the North Country Recovery Center will have access to behavioral health specialists for counseling services and behavioral health case management/care coordinators to identify social determinants and assist them in obtaining support services. Weeks' Behavioral Health Case Manager provides a much-needed service for their North Country Recovery Center MAT program and is an integral member of the MAT Interdisciplinary Team.

Huggins Hospital currently has one buprenorphine-waivered prescriber but does not offer MAT services to patients. However, the agency has received IDN funding to launch a MAT education and implementation program in July 2018 and expects to begin offering services in early 2019.

Mount Washington Valley Supports Recovery (MWVSR) has been very active and engaged during the January-June 2018 reporting period, and the agency logged 300 calls to the center, 72 walk-ins, 6 town inquires for housing or recovery services, and 19 town/administrative/program inquiries. The agency also logged 13 mental health referrals, 10 navigator referrals to White Mountain Community Health Center, 12 referrals to MAT programs, and 4 IOP referrals. MWVSR connected 18 clients to recovery coaches during the reporting period and held 24 recovery meetings with 4-6 participants in attendance each week. MWV Supports Recovery provided funds for 2 coaches to attend a CCAR ER Crisis Intervention training, a candidate to attend a Recovery Coach Academy at the Whitehorse Addiction Center training in Spring 2018, and a CRSW candidate to be trained in ethics and HIV/AIDS. MWVSR co-sponsored 2 Narcan distributions with Carroll County Coalition for Public Health; one during the county drug take back day and one at Endeavor House. A total of 19 kits were dispensed into the community. MWVSR recently hired their own MLDAC for one hour per week to do peer supervision to help their recovery coach academy graduates obtain hours as they work to become CRSWs.

MWVSR sponsored a quarterly provider meeting to discuss best practices for people on Medication-Assisted Treatment, including the importance of patient accountability to therapy, the need for peer supports, 12 step programs, and MLDAC services as patients work to remain in recovery. Twelve people attended the meeting; 4 MAT providers, 1 Alcohol Anonymous representative, 1 Narcotics Anonymous representative, 2 MLADCS, 2 offices nurses, and 2 peer recovery support workers.

North Country Serenity Center envisions building out infrastructure for a centralized recovery center, imagining a central hub in Littleton with a 24/7 telephone recovery support system for the region to access and use. The agency has seen an increase in their daily census with more people coming in to access peer recovery support services, and they have served 67 people to date, 38 of which were new clients this reporting period. For this reporting period NCSC reports 198 recovery coach services, and 177 telephone recovery services.

The agency continues to add programming, including a family support group, and collaborates with community partners for recovery related events, educational forums and sober activities. Examples of these activities include forums with the Governor's Advisor on Addiction and Mental Health.

NCSC has a MOU with Grafton County Drug Treatment Program to provide weekly Life Skills classes to program participants. These classes have been in place since January and reoccur every Monday. In addition, NCSC coaches meet with clients of the Alternative Sentencing Adult Diversion Program. NCSC has also had conversations with a local domestic violence shelter and a homeless outreach shelter to discuss bringing recovery-focused meetings to their agencies.

NCSC has completed their Medicaid site review and is awaiting response as to their Medicaid provider status. The agency is staffed by one full-time Executive Director who is a CRSW and three part-time staff working toward CRSW certification; including an Operations and Administration Coordinator to provide oversight to the business and financial operations of the center, a part-time Peer Lead/Telephone Recovery Support Coordinator, and a part-time Outreach and Events Coordinator. In addition to this staff, the agency currently has 7 active volunteers.

The region had 3 Peer Recovery Coach Academies during the reporting period; one sponsored by MWVSR in June that trained 11 people, one sponsored by Whitehorse Addition Center in March that trained 17 people, and one held at Northwoods Training Center at Weeks Medical Center from NADACA in March 2018 which trained 8 participants. North Country Health Consortium has partnered with NH Recovery Coach Academy to provide Region 7 with a comprehensive training plan designed to support workforce capacity training needs as the region creates a sustainable infrastructure for a peer recovery support network. The sustainability of this model relies on increasing the number of CRSWs in the region, so peer recovery services can be a billable Medicaid service. The 2018/2019 training plan to expand peer recovery services is shown below:

Training	Dates
Ethics	July 25-27, 2018
HIV/AIDS	August 9, 2018
Suicide Prevention	August 23, 2018
Peer Recovery Coach Academy	September 13-14 & 27-28, 2018
Train the trainer for Peer Recovery Coach Academy	October 11-12, 2018
Ethics & Train the Trainer	November 5-7, 2018
Suicide Prevention	November 29, 2018
HIV/AIDS	December 14, 2018
Peer Recovery Coach Academy	April 2019
Peer Recovery Coach Academy	September 2019
Suicide Prevention	October 17, 2019
Ethics	November 2019
HIV/AIDS	December 5, 2019

Region 7 IDN staff have started collaborative conversations with North Country Serenity Center, Hope for NH Recovery, Mount Washington Supports Recovery, and Whitehorse Addiction Center to create a regional peer recovery network which will follow an integrated approach to deliver services in the region. Three of the regions four recovery centers joined a call during this reporting period to start this conversation, and the next meeting has been scheduled for August 2018. The regional system is intended to strengthen pathways of communication between the centers, connect patients to peer recovery services in a timely and efficient matter, and help demonstrate progress as outlined in the IDN implementation plan. Friendship house, being the only residential treatment facility within Region 7 IDN, will be an important part of these conversations to ensure recovery coaches are available to work with clients when they transition back to the community. Region 7 IDN staff will invite the region's 2 Continuum of Care Facilitators to participate in these conversations as they evolve.

