New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 3 (CY2018)

Redacted January 2019

Region 7 IDN

Table of Contents

Introduction 5

DSRIP IDN Project Plan Implementation (PPI) 6

DSRIP IDN Process Milestones 18

Project A1: Behavioral Health Workforce Capacity Development 19

A1-3. IDN-level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan 19

A1-4. IDN-level Workforce: Evaluation Project Targets 24

A1-5. IDN-level Workforce: Staffing Targets 24

A1-6. IDN-level Workforce: Building Capacity Budget 27

A1-7. IDN-level Workforce: Table of Key Organizational and Provider Participants 28

Project Scoring: IDN Workforce Process Milestones 30

Project A2: IDN Health Information Technology (HIT) to Support Integration 31

A2-3. IDN HIT/HIE: Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan 31

A2-4. IDN HIT: Evaluation Project Targets 56

A2-5. IDN HIT: Workforce Staffing 57

A2-6. IDN HIT: Budget 58

A2-7. IDN HIT: Key Organizational and Provider Participants 59

A2-8. IDN HIT. Data Agreement 61

Project Scoring: IDN HIT Process Milestones 63

Project B1: Integrated Healthcare 64

B1-2. IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan 64

B1-3. IDN Integrated Healthcare: Evaluation Project Targets 77

B1-4. IDN Integrated Healthcare: Workforce Staffing 81

B1-5. IDN Integrated Healthcare: Budget 85

B1-6. IDN Integrated Healthcare: Key Organizational and Provider Participants 86

B1-7. IDN Integrated Healthcare: IDN Governance Leadership Sign-off 86

B1-8. Additional Documentation as Requested in B1-8a-8h 88

Project Scoring: IDN Integrated Healthcare Process Milestones and Achievement of *Coordinated Care Practice* Designation Requirements 131

B1-9. Additional Documentation as Requested in B1-9a - 9d 135

Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of *Integrated Care Practice* Designation Requirements 154

B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation 156

IDN Community Project Implementation and Clinical Services Infrastructure Plan 173

C-1. IDN Community Project: Core Components, Process Milestones, Training and Evaluation Project Plans 173

C-2. IDN Community Project: Evaluation Project Targets 176

C-3. IDN Community Project: Workforce Staffing 178

C-4. IDN Community Project: Budget 179

C-5. IDN Community Project: Key Organizational and Provider Participants 180

C-6. IDN Community Project: Standard Assessment Tools 180

C-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals 180

C-8. IDN Community Project: Member Roles and Responsibilities 181

C-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3. 182

Supervising a Peer Recovery Workforce 187

HIV Update for Substance Use Professionals 188

Project Scoring: IDN Community Project Process Milestones 189

IDN Community Project Implementation and Clinical Services Infrastructure Plan 190

D-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan 190

D-2. IDN Community Project: Evaluation Project Targets 201

D-3. IDN Community Project: Workforce Staffing 202

D-4. IDN Community Project: Budget 203

D-5. IDN Community Project: Key Organizational and Provider Participants 204

D-6. IDN Community Project: Standard Assessment Tools 204

D-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals 207

D-8. IDN Community Project: Member Roles and Responsibilities 207

D-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 208

Project Scoring: IDN Community Project Process Milestones 216

IDN Community Project Implementation and Clinical Services Infrastructure Plan 218

E-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan 218
E-2. IDN Community Project: Evaluation Project Targets 225
E-3. IDN Community Project: Workforce Staffing 228
E-4. IDN Community Project: Budget 229
E-5. IDN Community Project: Key Organizational and Provider Participants 230
E-6. IDN Community Project: Standard Assessment Tools 231
E-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals 232
E-8. IDN Community Project Member Roles and Responsibilities 233
E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 234
DHHS Project Scoring: IDN Community Project Process Milestones 240
Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning 241
DSRIP Outcome Measures for Years 2 and 3 243

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:

Kelley Capuchino
Senior Policy Analyst
NH Department of Health and Human Services
Division of Behavioral Health
129 Pleasant St
Concord NH 03301
Kelley.Capuchino@dhhs.nh.gov

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 to 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.

The committee met with the three governance workgroups in July at the Strategic Funding Meeting to design a new funding process which aligns with the shifting of incentive funds to a pay for performance methodology. The group reviewed the deliverables that the region is expected to achieve and discussed the importance of meeting established performance metrics to continue receiving incentive funding for the remaining DSRIP project. They talked about challenges that make the current process difficult and expressed options for improvement. The workgroups felt that more technical support is needed to execute the majority of IDN deliverables. They also identified the need for coordination of projects to avoid duplication of services and inefficient use of funds. Standardized data collection was discussed as a challenge because many partners have different systems that measure different things. The group made recommendations to improve the funding process which included the elimination of concept papers.

The Steering Committee met in August to review the results of the July Strategic Funding Meeting. The group stressed the importance of funding only being allocated to proposals that will clearly help the region meet DSRIP deliverables and requested that funds only be approved for projects that tie into existing projects or expand projects, instead of funding brand new initiatives. The committee agreed to eliminate the concept paper process. Agencies who submit a proposal will now be asked to prepare a 10-15-minute presentation for the Steering Committee to explain their proposal intentions and address any questions or concerns. The proposal scoring system was updated to encourage the workgroup review panel to focus on providing comments and questions instead of a numeric rating because this is more valuable information for the Steering Committee to consider as funding decisions are made. The group also discussed expanding the training and technology form to include additional categories if the request will help an agency meet DSRIP deliverables and not exceed $10,000. This process will start in early 2019 if there are available DSRIP funds to support the requests.

The 4th round of proposals were due in October. The Region 7 IDN team received a total of 15 proposals. The Steering Committee looked at the reviewers' feedback and listened to new presentations in November to help guide funding decisions. The following projects were approved contingent on the region receiving funding:

- *Tri-County Community Action Program* submitted a proposal to continue their Supportive Housing project to deliver a coordinated system of care utilizing The Critical Time Intervention (CTI) model. The primary goal of their project is to improve the participant's capability to remain housed beyond program participation by effectively connecting them with critical community supports and aiding them to achieve greater economic stability. TCCAP aims to support a successful transition into permanent housing by maximizing available resources and supports. TCCAP Prevention Programs is proactively exploring future options for delivery of some components of the program through secured teleconferencing equipment. As caseloads increase the ability to utilize technology to reduce the burden of travel time and expense would be vital.