The Family Resource Center (FRC) at Gorham, the new partner of this period, has also begun to increase capacity to deliver peer recovery support services (PRSS) to the region. The partner is using a Targeted Prevention Program for DCYF-Involved Families, as mentioned in C1, known as Strength to Succeed. FRC has been tasked to provide services to DCYF-involved children (aged 0-10) and their parents/caregivers who have a substance use disorder for the two District Offices of Littleton and Berlin. This program will impact the IDN counties of Northern Grafton and Coos by bringing PRSS to the population. A major aspect of the grant that will positively impact the relationship they have with Region 7 IDN is increasing training opportunities for the early childhood and home visiting workforce in substance misuse prevention, recovery, and trauma-informed care. In response to these tasks, FRC has been actively coordinating and seeking training opportunities for their staff to become CRSWs. This plan has begun to align with Region 7's Peer Recovery Coach Academy training schedule, allowing multiple FRC staff to obtain the hours they

need for certification through the IDN. The Family Resource Center is sponsoring their own Peer Recovery Coach Academy training in August 2018 to help build workforce capacity for both the Strength to Succeed project and Region 7 IDN. The agency currently has 7 staff trained as peer recovery coaches and will work to train additional staff and support them as they work to become certified recovery support workers. Ultimately, the agency plans to have 20 workers trained as CRSWs by June 2019.

Region 7 IDN had numerous community education programs during the reporting period of January-June 2018, some of which were also mentioned in the section of the report addressing the region's response to the opioid crisis:

- **"A Conversation on Addiction & Recovery with Brandon Novak":** 2/8/18 in Woodsville, May 22nd in Groveton, and May 23rd in Lancaster.
- **Straight Talk: Be Prepared: Eastern Lakes Coalition, April 2018**
- **Drug Recognition Trainings:** March 19th & May 14th
- **Legislative Breakfast:** May 7th at North Country Health Consortium. Six members of the Substance Misuse Program and the NCHC CEO each gave a presentation on the work they do to address the opioid epidemic. Approximately 30 legislators, press, school administrators and business leaders were in attendance.

A consistent barrier in delivering effective Substance Use Disorder treatment has been the stigma that surrounds it. During the last reporting period, the region has seen patients with SUD coming to ERs in situations where staff are feeling very uncomfortable understanding how to be culturally sensitive without stigmatizing patients with SUD related concerns. Patients present with a physical need but often the SUD goes unaddressed. Region 7 would like health professionals and healthcare organizations to better understand how language matters and address the SUD as a medical issue rather than a choice. The region has also seen Emergency Medical Services, First Responders and law enforcement have a difficult time in the field, as they are using Narcan, sometimes repeatedly on the same patients, without understanding the addiction which sometimes leads to judgment of the person. In hopes to bring more education to the region and help these professionals be more empathetic, Region 7 has been researching and discussing training options to raise awareness of SUD, decrease stigma, and provide professionals with the correct language and behavior needed for interacting with SUD patients. NCHC staff has been discussing these options with other IDNs in the state and has connected with potential trainers that may be able to adapt currently offered stigma and language trainings to the needs of our Region. IDN staff will also continue to explore training options related to SBIRT implementation, Clinical Supervision, and Compassion Fatigue.

North Country Health Consortium has received a federal grant from HRSA, Federal Office of Rural Health Policy, to implement a warm hand-off model in North Country emergency departments for individuals presenting with an opioid overdose or at-risk for overdose. The project also will focus on increasing access to various levels of treatment, education for the community about opioid use disorders, enhance the role of Community Health Workers and Recovery Support Workers, and collaborate with local law enforcement to explore innovative opportunities to address alternatives to incarceration. This project will enhance the work of the IDN while providing additional resources focused on opioid prevention, treatment, and recovery support services.

IDN staff continue to partner with the IDN Clinical Workgroup and SUD recovery/treatment partners to evaluate and enhance the D3 toolkit. This could be a potential platform to embed stigma awareness language, as well as contain ongoing updated treatment protocols, referral protocols, team roles and responsibilities, and a monitoring plan. IDN partners have used this reporting period to provide feedback on the toolkit and utilize some tools within it. This toolkit will be continuously evaluated and updated for the remainder of the demonstration.

D-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list of all of the progress toward targets or goals, that the program has achieved. 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 12/31/2018	1	2	
# of individuals to be served with new MAT services in Region 7	35 by 12/31/2018	0	10	
# of new sites offering intensive outpatient (IOP) services	1 by 12/31/2018	0	0	
# of individuals to be served with IOP services	144 by 12/31/2018	25	66	
# of existing IOP providers expanding services	3 by 12/31/2018	0	0	
# trained Peer Recovery Coaches	6 by 12/31/2018	22	59	
# of individuals served by Peer Recovery Coaches	50 by 12/31/2018	0	109	

D-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing 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	13	13	
Psychiatric Nurse Practitioners	3	1	2	5	
Peer Recovery Coaches	6	2	22	59	
MLADC	3	0	0	3	
Case Management	2	2	4	6	

D-4. IDN Community Project: Budget

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

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/19	01/01/2020-12/31/2020	01/01/2021-6/30/2021
	Expansion in SUD Actual Funds Spent	Expansion in SUD Actual Expense (6 months)	Expansion in SUD Budget Projection	Expansion in SUD Projection	Expansion in SUD Projection	Expansion in SUD Projection
SUD	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to December Projected	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
			(6 months)	(12 Months)	(12 Months)	(6 Months)
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$968	$71	$1,074	$2,147	$2,147	$1,074
6. Travel		$368	$0	$0	$0	$0
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$443	$421	$842	$842	$421
10. Marketing/Communications	$1,086	$572	$506	$1,012	$1,012	$506
11. Staff Education and Training		$522	$0	$0	$0	$0
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$930	$1,989	$3,979	$3,979	$1,989
Support Payments to Partners	$65,766	$59,987	$83,037	$166,074	$166,074	$83,037
TOTAL	**$91,231**	**$75,802**	**$99,784**	**$199,569**	**$199,569**	**$99,784**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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 in this reporting period using the format below.

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

D-6. IDN Community Project: Standard Assessment Tools

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

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.