- *North Country Health Consortium Clinical Services (Friendship House):* Submitted a proposal for continuation funds to continue focusing on enhancing care coordination and service delivery. Friendship house with continue researching best-practices clinical treatment curriculum to purchase, which will in turn enhance their ability to provide comprehensive care for co-occurring disorders. The organization 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. This proposal demonstrates collaboration and program enhancement, which will bring great things to the Region.

- *Memorial Hospital* submitted a proposal on behalf of four organizations in Mount Washington Valley (Memorial Hospital, Saco River Medical Group (SRMG), Children's Unlimited (CU) and Visiting Nurse Home Care & Hospice (VNHCH)) to expand their Collaborative Community Program Addressing Behavioral Health & Substance Use in Carroll County project. Each agency will build on and expand the collaborative work already begun. Memorial's patient care coordinators will continue collaboration of behavioral health, IMAT and A New Life prenatal substance abuse program. Memorial will also expand their IMAT program to full capacity of providers with waivers, provide staff education and training, and expand outreach and connections with other community partners particularly addressing social determinants of health. VNHCH will expand its "Crossings" Program which provides free facilitated peer support groups for children ages 3-18 and their families and ensure all resources in its multi-media library are available to the community. CU will continue to support the "Parenting from Prison" Program, provide training to support "children from hard places", and continue to provide comprehensive support services through its "Bridges" Program. SRMG will expand its current MAT program and continue coordinating transitions of care for all patients, including those with mental health and substance use disorders. They continue to improve integrated behavioral health care and are investing in their infrastructure by building a suite to be used for psychiatric care, mental health counseling and substance use disorder counseling.

- *North Country Healthcare (NCH)* submitted a proposal for a Regional Care Coordination Project involving ACO Care Coordinators from affiliates Littleton Regional Healthcare and NCH – Weeks Medical Center who will divide time between NCH care management activities and each affiliate organization's obligations. The Regional Care Coordinators will be responsible for establishing a Critical Time Intervention program to effectively transition patients from one setting to another. They will also 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. NCH – Weeks Medical Center, an NCH affiliate, submitted a proposal to expand Medication Assisted Treatment and behavioral health services to NCH – Upper Connecticut Valley Hospital and Indian Stream Health Center. These agencies will work together to ensure patients who are referred to NCH – Weeks Medical Center's North Country Recovery Center (NCRC) will have access to behavioral health specialists for counseling services as well as behavioral health case management/care coordinators to identify social determinants and assist patients in obtaining support services.

- *NCH – Weeks Medical Center* also submitted a proposal to support their Care Management department due to the increasing volume of patients needing care coordination management services. NCH – Weeks Medical Center's Behavioral Health Case Manager provides much needed support for the behavioral health department and MAT program, allowing the behavioral health providers to focus on services within their scope of practice. The Care Coordination Assistant helps to coordinate functions that are associated with both inpatient and outpatient services and 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.

- *Huggins Hospital* submitted a proposal to expand their "Huggins Health Neighborhood Care Coordination and Integration Services" project. The project would expand Huggins Hospital's integration of behavioral health and primary care and address the social determinants through expanded care coordination, adoption of assessment and screening related to the IDN project, and support for expanded MAT services.

- *North Country Serenity Center (NCSC)* requested funds to expand their "Substance Use Disorder Treatment" project. NCSC plans to expand services using recovery coaching, telephone recovery supports, and the closed loop coordinated cares systems model that is currently being developed with Ammonoosuc Community Health Services. This model will impact an individual's quality of health and address the unique needs of each individual as it relates to their social determinants of health. NCSC also plans to develop a regional partnership with other Recovery Community Organization and share processes and protocols with them that have been developed.

- *Northern Human Service (NHS)* submitted a proposal to implement Critical Time Intervention to assist patients who are transitioning from inpatient psychiatric units to their home communities. The goal of this program is to make needed community support connections over a prescribed 9-month period for the person being discharged to assure their successful transition back into the community. NHS also submitted a proposal to partner with Ammonoosuc Community Health Services (ACHS) to expand their existing Integrated Health Care Clinic project to the Littleton service area. The existing project in Berlin led to the opening of CrossRoads Clinic, a partnership between Coos County Family Health Services and Northern Human Services, offering a co-located primary care office embedded within a Community Mental Health Center. NHS and ACHS will address the needs of the IDN's target population by developing a second Integrated Health Home, to be located at White Mountain Mental Health Center in Littleton and operated by ACHS.

- *White Mountain Community Health Center* submitted a funding request to continue an existing project including care coordination, risk stratification, closed-loop referrals, and case conferences.

- *Ammonoosuc Community Health Services* submitted a proposal to continue and expand their "Integrated Behavioral Health/Substance Use Disorder Services across Settings" project. ACHS will continue to formally coordinate behavioral health and primary care between ACHS and Friendship House (FH); place Mental Health Clinicians at local area schools to provide substance use preventive and counseling services; and utilize its work flow to notify ACHS behavioral health staff when clients are seen in the EDs for behavioral health or substance use reasons. ACHS plans to expand internal Medication Assisted Treatment (MAT), as well as establish and maintain close coordination with recovery support organizations. They also plan to ensure clients served by ACHS behavioral health providers are assessed and referred to in-house patient navigator staff as appropriate to address social determinants of health.

- *White Horse Addiction Center, Inc. and MWV Supports Recovery (MWVSR)* submitted a joint proposal to provide 24/7 emergency recovery support services for those struggling with substance use disorders. White Horse will set up the on-call services in their Recovery Support Center in North Conway and plan to be the lead agency providing a full-time Coordinator of Services. White Horse will also provide a CRSW to supervise, train and directly support recovery coaches who will make weekly recovery support phone calls and introduce clients to recovery resources. Recovery coaches from both organizations will provide 24/7 coverage for emergency situations on a rotational basis. MWVSR will provide a part-time Peer Recovery Coordinator and be on call the last two weeks of each 6-week period.

NCHC had hoped to enter new MOUs for these proposals in December, but due to funding uncertainties that hasn't occurred yet. It is likely that the Steering Committee will need to meet again to have additional discussions on prioritizing the funding decisions related to these proposals once the region knows the total amount of its incentive payment for the period. Region 7 IDN staff continues to update the Steering Committee regarding funding as updates come in from NH DHHS. IDN staff have also been increasingly involved in county and state level conversations over the past 6-months to encourage the counties to contribute to IDN funding. Members of the IDN team have presented at multiple county delegation and commissioner meetings to help secure funding for these projects and will continue to inform the Steering Committee and partners regularly.

Community Engagement Workgroup:

The Community Engagement Workgroup continued to work together to develop strategies of communicating IDN messages to the community and partners. The group determined a new monthly meeting schedule to increase attendance, which seemed to work for most members during the first few months. The group continues to struggle with participation, resulting in a quarterly meeting model to be implemented in 2019. The core group of partners that have been in attendance regularly will continue to collaborate more often as necessary to prepare for the community engagement quarterly meetings moving forward. The IDN team continues to update the workgroup on funding and discussed the new request for funds process that will be utilized.

The IDN 7 Partners will continue to work on engaging patients and families to assure that IDN work is done with their feedback and insight which is critical to the work of creating and embedding evidence-based systems of integrated care. The community engagement workgroup has continuously discussed effective strategies of capturing patient and family input and community outreach activities to be reported on as the region shifts to pay for performance. The Chair of the workgroup came up with the following list of questions that the group will use to help guide further conversations as the project continues:

1. Do you feel you have the information/communication needed to successfully participate in the IDN project? If no, what are ways that communication could be improved or made more informative for you/your agency?
2. Do you feel you have a good understanding of other partners' work?
3. How, if at all, are you communicating with your Medicaid population about IDN work?
4. What kinds of communications are happening with your Medicaid population regarding new practices/services resulting from IDN work?
5. Have you requested and/or received feedback from your Medicaid population (or their support networks) regarding IDN work?
6. How would you like to see our partners share info and receive feedback from each other and with the Medicaid population?

The workgroup was encouraged to like and share the Region 7 IDN Facebook page and submit posts from their agencies to be shared. The NCHC media team has expressed the importance of partner engagement through their agency Facebook pages and the IDN Facebook. The media team reiterated the value of sharing the IDN Facebook page with those who manage IDN partner agency pages to help grow the IDN's social media presence. Aside from partner engagement, the IDN team shared that a post about the opening of Crossroads Clinic reached over 7,000 users, showing the impact of the new social media approach. The Facebook page has been proven to be a valuable resource to share relevant information, events, and help Region 7 acknowledge partners on their progress.

The IDN team has continued to update the workgroup on trainings and encouraged members to promote these trainings to appropriate staff to ensure the right audience is reached. The IDN team moved forward and developed the Region 7 IDN Webinar Series that was briefly mentioned during the last reporting period. The HIT Integration Coach worked diligently with IDN staff and the Community Engagement workgroup to decide the most effective approach to delivering relevant trainings that providers could attend or easily watch as a recording during their spare time. The workgroup provided valuable feedback and ideas for webinar topics and will continue to be part of program development as the project continues. The group discussed promotion strategies and the IDN team asked members to share webinar links as they become available. The workgroup discussed the idea of an IDN rack card that could explain integrated care to patients and help them understand the changes that are occurring. The core group will continue to brainstorm the most effective way to create this and share ideas with the rest of the Community Engagement Workgroup at the first quarterly meeting in 2019.

Data Workgroup

The Data workgroup met less as a group this reporting period due to the increase in individual meetings with MAeHC regarding reporting. Members did attend the Strategic Funding Meeting in July, providing valuable feedback about funding and data collection strategies. The group met in September to participate in a Shared Care Plan presentation from the IDN HIT Integration Coach. The team has decided to include this work to broaden the audience of the workgroup and seek ideas and topics that can be helpful to the group. The workgroup was educated on basic features of the shared care plan including PreManage ED, PreManage Primary, and Event Notifications. Admission Discharge Transfer feeds were

also discussed; the workgroup was notified that a high percentage of IDN 7 hospitals are submitting this data to Collective Medical Technologies. The workgroup was updated on the partners that have been actively engaged in implementing the Shared Care Plan and encouraged to reach out to the HIT Integration Coach to discuss the process.

Monthly technical integration calls and quality measure meetings took place during this reporting period with the following agencies:

- Cottage Hospital
- White Mountain Community Health Center
- Ammonoosuc Community Health Services
- Coos County Family Health Services
- Huggins Hospital
- NCH – Weeks Medical Center
- North Country Healthcare
- Indian Stream Health Center
- Saco River Medical Group

The IDN team has been having conversations with partners to determine how to align various agency measures such as HEDIS, ACO, and IDN measures. The group was informed that the historical lookback to 2015 will be due in October 2018 to establish a baseline. It was stressed that data reporting will become increasingly important in 2019 due to the shift to pay for performance.

Clinical Workgroup

Clinical Workgroup members attended the Strategic Funding Meeting in July to help brainstorm efficient ways to allocate funds moving forward. The workgroup was essential to the discussion and has continued developing strategies to meet IDN deliverables. They continued discussing the core comprehensive standardized assessment, multi-disciplinary core teams, and protocols and workflows. The expertise within the clinical workgroup has been crucial in the development of the region's sample protocols and strategies to implement the deliverables mentioned above.

The workgroup also spent the period discussing workforce updates, shared care plan updates, training schedules, IDN funding, and reporting. The IDN Team updated the Clinical Workgroup on the Site Self-Assessment survey from June 2018 to illicit feedback and develop strategies to increase scores in the keys areas that were lacking. The primary area the workgroup discussed was patient and family input to integration management; the partners explained current practices at capturing this information and ways to improve and implement the process at other agencies. The group determined that barriers to involving patients and family include stress and increased demands of staff member. In addition, the large region makes it difficult to get full representation of the population being served. The Clinical and Community Engagement workgroups will continue strategizing on ways to involve the Medicaid population throughout the remainder of the waiver.

Workforce discussions mainly revolved around the lack of behavioral health workforce and the need for more trainings in the area to help maintain certifications and licensure. The Region 7 IDN team has worked diligently to provide an array of trainings that count towards certification and licensure and have called on the clinical workgroup for training recommendations as they begin to develop the region's 2019 training plan. The workgroup strongly suggested bringing more LADC specific trainings to the region to encourage more individuals to work in this field and in the North Country.

Implementation of the CCSA continued to be a main topic on the agenda each month, the group worked to clarify the specific requirements regarding the deliverable and discussed ways to effectively document the completion of the process for each patient. Multiple partners have been working to integrate this in their EMR's and intake workflows, setting an example for the entire region. The sample protocol has been

shared region wide and the IDN team has been working with remaining agencies to help them adapt it to their specific processes. The IDN Quality Improvement Coach and the IDN Medical Director spent the reporting period developing more protocols around various topics such as closed-looped referrals, depression management, and collaborative care agreements. These draft protocols will be shared with the clinical workgroup for feedback and then disseminated to the region for adaptation across partner agencies. Members of the clinical workgroup continued to discuss the formation of multi-disciplinary core teams, and the IDN team solicited the group for ways to expand the use of the multi-disciplinary core team at additional partner agencies across the region.