Standard Assessment Tool Name	Brief Description
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.
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. Toolkit will be deployed by 3/29/18
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 underway. Toolkit to be deployed by **3/29/18**
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 review underway. Toolkit will be deployed by 3/29/18
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 review underway. Toolkit will be deployed by 3/29/18

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
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

Project Team Member	Roles and Responsibilities
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

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	B1

	mental health problems, and become comfortable addressing 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	B1

	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.	
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 Training (SMART) program-	Participants get motivated to address substance use disorders	D3

	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 webinars, core training, SBIRT model and validated screening tools, case	B1, D3, E5

	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 services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and	B1

	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 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	D3

	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 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	B1

	guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	
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

Project Scoring: IDN Community Project Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
D-2	IDN Community Project Evaluation Project Targets	Table				
D-3	IDN Community Project Workforce Staffing	Table				
D-4	IDN Community Project Budget	Narrative and Spreadsheet				
D-5	IDN Community Project Key Organizational and Provider Participants	Table				
D-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
D-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
D-8	Clinical Infrastructure: IDN Community Project	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Roles and Responsibilities					
D-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

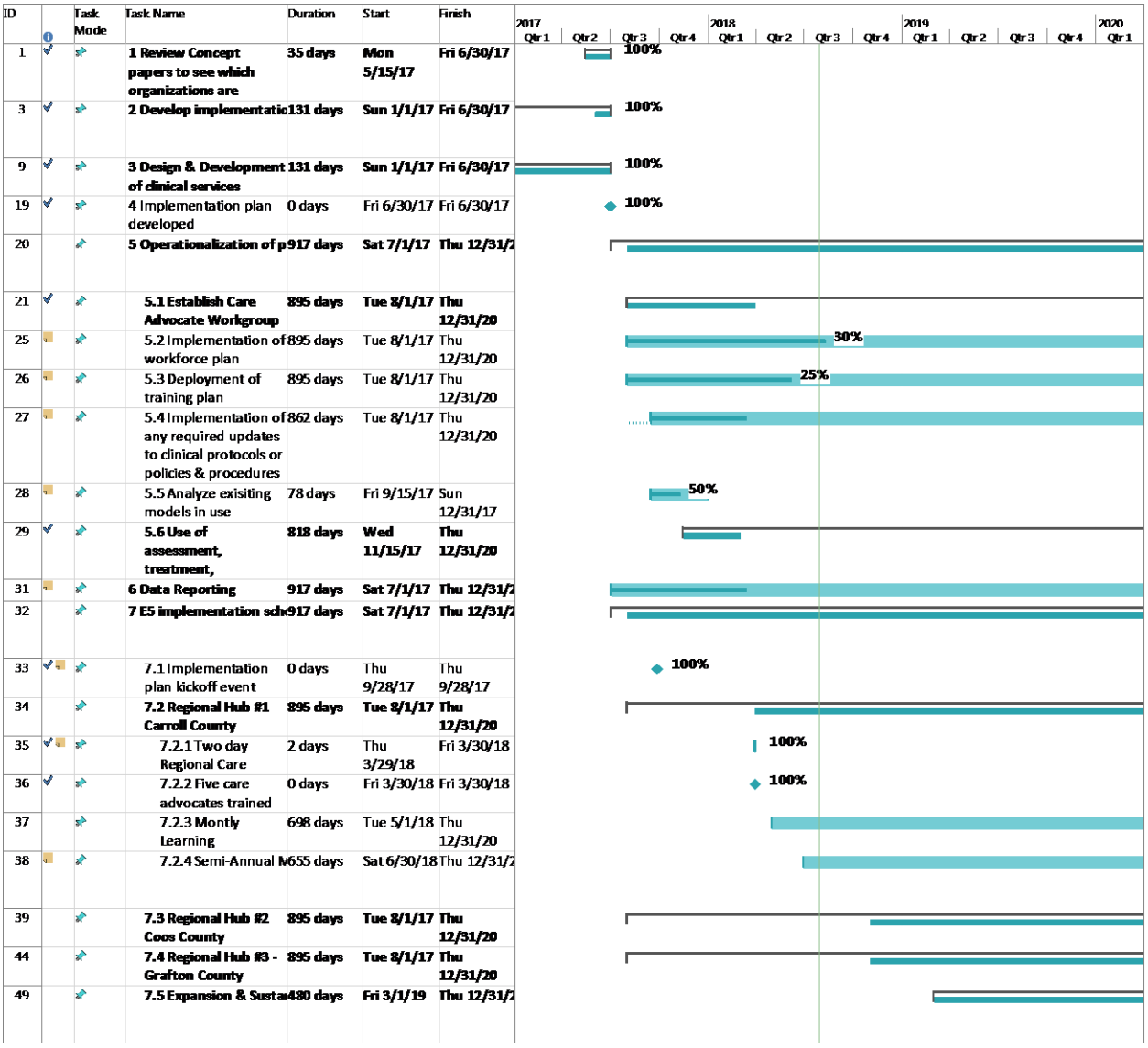
Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Provide an update to the 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 update to the 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.

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables E-2 through E-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.



Attachment_E5_1

During the reporting period of 01/01/2018-06/30/2018, Region 7 IDN had one new agency, Family Resource Center in Gorham, join the IDN network and no members leave.

Region 7 IDN has made significant progress on Project E5, Enhanced Care Coordination for the High Needs Population, during the reporting period of January-June 2018. Region 7 IDN partner agencies had opportunities to attend trainings to improve care coordination services, participate in panel discussions to identify both strengths and weaknesses in current care coordination services across the region, and to utilize resources with the region's Enhanced Care Coordination Toolkit. NCHC was able to leverage existing relationships with White Mountain Community Health Center, Northern Human Services, and Huggins Hospital to serve as a foundation for the regional care coordination work.

To assist IDN partners as they work to enhance care coordination services for the region's high needs population, Region 7 IDN staff coordinated a 2-day Regional Care Coordination training in March of 2018 in Chocorua, NH. The region's implementation plan focused on training 5 Care Advocates in each sub-region. A Care Advocate is a care coordinator who has taken additional trainings through the IDN to strengthen skills needed to work on a regional care coordination approach to enhance care coordination

for the high needs population. Staff from Northern Human Services, Huggins Hospital, White Mountain Community Health Center, Carroll County Department of Corrections, and Saco River Medical Group came together to learn how to improve care coordination services for the high needs population as these patients transition between agencies. The training agenda was developed based on the requirements of care coordination explained in the region's implementation plan and to strengthen care coordination among agencies in the region in contrast to only building internal care coordination services at IDN partner agencies. Following the PDSA model, Region 7 IDN staff created a participant evaluation, with the plan to use the feedback to adjust the other regional care coordination trainings based on participant feedback. The agenda for the training is shown below:

Day 1:

- Who's Driving the Bus to Integrated Healthcare?
- What is the Shared Care Plan and How Can It Help?
- Ethical Communication and Decision-Making in an Integrated Care Environment

Day 2:

- Connecting with Regional & State Resources
- Patient Advocacy & Cultural Humility
- Health Literacy
- Enhanced Care Coordination for High Needs Population
    - Enhanced Care Coordination for High Needs Population Project Overview
    - Review toolkit and how to utilize it
    - Review sample workflows
    - Breakout sessions for workflow development
    - Encourage discussion and collaboration

The training agenda was created to showcase the value of care coordinators in an integrated healthcare model and to provide care coordinators with the opportunity to augment skill sets as they work to enhance care coordination for the high needs population using a regional approach. The region planned to deliver three of these trainings, one within each sub-region, by the end of 2018 to provide an opportunity for participants to have in-depth conversations about care coordination in each sub-region. The first of these 3 trainings were for Carroll County organizations to provide them with 2 days to have in-depth conversations about care coordination in that sub-region. The first day of the training started with an overview of integrated care, including the use of a comprehensive core standardized assessment, multi-disciplinary core team, and a shared care plan, because all these components create a strong foundation to deliver enhanced care coordination. The participants had numerous questions regarding the CCSA domains, but with guidance from the IDN Quality Improvement Coach, concluded that the number and scope of questions for any domain is dependent on the organization conducting the assessment so long as all domains are covered. Participants discussed how to move forward with developing a regional multi-disciplinary core team but expressed concerns on both the logistics and value of using a regional approach. The participants said they were not sure how to get started on developing a multi-disciplinary core team, and to address this challenge, the IDN Quality Improvement Coach suggested a training on the Plan-Do-Study-Act (PDSA) Cycle as a model for improvement.

Region 7 IDN HIT Integration Coach joined staff from Collective Medical Technologies to highlight the value of CMT's shared care plan platform in improving care coordination particularly when patients

receive services from multiple provider agencies. The care coordinators were shown how the platform could be adapted to fit their needs and lead to improved patient care. Participants were reminded that the platform was designed to be a place to document care guidelines and patient goals, which can then be accessed by other agencies caring for the same patient if those other agencies are also using the CMT product. One comment from the evaluations was, "It was nice that the presenters were directly involved in our specific project and could refer to our personal needs and progress".

Care coordination within an integrated healthcare network system can be challenging due to the variety of providers and organizations involved. For an integrated model to be successful it is important to understand the roles of all partners in the integrated care environment and how agencies need to work together to treat a patient. Sharing of information is vital to this process, but IDN partners have expressed concerns that 42CFR Part 2 has created a barrier to information sharing. To address this barrier, Region 7 IDN staff invited Jacqui Abikoff, the Executive Director from Horizons Counseling Center, to deliver a presentation titled *Ethical Communication and Decision-Making in an Integrated Care Environment.* The objectives for the presentation included: identifying the different roles of providers on an integrated care team and the differences in the type and scope of information required to be shared consistent with each role, understanding the parameters of HIPAA and Part 2 and the roles they play in the sharing of protected healthcare information, and understanding how to balance the provider's need to know with the patient's rights to privacy and self-determination. Participants found this session to be helpful and gained a better understanding of substance use and consent but requested more training as it is a complicated topic.

Part of a Care Advocate's role is to connect clients with social service providers in the community to address the unmet needs of the patient and to know how to access services that may be valuable for the high needs population. To make it easier for the care advocates to be aware of services that are offered in the region, a panel of regional and state resources from social service and homecare agencies were invited to speak about their agencies, share brochures, and provide contact information to the attendees. The training participants found it very valuable to have time after the formal presentation to interact one-on-one to discuss individual situations and ask questions.

Additional training topics as they relate to enhanced care coordination were patient advocacy, cultural humility and health literacy. Although care coordinators are already familiar with these topics, studies have shown that there is great room for improvement from the clients' perspective. The coordinators also agreed that it is important to step back and reflect on how well individuals and agencies are performing in these areas. A few shared that they had learned about cultural competency in the past but felt a little overwhelmed by the pressure of needing to know so much information. Participants commented that Cultural Humility was helpful as they think about how to best relate to patients.

The training ended with a breakout session to provide the participants with an opportunity to apply what they learned during the training. The Region 7 IDN Quality Improvement Coach reviewed the DSRIP requirements to meet the deliverables associated with the E5 project and shared samples from the region's E5 toolkit that might help make their work more efficient. The participants discussed risk-stratification to identify high risk patients and spent time collaborating on care coordination workflows. At the end of the training, participants were tasked with choosing 1 or 2 patients to serve as pilots as the agencies work to implement shared care plans and multi-disciplinary teams. The region now has 5 trained Care Advocates: 1 from Northern Human Services, 3 from Huggins, and 1 from White Mountain Community Health Center. Carroll County Department of Corrections and Saco Medical Group each sent

a care coordinator position for 1 day, but those individuals are not considered Care Advocates since they did not complete both days of trainings.

The E5 toolkit has been continuously updated through this reporting period and shared with partners for feedback and to allow them to adapt the sample workflows, forms, and best practices into their current work. The toolkit has received significant positive feedback and partners have expressed how helpful it has been in implementing new protocols and procedures in their care coordination departments. The toolkit will continue to be edited as necessary as we see it as a working document to follow the changes in best practices, consent regulations, and standard assessments.

The Coos County Care Coordination training that was originally planned for June of 2018 was postponed and will be combined with Northern Grafton County later this fall to give partner agencies more time to be ready to engage in the process. It is important for partners to see the value in the components of the project, such as the shared care plan, before moving forward with the training. Strategically, this makes sense because many of the care coordinators work for agencies which are part of North Country Healthcare and are already working together to coordinate services. Offering 2 separate trainings for these care coordinators would not be using resources efficiently or meet their needs. The overall region has seen progress since March 2018, with many agencies engaging in conversations with Collective Medical Technologies, trying to get a CCSA in place, and standing up multi-disciplinary core teams. Delaying the regional care coordinator training and combining both sub-regions into one training should prove to be beneficial to the participants because they will have had additional time to get systems in place and come to the training with a better sense of the work related to this project.