The Clinical Workgroup revisited the topic of collaborating with Managed Care Organizations to enhance care coordination and avoid duplication. New Hampshire Healthy Families (NHHF) representatives joined a clinical workgroup meeting in October to explain opportunities that their MCO could provide. The MCO mentioned that they provide report cards to providers regarding patient progress and a provider/patient analytic tool to look at population health within that provider group, including looking at information at the individual provider level. This allows access to look at high complex patients to identify gaps in care. The workgroup suggested further follow up with NHHF and the second NH MCO, Well Sense, to learn more about each program. The IDN team met with both individually to learn about potential trainings and demonstrations and discuss collaborative opportunities for delivering trainings to IDN partner agencies.

The Clinical Workgroup also spoke about the Cherokee Health System training that IDN staff attended in October. The IDN team mentioned using this model to guide them as they assist partners with advancing along the continuum of integrated healthcare. The Clinical Workgroup will continue to work together to finalize protocols, assess training needs, improve communication, increase provider involvement and move the region towards integrated care.

Financial Workgroup

The Financial Workgroup participated in the proposal review process and provided feedback related to the budgets submitted from IDN partner agencies. The NCHC Chief Financial Officer, a member of the Financial Workgroup, assisted IDN staff in reviewing budgets to help the Steering Committee understand the status of funds available to the region. The workgroup was invited to the Strategic Funding Meeting in July to participate in the discussion regarding allocation of funds as the region moves to pay for performance. The group will continue to be a resource to the region as necessary and review proposals and budgets regularly.

Opioid Crisis:

Region 7 IDN has continued to work collaboratively with partners and existing initiatives to address the opioid crisis. These relationships have proven foundational to impacting the crisis, expanding services, and improving prevention strategies across all counties. The Carroll County Coalition for Public Health and North Country Health Consortium's Substance Misuse Prevention Program have continued to be crucial in helping the region to address the opioid epidemic. NCHC has also received grants to address the opioid crisis further, their Wellness and Recovery Model will help bring more peer recovery coach services to the north country and help involve EMS, Law enforcement and emergency departments in the initiative. The region is excited to see 2 Hubs stood up in Coos and Northern Grafton county; NCH – Androscoggin Valley Hospital and NCH – Littleton Regional Healthcare will develop their HUB models while Region 7 IDN works to collaborate with all initiatives to determine the best use of resources. Region 7 IDN will continue to leverage these new state initiatives and projects to avoid duplication and build collaborative relationships to address the opioid epidemic.

During the last reporting period, a new residential treatment facility opened its doors in Bethlehem to accommodate 28 clients and provide improved treatment strategies. The Friendship House held its official Ribbon Cutting on October 16th, 2018. The opening of the new Friendship House reflects the commitment,

hard work and resourcefulness of the many stakeholders invested in addressing the opioid crisis locally. The community celebrated having effective, evidence-based treatment for substance use disorder and other addictions brought to fruition.

The availability of peer to peer services to augment and enhance the aforementioned model of care is a priority of the four Recovery Community Organizations of Region 7 IDN. They have participated in collaborative conversations to develop a peer recovery support network for people suffering from substance use disorder. Region 7 has provided multiple trainings to help partner staff become recovery coaches and certified recovery support workers. The region has expanded its capacity to increase recovery support and treatment services and is developing projects to continue building the network.

The North Country Substance Misuse Prevention (SMP) team planned and carried out multiple events during the last period that have positively impacted the opioid crisis. The team saw the Community Anti-Drug Coalitions of America's (CADCA) Youth Leadership take place on Aug. 8 & 9, 2018 for 10 Haverhill/Woodsville Middle & High School Students at Haverhill Cooperative Middle School. CADCA's National Youth Leadership Initiative (NYLI) works to engage youth to become involved in community coalitions, develop their skills and character to be strong, capable, and visionary leaders through training, and inspire them to create lasting change. The Drug Enforcement Agency organizes two Drug Take Back Days each year, one in April and the other in October. In October, the state of New Hampshire collected a total of 11,880 pounds of unneeded or expired prescription drugs. More than 600 pounds of these drugs came from North Country communities where they were collected at local police departments. The SMP Coordinator also worked with NCH – Upper Connecticut Valley Hospital to secure a permanent drop box at their agency.

The SMP Coordinator has also been working hard on the Recovery Friendly Workplace Initiative that Governor Sununu launched statewide. This initiative creates a safe recovery environment for employees by opening the line of communication between the employee and employer when the employee is struggling. The employer helps to remove barriers and stigma associated with getting help for a substance misuse disorder. Tender Corp, Gen-foot America, North Country Health Consortium and Phlume Media have all signed on to become a Recovery Friendly Workplace in the North Country to date.

The Granite Youth "UP" Conference was attended by 140 youth in the North Country on September 21, 2018 at the Mountain View Grand in Whitefield. Students were encouraged to show up, stand up, and speak up to promote healthy school culture. The conference welcomed national speaker Tony Hoffman who shared an incredibly inspiring recovery story. Also, in September 2018, The North Country Health Consortium (NCHC) & the NH Oral Health Coalition hosted "*Putting the Mouth Back in the Body: The Role of Oral Health in Addiction, Treatment and Recovery*." Participants learned about local community oral health programs and partners, low cost solutions to caries management, payment sources for dental and oral health, and community-based public health hygienists.

The SMP team has also been involved with Law Enforcement Against Drugs (LEAD), an organization that supports local law enforcement officers by training them to teach students in the classroom about drugs, bullying, and violence prevention. LEAD uses the only K-12 evidence-based program by partnering with the Mendez Foundation to use their 'Too Good For' curriculum. NCHC has 2 initiatives focused on the region's young adult population, ages 18-25: Young Adult Strategies and Young Adult Leadership.

NCHC sent 2 staff to the NAMI Young Adult Prevention Training on Mental Health, Substance Use & Suicide Risk to become young adult trainers, as a strategic plan to repeat the training across the Region during 2019. The two young adult leaders also attended a film screening event of Kevin Hines: "Suicide: The Ripple Effect" on October 30th, 2018. This event served as a starting point for a conversation with other young adult trainers around the state on how to address substance use disorder and suicide prevention moving forward. The young adult trainer program will focus on bringing substance use disorder and suicide risk awareness to 18-25-year-olds. Carroll County Coalition for Public Health also held the NAMI

Young Adult Prevention Training on Mental Health, Substance Use & Suicide Risk training for community members to participate in. NAMI staff and the 2 NCHC staff traveled to train participants on the subject to increase capacity to prevent suicide and the burden of mental health and substance use issues among the region's young adults.