The Region 7 IDN team is working to coordinate another regional care coordinator training for late fall of 2018 and anticipates that some of the current progress that is happening will lay the foundation for a great training as partners come together. Based on lessons learned from the first training, Region 7 IDN staff will build in more time throughout the 2 days for participants to work on issues related to improving the coordination of care for high needs patients. In addition, the social service provider panel was a little smaller than expected, so staff will reconnect with presenters just prior to the training to remind them about the event. Topics offered will be similar with the possibility of combining and shortening a few to make more time for collaboration and possibly shorten the training. Turning the Health Literacy presentation into a webinar for consumption by Care Coordinators at a more convenient time is also being explored since feedback from some was that it is difficult to be away from work for 2 days in a row. In preparation for the next training, Region 7 IDN staff attended a meeting in April 2018 for regional resource sharing in Berlin to make connections and get contact information for possible presenters at the next Regional Care Coordination training.

The region's Care Advocate Workgroup met several times in early 2018 to discuss how to create a care coordinator panel that would bring the most value to the region. Once a framework was developed, Region 7 IDN staff reached out to partner agencies to see who had staff that would be willing to participate on a care coordinator panel at the March 2018 quarterly meeting. However, due to a snowstorm, the March 2018 meeting was cancelled, so the region used the June 2018 Annual conference to highlight care coordination and included the care coordinator panel as part of the agenda. One of the challenges for care coordinators who are trying to connect clients with community services is the difficulty of staying up-to-date with resources and contact information, so Region 7 IDN staff invited representatives from Granite United Way's 2-1-1 program and the Regional Access Point Services (RAPS) to present to the region about these programs. The presentation about the 2-1-1 program focused on utilizing 2-1-1 to connect to available resources. The presentation about the RAPS focused on their use of the NH Treatment Locator

& the Statewide Addiction Crisis Line to take calls from people struggling with substance use disorder (SUD) issues and family members who are struggling to help a loved one with SUD and connecting these people to the SUD treatment services that they need. In addition to these presentations, the IDN Quality Improvement Coach and the HIT Integration Coach facilitated a panel of care coordinators from Ammonoosuc Community Health Services, Littleton Regional Healthcare, Memorial Hospital, Northern Human Services and North Country Health Consortium who came together to discuss how to improve care coordination for high needs clients. The format of hearing directly from the people who work to coordinate care provided a chance for multiple agencies, including those in the audience, to discuss opportunities to improve communication for the benefit of clients. The panelists shared what was going well and where barriers exist. Barriers uncovered include: lack of comprehensive referral information, lack of solid eligibility criteria to follow during referral, 42 CFR Part 2 consent for information sharing, and timely communication. Region 7 IDN will work to improve these issues by helping partners see the value in the shared care plan and develop comprehensive closed-looped referral processes including eligibility criteria. This will help providers refer the right patients and improve the timeliness of the interactions. The new CMT consent form released in June of 2018 should mitigate some concerns related to 42CFR Part 2 and lead to more provider willingness to utilize the shared care plan platform, which will lead to an improvement in care coordination.

With the growing need to provide managed patient care, North Country Healthcare (NCH) has established a unified care coordination structure. NCH has identified two ACO Care Coordinators, employed by affiliates Littleton Regional Healthcare and Weeks Medical Center who have successfully partnered in care coordination initiatives and have provided a basis for employee sharing opportunities. Within this organizational structure, each ACO Care Coordinator will divide time between NCH care management activities and each affiliate organization obligations. The two RN Care Coordinators will share responsibilities for integrating care services among North Country Healthcare affiliates and partners. They will provide a unified team-based approach with shared control of tasks, phases, and deliverables of population health and clinical initiatives, promoting a culture of coordination and integration between physical, behavioral health, and social service systems throughout the North Country. Functioning under a co-leadership strategy, standardized operational procedures will be implemented which will promote the integration of services, improve transitions of care, apply cost-effective methods of intervention and reduce avoidable healthcare utilization. Operating together, with representation from NCH affiliation (Androscoggin Valley Hospital, Littleton Regional Healthcare, Upper Connecticut Valley Hospital, Weeks Medical Center, and North Country Home Health & Hospice) and CCO partners (North Country Health Consortium, Indian Stream Health Center, Ammonoosuc Community Health Services, and Coos County Family Health Services), organizations are identifying their high-risk patient populations and determining missed opportunities with focus on improving care coordination. The Regional Coordinators will cultivate strong interrelationships with multiple service agencies state-wide, (nursing homes, home health, substance use facilities, behavioral health providers, housing agencies, payors, social services, state agencies, schools, law enforcement agencies), linking patients with all resources available. NCH anticipates reductions in acute hospital care, post-acute care, emergency department use, with significant cost-savings occurring in the reduction of readmissions and inappropriate ED utilization, and has the following goals for this project: Utilization management and cost effectiveness as measured by a 2% reduction in the annual per patient cost, 2% reduction in emergency department utilization as it relates to behavioral health disorders, and 1% reduction in admissions for substance use disorders.

Weeks Medical Center has continued to work on its internal care coordination efforts, and how to connect patients within their primary care practice to services offered through their North Country Recovery

Center. During the reporting period of January-June 2018 Weeks Medical Center hired a behavioral health case manager and care coordination assistant to help support inpatient and outpatient care coordination activities for physical and behavioral health services. In addition, as Weeks plans to expand MAT services to Upper Connecticut Valley Hospital (UCVH) and Indian Stream Health Center (ISHC), they hired another LCMHC to provide counseling services, and is currently looking for another psychiatric mental health nurse practitioner to provide MAT services to accommodate patient volume.

Weeks Medical Center's behavioral health case manager is providing support for the behavioral health department and medication assisted treatment (MAT) program, allowing behavioral health providers to focus on services within their scope of practice, such as counseling for mental health issues & substance use disorders; medication management; and creating treatment plans. The behavioral health case manager assists patients in navigating multi-agency systems, works with patients struggling with mental illness and/or substance use; communicates with multi-disciplinary teams, payors, and various agencies within the State; assists families as they cope with social and emotional needs; tracks patient care to ensure follow-up and recommended services are provided; works with internal and external service providers; maintains the flow of information across the different levels of care; and helps to create better health outcomes for individuals in our North Country communities.