C3PH participated in multiple activities relating to fighting the opioid crisis and has been a pivotal player in many collaborations. The partner's CoC participated in a newly formed meeting designed for treatment providers and recovery coach volunteers to come to share updates, resources and build collaboration. At this Medication Assisted Treatment Providers meeting at Mount Washington Valley Supports Recovery the CoC was able to meet providers and coaches in person and offer the support of the public health network. The partner has also been a crucial participant in the Peer Recovery Support Network meetings to help facilitate the collaboration between the region's Recovery Community Organization as they work to set up emergency response dispatch systems that would link recovery coaches to individuals in need at emergency departments. C3PH was also a major participant in the development of a local video that was produced highlighting the work happening in northern Carroll County to respond to the needs of individuals and families impacted by SUD across the continuum. The video was shared with NH BDAS, NH DHHS and featured at the quarterly regional meeting of the IDN Region 7, and well received by audiences in those offices across the state.

Region 7 IDN will continue collaborating to strategically address the opioid crisis and leverage each other's work to avoid duplication. The programs will continue to provide education, raise awareness, and prevent substance use disorders. The regions' coalitions will continue to work together to be a community voice and youth groups will be used to help reach the school-aged population. Statewide and local initiatives coming to the region will complement these efforts and help move the region toward recovery.

Community Input:

The Region 7 IDN is diverse with significant geographic barriers between the communities it serves. The IDN works closely with partners to understand the unique characteristics and needs that their local areas present individually and collectively. This requires active and ongoing engagement with representative stakeholder groups to identify, target and address needs in a meaningful and effective way. The goal of these conversations is to help agencies create sustainable systems which promote integrated healthcare and enable the region to articulate the impact the IDN project.

The IDN's community engagement workgroup gathers input from the community regarding needs and IDN activities within the Region. The community engagement workgroup also strategizes and plans with partners how to best present the IDN to the community and ensure visibility of the IDN's work. This has included maintaining a Region 7 IDN Facebook page that shares relevant information with partners and community members as well as refreshing the IDN website. In addition, the IDN webinar series aids in creating community awareness of the IDN and its mission. The discussions and questions that occur during these webinars assists the IDN team to better understand the needs of the community.

IDN 7 Partners recognize how important it is to engage patients and families on multiple levels to assure that IDN work is done with their feedback as well as their insight and investment. Critical to the work of creating and embedding evidence-based systems of integrated care is the assurance that patient and family provide feedback as systems and polices are developed. Partners play a key role in engaging patients and families to provide feedback about specific services. Ammonoosuc Community Health Services Board of Directors is comprised of multiple representatives and disciplines, including patients. Northern Human Services also has patients and family members on their Board of Directors and has continued to use their annual patient satisfaction survey to assess quality of care.

Currently, Coos County and Northern Grafton County have five coalitions combined, made up of community members who are doing their part to fight the opioid epidemic. North Country Health Consortium's Substance Misuse Prevention Coordinator helps facilitate and provide direction for the

coalitions who are dedicated to reducing the incidence and effects of alcohol, tobacco, and other drug use in their communities. Regional coalitions include Littleton Alcohol, Tobacco & Other Drugs Coalition (ATOD), Lancaster/Groveton Coalition, Haverhill Area Substance Misuse Prevention Coalition (HASMPC), Stand Up Androscoggin Valley (SUAV), and North Woods Action Committee (NWAC).

In August 2018, NCHC hosted the Bi-Annual Coalition Learning Collaborative at Echo Lake attended by 25 participants including members from all five regional coalitions as well as neighboring Vermont Coalitions. Multiple presenters including Staff Sergeant Rick Frost of the N.H. National Guard Counterdrug Task Force, IDN 7 staff, and staff from the Teen Institute presented on topics related to drug recognition, harm reduction strategies, local substance misuse prevention efforts, and youth engagement topics.

The Carroll County Coalition for Public Health (C3PH) continues to be an active partner in the region and have staff who routinely participate in the IDN Community Engagement Workgroup. C3PH staff coordinate and attend a variety of community forums focused on assessing public health needs and priorities in order to inform their community health improvement plan and are instrumental in sharing DSRIP related information.

The hospitals in Region 7 IDN play a key role in aggregating community input through their Community Health Needs Assessment process and related public documents. As part of the Memorial Hospital Community Health Needs Assessment, C3PH Continuum of Care (CoC) facilitator participated in a public forum held by Memorial Hospital to share data about current health trends in the region as well as to collect community input about perceived top priorities in health issues.

Carroll County has done impressive work to engage the community to participate in many initiatives to express their support. The Carroll County CoC had an opportunity to meet a newly relocated trained recovery coach. This recovery coach became a new member of the SMP/CoC Stakeholder workgroup. C3PH held bi-monthly SMP/CoC meetings in October and December 2018. The detailed minutes with follow up links and action items are shared not only with the average of 20 regular participants but with a larger email list of 190 subscribers throughout the community. The combined SMP/CoC Stakeholders Workgroup included participation of 29 community members representing 22 different agencies, including state legislature candidates and concerned citizens. The C3PH bi-monthly workgroup attracted the first-time participation of three state legislature candidates who became more informed about local SUD public health issues before the November election. All have stayed engaged regardless of the outcome of their personal bid for office. Carroll County Coalition for Public Health continues to be an asset to the region regarding community outreach, input and engagement. They will continue to work with stakeholders and community members to improve systems and services throughout the county.

Network Development:

Region 7 IDN continued to foster relationships between partners over the past six months, improving current partnerships and creating new ones. The region held two quarterly meetings that continued to allow partners to participate in collaborative conversations and update the region on their progress. IDN partners have expressed how valuable these meetings have been in coalescing their understanding of IDN goals and reinforcing their shared commitment to learning what is happening in the region and facilitating ideas for further collaboration.

The partnerships that have stemmed from this DSRIP funding continue to flourish and impact the region. An IDN funded project involving Memorial Hospital, Saco River Medical Group, Children Unlimited, and Visiting Nurse Home Care & Hospice has made great progress in the Carroll County area. The project has strengthened relationships between the four agencies and community partners throughout the region. The project has resulted in the creation of a 9-minute video explaining the IDN and the work that the agencies have been doing to improve the health of the community. The video was shared with Region 7 IDN at the December quarterly meeting and Carroll county partners have been sharing it region wide in hopes of reaching all levels of the community.

White Horse Addiction Center and Mount Washington Valley Supports Recovery submitted a proposal to develop an 24/7 emergency peer recovery support service program for Carroll County. The request was approved contingent on the results of the Strength, Weakness, Opportunity, Threat (SWOT) analysis for White Horse Addiction Center and available funding. The four recovery community organizations in the region have also been working together throughout this period to develop a strategy to implement a Regional Peer Recovery Support Service Network. The agencies will continue to have conversations on how to proceed with developing coordinated systems which will be sustainable and not duplicative of other initiatives in the region.

North Country Serenity Center continues to collaborate with Ammonoosuc Community Health Services to help their clients receive medical care. Conversely, they agree to provide recovery support services to ACHS patients who have been seen in the ED. The partners have developed a referral process and are working to develop strategies to close the loop during the process. ACHS enjoys collaborative relationships with local schools to provide students with behavioral health services. They also have an agreement with Friendship House to provide clients with physicals required for admission.

Northern Human Services and Coos County Family Health Services opened their CrossRoads Clinic in July and have seen an improvement in the care of patients from both agencies due to this collaboration. NHS submitted a proposal to replicate this integrated health clinic in Littleton with ACHS. NCH – Weeks Medical Center, Indian Stream Health Center and NCH – Upper Connecticut Valley Hospital have also partnered with the aim of expanding the Medication Assisted Treatment program to Northern Coos County.

Huggins Hospital received funding from Health Resources and Services Administration to be a Rural Health Network. Huggins launched the project in 2018 to create a strategic partnership to promote optimal community health and well-being by delivering screening, referral and navigation services to address the community's social determinants of health. They are building a Rural Health Network of multi-sector stakeholders to identify and pinpoint community needs, identify unmet needs and gaps in services, and develop a collaborative plan to build capacity and improve services. The goal of their planning grant is to build a strong and sustainable Network, which depends on including the right partners. The Network's programmatic focus areas are (1) integrated mental/behavioral health and substance abuse services, including needs arising from the opioid epidemic, and (2) the needs of the aging rural population including those related to chronic disease and healthy aging. The first activities of this Planning Grant are to mature the Network infrastructure and vision, as well as conduct a service gap analysis and strategic planning. The next activities of this Planning Grant are to establish a "no wrong door" system of social needs screening, referral and navigation of residents to health and social services to address the social determinants of health, and a system of "hotspotting" services to geographic areas and residents of greatest need. The social determinants model is guided by the promising practices of the CMS Accountable Health Communities demonstration model that screens, refers and navigates residents to services to address unmet health-related social needs. The evidence-based Healthcare Hotspotting program designed by the Camden Coalition in Camden, NJ, will assure that data is used strategically to allocate resources and services where they are needed most in the community to promote optimal health outcomes. This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Grant number P10RH-31838.

The collaborations within Region 7 IDN help partners on many levels, from cementing professional relationships, to building trust and social capital necessary to begin thinking of patients as common consumers of care, rather than in separate and discrete "billing" encounters. This is seen as integral to moving not just toward but into the integration of behavioral health with primary care services, as a real paradigm shift in healthcare. The vision of enhanced treatment that is effective and accessible for all is the center of the work that brings the partners together.

Region 7 IDN Total Project Budget -PPI

Project	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
PPI	$ 66,115	$ 1,148,128	$1,156,435	$878,004	$2,653,647	$2,653,647	$1,326,824
A1	$15,956	$277,087	$229,443	$194,706	$646,563	$646,563	$323,282
A2	$8,822	$153,205	$332,433	$179,030	$332,228	$332,228	$166,114
B1	$25,576	$444,143	$367,152	$310,449	$1,030,999	$1,030,999	$515,499
C	$5,254	$91,231	$75,802	$64,607	$214,619	$214,619	$107,309
D	$5,254	$91,231	$75,802	$64,607	$214,619	$214,619	$107,309
E	$5,254	$91,231	$75,802	$64,607	$214,619	$214,619	$107,309

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

DSRIP IDN Process Milestones

DHHS will use the tool below to review and document each IDN's Implementation activity. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet				

Project A1: Behavioral Health Workforce Capacity Development

A1-3. 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.

During the reporting period of July 1, 2018-December 31, 2018, Region 7 IDN had no new members join the network, and no members leave.

Region 7 IDN continues to make 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 continues to be 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 to the region addressing workforce issues, specifically those related to education, training, recruitment, and retention. Region 7 IDN's Executive Director continues to serve as the Vice-Chairperson of the Behavioral Health Workforce Taskforce, as well as Co-Chairperson 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.

As of September 2018, the Statewide IDN Training and Education workgroup made the decision to start meeting bimonthly. The September and November meetings focused primarily on workshop topics and presenters appropriate for a clinical track at the annual New Hampshire Behavioral Health Summit. This led to the partnership between North Country Health Consortium/ IDN 7 and Northern Vermont Area Health Education Center to provide a Continuing Medical and Continuing Nursing Education track at the annual NH Behavioral Health Summit on December 10 & 11, 2018 in Manchester, NH. This state-wide conference targets behavioral healthcare providers and organizations including mental health and substance use disorders. This year, planners felt it was important to encourage more providers and nurses to attend by providing a continuing education track for them. Over the course of the 2-day event, up to 9 continuing education credits were available for providers and nurses. From the live event, six – 90-minute sessions were recorded and will be available online for continuing education credits through an online Moodle platform that the North Country Health Consortium administers. Each of the 7 Integrated Delivery Networks agreed to support this clinical track; the sessions are available at no charge across the state to the IDN partner members.

The webinar topics soon to be available online include:

- The Community Care Team: A Model Strategy for Systems Alignment
- Understanding and Addressing Substance Use Disorders as Chronic Medical Conditions
- Enhanced Care Coordination for High Needs Populations from Multiple Perspectives
- Core Competencies for Primary Care Behavioral Health Integration: Knowledge, Skills and Attitudes
- Chronic Disease information for Behavioral Health Providers
- Facilitated Integrated Care Success with Co-Occurring Disorders: A Case Study

Other discussions included the possibly of creating and utilizing a centralized state-wide training calendar and an update on the progress of the next Health Career Catalog with the integration of behavioral health professionals from the NH AHEC. IDN 7 Team members and Northern AHEC staff at NCHC have been working closely with Southern AHEC to edit and develop content for the 5th edition Health Career Catalog. The seven IDN's have agreed to support the development of this catalog to allow creators to incorporate more behavioral health careers and emerging careers that are blossoming throughout the region.