The care coordination assistant helps to provide case management teams with added support, which allows them to concentrate on preventing unnecessary admissions, readmissions, and over utilization of the healthcare delivery system. This care coordinator assistant performs both administrative and clinical support duties which includes helping with the admissions and discharge process; facilitating access to hospital care, transfers to skilled nursing facilities, rehab or long-term care; assisting patients with marketplace health plans; Medicare D and Medicaid applications; coordinating transportation, housing, and any other resources needed.

The development of North Country Healthcare's regional call center, or connection center as they refer to it, is progressing. During this reporting period a contract was signed with Hospital Portal.net, NCH's intranet system for NCH providers and staff. An internet link will be provided for FQHC partners and patients, as this system will act as the connection center's 24/7 searchable on-call availability platform, with quick and easy methods of scheduling appointments and making referrals. A second contract has also been signed for Message Management Center, LLC services, a service NCH affiliate Littleton Regional Hospital has been utilizing. This platform will be used across all NCH affiliates as a message management center.

The goal of the connection center is to unite organizations and help to prevent delayed treatment, reduce medical errors and readmissions, expedite care delivery time, improve transitions of care and proper hand-offs, enhance communication between all resources, increase workforce productivity, and help to promote quality, cost effective healthcare services. North Country Healthcare affiliates and CCO partners (Ammonoosuc Community Health Services, Coos County Family Health Services, Indian Stream Health Center, and North Country Health Consortium) recognize that current care coordination processes are fragmented with each facility separately managing communications and connections to resources. Cost savings can be realized in the consolidation of affiliates' and partners' directories, provider schedules, and availability information which is essential for the region to transition to a value-based payment model and explore opportunities to improve operational efficiencies. Working collaboratively, NCH affiliates and CCO partners will develop and implement protocols necessary to integrate the call center with other partners in health and actively reach out to behavioral health, SUD, and Medicaid-type service facilities. The connection center will include a scheduling system which will store appointment availability for NCH

affiliates' primary care providers, behavioral health counselors, specialty providers, care coordinators, and support staff. The connection center staff can review all schedules and connect patients to the appropriate services. This is especially important for patients who are struggling with mental health, SUD, and/or concurrent physical health conditions as they are more likely to need other support services. The connection center can locate an available care coordinator at any NCH affiliate organization, which is critical in getting services wrapped around patients quickly and efficiently. The initial provider directory is anticipated to be completed by the end of August 2018 and ready to be used for scheduling appointments and making referrals beginning in October 2018. North Country Healthcare affiliates anticipate granting access to other regional resources such as nursing homes, home health/hospice agencies, mental health agencies, and private practices in late fall 2018 to help these agencies to improve patient care coordination. The connection center will be open for patient use in early 2019.

North Country Health Consortium (NCHC) has added one more Community Health Workers (CHW) to their Ways2Wellness Connect program, to bring their total up to four. The target population of this program continues to be patients over 65 with chronic health problems and no SUD problems. NCHC CHWs have built a strong relationship with Weeks Medical Center and are being called in to meet with patients before they are discharged from the hospital. The care transition team at Weeks Medical Center is responsible for connecting patients to NCHCs CHW program and serves as the point of contact when one of the CHWs need to follow up with Weeks Medical Center. To ensure that this is an efficient process, Weeks Medical Center includes information about the NCHC CHW program during the orientation of all staff, so they are aware of the referral process. Some referrals are coming from Coos County Family Health Services, and they are moving forward with partnerships with other agencies in the region including Indian Stream Health Center, Littleton Regional Healthcare, North Country Home Health and Hospice, and Androscoggin Valley Hospital. The CHW Program is launching a webinar that includes a chronic care transitions team manager at Weeks Medical Center who explains the positive impact on clients. This will be a 1-hour brown bag webinar with CEU available that covers conception and history of community health workers, training, implementation, role of CHW, how it fills the gaps that other positions do not, how it is different, and return on investment. The NH CHW Coalition, governed by a steering committee that is led by a CHW at NCHC, brings together community health workers, health professionals, stakeholders and community leaders throughout NH, to inspire and educate about the value of the CHW in NH. This coalition meets quarterly to provide opportunities for organizations to collaborate and learn from one another.

Region 7 IDN is watching how this program continues to evolve and plans to use lessons learned to help develop care coordination models across the region. Templates used within the CHW program are extremely helpful to IDN partners as they work to meet the DSRIP requirements. Additional opportunities exist for NCHC's CHW program to pilot CMT's shared care plan platform, which could be valuable as IDN partners start to adopt the same platform.

The region's implementation plan stated that NCHC would offer 2 Community Health Worker trainings per year. Due to staffing transitions, NCHC was unable to offer a CHW training in spring of 2018 but will offer a 2-month Community Health Worker (CHW) Training starting in October 2018 to expand the CHW workforce in the region. CHWs promote healthy behavior and improve overall quality of life, with compassion for the communities that they serve. They build relationships on a foundation of mutual respect and trust to guide individuals in overcoming barriers and creating a path to personal success which make them a perfect fit as care advocates in the enhanced care coordination project. Motivational Interviewing will also be offered in the fall of 2018.

White Mountain Community Health Center (WMCHC) and Huggins Hospital both have worked with the IDN Quality Improvement Coach to progress towards becoming a coordinated care practice site as described under project B1. In addition, each of these agencies have also spent a considerable amount of time building robust care coordination programs including the development of workflows to look at behavioral health integration, utilization of risk stratification models, treating complex patients, and ensuring a closed loop referral process is in place. These 2 agencies had staff participate in the March 2018 regional care coordination training and are working closely with Northern Human Services as processes are put into place related to the use of the shared care plan and a multi-disciplinary core team which will assist with enhanced care coordination for the high needs population. The 2 agencies have spent time to develop workflows which will address the differences between behavioral health integration and coordination for complex care patients, compared to patients with fewer needs. As they work to finalize risk stratification processes, they will incorporate specific definitions and processes into the risk stratification system, so high risk patients can easily be identified with their needs addressed in a timely fashion. The agencies will continue to develop risk stratification policies and procedures, which follow the American Academy of Family Physicians guidelines below, and review transitions of care policies to ensure they include guidelines on starting care coordination for high ER utilizers and hospital discharge follow up.