<u>Staffing:</u>

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

- Ammonoosuc Community Health Services hired a new patient coordinator and a school-based Licensed Independent Clinical Social Worker.
- Cottage Hospital hired a Licensed Clinical Social Worker to work 32 Hours per week. They also hired a Certified Medical Assistant and a Chronic Care Management Nurse for the Internal Medicine department. Cottage also hired 2 APRNs in Primary Care/Internal Medicine. The partner los one Chronic Care Nurse and 2 APRN's during this period.
- Friendship House hired 5 Recovery Support Staff and an intake coordinator. They lost 5 Recovery support staff and a program advisor.
- Huggins Hospital hired a new nurse care coordinator, a Rural Health Program Coordinator and a family nurse practitioner.
- Indian Stream Health Center hired 3 new nursing staff, 2 for ISHC and 1 for school health. They also hired 2 medical assistants with one later leaving. One pharmacy tech and one medical provider was hired as well. ISHC has been actively recruiting for 1 LICSW and 1 Pharmacist.

- NCH – Littleton Regional Healthcare hired a Behavioral Health Counselor who is a social worker currently working through supervision in order to get their LICSW. They also hired a registered nurse for and a medical assistant float for adult primary care, along with a per diem medical secretary. NCH-LRH lost a pediatric RN, a RN/Patient Care Coordinator for the ACO, a physician for adult primary care, a practice manager for the ACO and a per diem Physician for pediatrics. The practice shifted staff to mitigate these losses resulting in an adult primary care RN moving to an ACO RN/Patient Care Coordinator, an ACHO RN/Patient Care Coordinator moving to an ACO Practice Manager and an Adult primary care medical assistant to a primary care/ACO clinical team leader.
- Memorial Hospital hired a Psychiatric Nurse Practitioner, a MAT waiver PCP, and a general PCP. They had 1 primary care nurse practitioner leave the agency.
- Northern Human Services hired 5 case managers, 2 Licensed Mental Health Clinicians and 1 psychiatrist. The agency lost 4 case managers and 9 LMHCs.
- Saco River Medical Group hired a new primary care physician who is MAT waivered and 2 nurses. The agency lost on nurse and 3 reception staff.
- NCH – Weeks Medical Center hired 4 receptionists, a specialty medicine practice manager, two medical assistants, a behavioral health APRN, a primary care APRN, a social worker (BSW), a communications assistant, an office coordinator the MAT program, a behavioral health case manager, a new physician, and one RN.
- Whitehorse Addiction Center hired 2 administration staff to support billing and RCO. They also hired 2 LADC candidates, 3 CRSW candidates. The executive director resigned resulting in a transformation of their leadership structure mentioned in D3.
- Tri County Community Action Program hired a Director of Compliance, trained 4 individuals in CTI, 1 trained as a CTI trainer and 3 staff members completed the Community Health Worker course. The agency lost their Carroll County CTI specialist due to unforeseen family emergency. The partner will begin actively recruiting for the CTI program once IDN funding is secured.
- North Country Serenity Center lost 2 employees during this period. In their place the RCO hired 1 new CRSW, a new volunteer coordinator, and 1 administrative assistant.
- We have been able to recruit and enroll three behavioral health students in the *Live, Learn, Play in Northern New Hampshire (LLP-NNH)* Program for late fall and into early 2019. They include:
    - A Master's Level Social Worker interning at Northern Human Services August 2018 through May 2019.
    - A Bachelor level Psychology major interning at White Horse Addiction Center May 2018 to March 2019.
    - A Master level Social Worker interning at Rowe Health Center, starting in January of 2019 through August 2019.

These students will receive an educational stipend in the amount of $1000 each after successful completion of a community service project as part of the program requirements.

In addition to these students, we are anticipating more behavioral health students at different Northern Human Service sites and a new student at Friendship House interested in the program in upcoming 2019. Follow up is planned with our partners at Memorial Hospital in early January for planned UNH psychiatric nurse practitioner students.

Northern NH Area Health Education Center also has 4 medical students from the University of New England enrolled in the Live, Learn and Play Northern NH clinical program. The Northern NH AHEC Workforce and Education Coordinator has provided multiple resources to the medical students to help them better understand the Integrated Delivery Network system of New Hampshire. At least two of the medical students are planning projects related to integrated health; one on the topic of opioid Infant Neonatal Abstinence Syndrome. The second on patient education related to overall holistic approach to wellness integrating healthy eating, exercise and education related to diabetes management.

Mental Health First Aid

NCHC's two Mental Health First Aid trainers continued to work together to bring more trainings to the region between July-December 2018. The trainers were able to bring a third MHFA training to Huggins Hospital in Wolfeboro to train an additional 21 staff members. The training took place on October 26th bringing the number of MHFA trainings to four for 2018. The region was successful in training a total of 93 partners for 2018; this period has helped Huggins exceed their targeted number of staff members trained. The region plans to work with remaining partners that expressed need previously to help them achieve this goal during the next six months. On the evaluation survey participants expressed two changes they would make as a result of the session. A participant expressed that they plan to "be a better listener without judgement" and another participant explained that the training gave them "more confidence and tools to use as a nurse to help my patients with mental illness or drug/alcohol abuse." These quotes demonstrate the impact this training has on one the staff members and how it will begin to impact the care they give to patients.

Shared Use of Resources

North Country Healthcare continue to be the champions regarding shared use of resources. NCH has put significant effort in enhancing their regional care coordination department that spans across the entire affiliation. Affiliates Weeks Medical Center, Littleton Regional Hospital, Androscoggin Valley Hospital and Upper Connecticut Valley Hospital all share care coordinators and processes for care coordination. The partners have also worked to build capacity for the HUB funding that is coming into LRH and AVH from the state to address the opioid epidemic. NCH plans to leverage IDN resources to bring enhanced services to the region through care coordination and HUB services.

Northern Human Services continues to be an asset to the region as the region's only community mental health center. NHS has worked with NCHC IDN staff to finalize an agreement to provide psychiatric consultation throughout the region to stand up MDCT's with other partners. NHS has continued to work closely with Huggins Hospital and White Mountain Community Health Center on their MDCT. NHS has many shared patients with fellow partners and shares resources regularly throughout the region. NHS has been working with Coos County Family Health Services to provide integrated care to mutual patients and plans to replicate this project with Ammonoosuc Community Health Services.