The region is looking to improve care coordination services for heavy utilizers of Medicaid and emergency services, including: individuals with behavior health disorders (specifically, serious mental illness (SMI) or substance use disorders (SUD) including opioid addiction) with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors (such as homelessness) that are barriers to community living and well-being and children diagnosed with chronic serious emotional disturbances. Since the region has only had one regional care coordination training to date, only Huggins and WMCHC were asked to report how many patients they have been working with which fall into the criteria above. Huggins Hospital identified 20 high risk patients who received enhanced care coordination services and WMCHC identified 12 patients. These numbers were the based on the best information that was available to the agencies. The accuracy in reporting will be enhanced as systems are developed for risk stratification, referral management, and tracking outcomes and agencies adopt policies, procedures, and protocols to support these systems.

Four organizations in northern Carroll County; Memorial Hospital, Saco River Medical Group, Visiting Nurse Home Care & Hospice, and Children Unlimited, are working collaboratively to enhance care coordination and address substance use disorder needs. These agencies meet routinely to ensure they are working cohesively and avoiding duplication. They continue to work closely with Carroll County Coalition for Public Health (C3PH) relying heavily on the Continuum of Care (CoC) facilitator to assist on convening and playing a key role in developing the plan as it relates to SUD. They are in the final phase of developing a short video highlighting services in place and demonstrating collaboration among agencies in northern Carroll County. This group also intends to create a second video, highlighting testimonials of people receiving services from these agencies, later in 2018 or early 2019. Specific progress from each of the four agencies as it relates to enhanced care coordination is below:

- Saco River Medical Group hired a patient care coordinator who is a registered nurse dedicated to coordinating transitions of care for all patients, including those with mental health and substance use disorders. The patient care coordinator has been working to develop processes and protocols to identify high risk patients, coordinate services, identify gaps, and meet need. Using screening tools developed in 2018, the patient's primary care provider can identify at-risk patients in primary care settings and refer them to the patient care coordinator for assistance in addressing their behavioral health needs. The patient care coordinator screens SUD patients for Saco's MAT

program, initiates first appointments with providers, and will get busier with this piece as Saco plans to add another MAT provider in September 2018.

- Effective January 1, 2018, Memorial Hospital has a behavioral health division within its primary care practice known as Mount Washington Valley Rural Health – Behavioral Health. They have a PMHNP-BC serving as the Director of Behavioral Health and shifted staffing around to have a behavioral health patient care coordinator. Two nurse practitioners within the primary are practice were waivered to prescribe for MAT during this reporting period, so they now have a total of 3 APRNs waivered to prescribe for MAT and have seen 55 patients this reporting period. In addition, the hospital also currently has three staff waivered to provide MAT services in their New Life Prenatal Program to treat pregnant and postpartum mothers struggling with SUD. Currently, this program has provided MAT services for approximately 16 additional patients.

- Visiting Nurse Home Care and Hospice (VNHCH) worked to expand their *Crossings* program, a bereavement program that serves children and families in the Mount Washington Valley and surrounding communities. With the current opioid crisis, the community has seen a significant increase in children who have lost a loved one to substance overdose. These children and their families are at increased risk for depression, anxiety, and maladaptive coping. Fifty percent of the children currently being served have lost a parent to accidental overdose and are now being cared for by grandparents, who are grieving the loss of their own adult child. *Crossings* hopes to expand services in the future to meet the needs of children experiencing grief related to the separation from parents due to incarceration. VNHCH initiated an advertising campaign in February 2018 to increase community awareness of services and created a 4-hour/week position dedicated to outreach services. The program identified the need for a satellite group to meet in the southern part of the county to meet the needs of underserved families in the community with high numbers of opiate related losses who would be unlikely to travel to groups meeting in the northern part of the county.

- Children Unlimited met with the Program Director at Carroll County Department of Corrections to discuss parent education during incarceration, and in spring of 2018 the agency started to facilitate an educational class at the correctional facility called Parenting from Prison. The program curriculum teaches inmates skills to strengthen family functioning, increase positive behaviors, decrease substance use, and increase knowledge of risk and resilience factors. Family Connections Resource Center, a program of Children Unlimited, provided comprehensive support services to 5 high risk families, including those affected by the opioid crisis and/or mental health issues through its “Bridges” Program. The Bridges program provides, not only childcare so parents can re-enter the workforce, but also parenting support and education. It requires meeting with parents, setting goals, identifying barriers in achieving those goals, and offering life skills training to achieve success. In addition, staff from Children Unlimited collaborate with many other agencies in the region including White Mountain Community Health Center and Whitehorse Addiction Center.

E-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list all of the progress toward targets or goals that the program has achieved. 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 12/31/2018	0	34	
Reduced hospital inpatient readmissions for patients with BH indicators *This measure corresponds closely to the statewide outcome measure Hosp_ED.01 – Frequent Emergency Department Use in the Behavioral Health Population* *Once the state releases IDN Region 7s performance on this measure using claims data, we will be able to assess our performance in this area.*	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	0	N/A	
# of ED visits for patients with BH indicators *This measure corresponds closely to the statewide outcome measure Hosp_ED.01 – Frequent Emergency Department Use in the Behavioral Health Population* *Once the state releases IDN Region 7s performance on this measure using claims data, we will be able to assess our performance in this area.*	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.	0	N/A	
# of sub-recipient proposals received which are related to Enhanced Care Coordination	5 by 12/31/2018	3	2	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Convene 1 Care Advocate Workgroup	1 by 12/31/2017	1	2	
# regional care coordination trainings	3 by 12/31/2018	0	1	
# Community Health Worker Trainings	3 by 12/31/2018	1	0	
# of CHW cross trained as Peer Recovery Coaches	8 by 12/31/2018	5	5	
# of Region 7 IDN agencies with embedded Community Health Workers	5 by 12/31/2018	4	4	
# of agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3 by 12/31/2018	0	2	
# of trained Care Advocates	15 by 12/31/2018	0	5	
# of partner organizations that have agreements in place for referral process	4 by 12/31/2018	0	2	

E-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing 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 12/31/2018	0	0	5	
Regional Care Advocate Supervisors	1 by 12/31/2018	0	0	0	

E-4. IDN Community Project: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Care Coordination Actual Funds Spent	Care Coordination Actual Expense (6 months)	Care Coordination Budget Projection	Care Coordination Projection	Care Coordination Projection	Care Coordination Projection
Care Coordination	**CY 2017 Actuals**	**CY 2018 January to June Actual**	**CY 2018 July to December Projected**	**CY 2019 Projected**	**CY 2020 Projected**	**CY 2021 Projected**
			(6 month)	(12 months)	(12 months)	(6 months)
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	968	$71	$1,074	$2,147	$2,147	$1,074
6. Travel		$368	$0	$0	$0	$0
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$443	$421	$842	$842	$421
10. Marketing/Communications	1,086	$572	$506	$1,012	$1,012	$506
11. Staff Education and Training		$522	$0	$0	$0	$0
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	1,634	$930	$1,989	$3,979	$3,979	$1,989
Support Payments to Partners	65,766	$59,987	$83,037	$166,074	$166,074	$83,037
TOTAL	**91,231**	**$75,802**	**$99,784**	**$199,569**	**$199,569**	**$99,784**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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 in this reporting period to this project using the format below.

Organization/Provider	Agreement Executed (Y/N)
Tri- County Cap	N
Northern Human Services	N
Weeks Hospital	Y
Rowe Health Center	N
Life Coping	N
White Mountain Health Services	N
Ammonoosuc Community Health Services	N
Crotched Mountain	N
Memorial Hospital	Y
North Country Healthcare	Y
Huggins 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.

Standard Assessment Tool Name	Brief Description
Risk Stratification -	To determine the level of case management a high needs patient should be provided. The California Quality Collaborative Risk Stratification Report identifies need based on 12 domains: age, hospitalization in last 12 months for any reason, ER visits in last 12 months any reason, sever diagnosis w/in last 2 years, co-morbid diagnosis w/in last 2 years, Rx # of unique prescriptions in last 12 months, behavioral health diagnosis w/in last 2 years, hospitalization last 12 months with sever or co-morbid diagnoses, ER visits last 12 months with sever or co-morbid diagnoses, cancer diagnosis w/in last 2 years, member has LTC Aid code 23, 63, 13, 53, member is LTC institutionalized or has aid code.
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. Written protocol containing these elements will be finalized and deployed by 3/29/18
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. Will be deployed by 3/29/18
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. Written protocol containing these elements will be finalized and deployed by 3/29/18
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 . Written protocol containing these elements will be finalized and deployed by 3/29/18.
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. Written protocol containing these elements will be finalized and deployed by 3/29/18.

E-8. IDN Community Project Member Roles and Responsibilities

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

Project Team Member	Roles and Responsibilities
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, in order to maintain or improve the patient's health and functional status.
Care Advocate Supervisor	The Care Advocate Supervisor will offer technical assistance as it relates to care coordination to ensure Care Advocates follow fidelity to the Enhanced Care Coordination project. This will include assisting with the identification of the training needs of the regional Care Advocates, monitoring workflow development, assisting Care Advocates with developing policies and procedures that meet the DSRIP required core components of the Enhanced Care Coordination project.
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.
NCHC Program Coordinator	Works closely with the Care Advocate Supervisor and IDN Program Manager to coordinate and support the work of the Enhanced Care Coordination project. This includes coordinating training needs, coordinating funding proposals, and follow up on identified needs of the Care Advocates as they work to ensure the DSRIP requirements of the project are met.
IDN Program Manager	Works closely with the Care Advocate Supervisor and NCHC Program Coordinator to ensure all the DSRIP requirements of the Enhanced Care Coordination are met, including reporting requirements.

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

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	B1

	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	
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, 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 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 health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks	B1

	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 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	D3

	(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 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

DHHS Project Scoring: IDN Community Project Process Milestones

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

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

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

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of 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.

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

Provide a brief narrative describing the current use of APMs among partners.

Use the format below to: identify the IDNs participation in workgroups for the development of the DSRIP APM Implementation Plan; assess the current use and/or capacity for engaging APMs amount IDN participants; develop an IDN-specific plan for implementing the roadmap to include IDN-specific outcome measures; and develop the financial, clinical and legal infrastructure required to support APMs.

Region 7 IDN continues to be actively involved in alternative payment model discussions on a regional and statewide level. The Region 7 IDN Executive Director has been involved with the APM stakeholder meetings and has shared this information with the region during quarterly meetings. Region 7 IDN staff will share the NH APM Roadmap, DHHS Alternate Payment Model Strategy Design Summary with the IDN Steering Committee to identify what will be most beneficial for the region and will continue to use this resource to explore the use of APM's throughout the July-December reporting period.

As the state reviewed lessons learned from conversations with Medicaid Managed Care organizations it was realized that New Hampshire's small population creates challenges when it comes to implementing APM's. MCO's have been involved in intensive conversations and have some "total cost of care" models implemented, with cost and quality goals, which is focused and supported by systems with sufficient Medicaid members. Region 7 can specifically relate to this issue to due to its large geographic area of multiple small communities. To mitigate this challenge Region 7 has been looking for opportunities to use innovative strategies to meet deliverables. Research has been conducted over the past reporting period related to billing and coding, and the region anticipates bringing trainings to partners to address the discrepancies that are involved with current billing and coding systems. An example of these efforts is North Country Healthcare working with White Mountain Community College to offer a boot camp to prepare coders for certification. The State of NH reports that to support integrated behavioral health administrative changes, such as billing and coding, will need to reflect care delivery best practices.

Region 7 IDN has chosen to work with all partners to improve the use of technology, data sharing, and data literacy as they work on implementing APM's. A continuous issue for Region 7 as they are building infrastructure is the concern of ensuring ultimate sustainability for new services and functions, especially as they relate to APM'S. Two examples of the new services which could be covered by Medicaid and other insurers include the Critical Time Intervention and services provided by community health workers. The region will work with partners to ensure collaboration across organizations to allow for more assurance regarding sustainability.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Yes	Yes	
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		No	
Develop the financial, clinical and legal infrastructure required to support APMs		No	
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs		No, but trying	

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