Region 7 IDN team will continue to share resources and opportunities to partners via Basecamp and Constant Contact to help improve collaboration throughout the region. Basecamp will allow partners to share resources they have created and request guidance to appropriate resources as needed. The new Policy and Protocol Clearinghouse will be exceptionally useful for sharing resources between partners as they all work toward integration.

Centralized Peer Recovery Support

The Centralized Peer Recovery Support Network has been discussion at length throughout this reporting period. The IDN team has facilitated two collaborative planning meetings with the four Recovery Community Centers of Region 7 to strategize the most effective way to develop the Peer Recovery Support Network. The group met in August and October to discuss models that will be the most effective, efficient and sustainable between all agencies. The 4 RCO's have worked to build capacity to create this network together over the past 6 months, which includes increasing staff and adding more services.

A tentative model was suggested which will involve creating two hubs, one for Carroll County and one for Northern Grafton and Coos with each hub containing 2 RCOs. The hubs would be overseen by an advisory board to provide guidance for all four RCOs which will include help with the development of systems and processes for referrals and establishing a peer recovery workforce that is equipped to be deployed to clients in their time of need. The RCOs felt it was important to leverage existing initiatives as the model is developed. The group plans to reconvene in early 2019 to learn more about the implementation of NCHC's WARM model and the NH Doorway hub model, and then discuss next steps in the implementation of this regional approach.
The Recovery Coach Academy training plan started in July 2018 with the following trainings held throughout the reporting period:

- 7/25/2018: Ethical Considerations for Recovery Coaches; trained 13
- 8/9/2018: HIV/AIDS; trained 13
- 8/23/2018: Suicide Prevention;16
- 9/13/2018: Recovery Coach Academy; 8
- 10/11/2018: Recovery Coach Academy Train the Trainer, trained 6
- 11/5/2018: Ethics Training; trained 13
- 11/7/2018: Ethics Train the Trainer; trained 4
- 11/14/2018: Suicide Prevention Training; 26

The trainings had impressive participation and helped build the region's peer recovery network substantially. Multiple participants have taken all or most of the trainings required to become a Certified Recovery Support Worker, which will help create sustainability in the Region. Currently, 8 partner staff have been trained in 3 out of the 4 topics needed to move forward in becoming a CRSW and several partner staff have taken more than 1 training to move toward CRSW.

Region 7 IDN plans to continue the Recovery Coach Academy training plan through 2019 to increase the workforce and more Recovery Coaches toward CRSW certification. The remainder of the original 2018 PRCA Training plan is below:

HIV/AIDS	March 2019
Peer Recovery Coach Academy	April 2019
Peer Recovery Coach Academy	September 2019
Suicide Prevention	October 17, 2019
Ethics	November 2019
HIV/AIDS	December 14, 2019

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	6
# 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	2
# of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018	0	0	0
Expanded supervision for master's level clinicians	1 by 2018	0	0	1
# contracts in place in Region 7 for consultation with psychiatrists as member of multidisciplinary teams	1 by 2018	0	1	1

Statewide workforce shortages related to LADCs has made it challenging for the region to meet the metric of having mobile LADCs ready to deploy to area agencies as needed. Despite extensive advertising efforts to recruit LADCs Friendship House still has vacancies for these positions, and as a result does not have staff readily available to deploy to agencies as needed. NCHC will continue recruitment efforts and will work with other area agencies to see if there are any LADCs in the area who could be deployed on an as needed basis. In addition, Region 7 IDN will continue to leverage the work of NCHC's new Wellness and Recovery Model (WARM) and the 2 NH Doorways in the region to develop a network of mobile LADCs throughout the region.

Friendship House was able to expand supervision for master's level clinicians by shifting around responsibility of an existing MLADC so their role now includes supervision of LADC staff and providing peer collaboration for newly licensed MLADCs. Clinical Supervision training will be offered to applicable staff at Friendship House through NCHC's Relias Learning Management System as a way to augment their supervisory skillset.

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	14
Licensed Mental Health Professionals	23 by 2018	14	18	16	9
Peer Recovery Coaches	6 by 2018	2	22	59	67
CTI Workers	15 by 2018	0	11	24	37
CTI Supervisors	3 by 2018	0	3	3	3
Community Health Workers	4 by 2018	0	13	13	13
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2	5	7
Care Advocates	15 by 2018	0	0	5	11
Other Front-Line Provider	1 by 2018	0	10	16	52
Care Advocate Supervisors	1 by 2018	0	0	1	1
Case Management	2	2	4	6	15
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Physician assistant (round 1 funds for baseline 6/30/17)	1	1	1	3	3
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	4
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	7
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	4
IDN QI Coach	1	0	0	1	2

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
HIT Integration Coach	1	0	1	1	1
IDN Data Specialist (NCHC)	1	0	0	0	1
Data Specialists for IDN partners	Up to 3	0	0	0	3

Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care.

Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.

Region 7 IDN held two Regional Care Coordination trainings during 2018. This was a shift from the original 3 that were planned, one for each county. The northern Grafton and Coos County training was combined into one training to better fit IDN partner needs, specifically those of North Country Healthcare affiliate organizations. North Country Healthcare only sent 2 staff instead of 1 from each affiliate agency, and other partner agencies chose not to send staff because of the need to serve patients, so the region did not meet metrics for the number of care coordinators trained. The Carroll County training had two individuals who were partially trained during the 2-day training that were not counted in this measure, however they received valuable content from the day they attended. Region 7 IDN staff will adapt the care coordination training into webinar modules to make the training easier to access.

After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT lead at NCHC. In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coos County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coos County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

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 Dec. Actual	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	$229	$26,751	$26,751	$13,376
6. Travel	$ 2,233	$1,108	$873	$17,883	$17,883	$8,942
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	$0	$1,011	$1,011	$505
10. Marketing/Communications	$ 3,272	$1,722	$5,416	$23,554	$23,554	$11,777
11. Staff Education and Training		$1,547	$1,786	$35,145	$35,145	$17,573
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	$1,276	$4,323	$4,323	$2,161
Support Payments to Partners	$ 198,135	$181,979	$130,609	$476,689	$476,689	$238,345
TOTAL	**$ 211,479**	**$190,586**	**$140,189**	**$585,357**	**$585,357**	**$292,678**

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

IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

Region 7 IDN has numerous positions listed within A1-5 that don't impact the budget in A1-6 because most of these positions are existing care coordinators at our partner agencies who are not supported by IDN funds, or agencies request for funds to support salaries through the regions' subrecipient process.

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, D3, E5
White Mountain Community Health Center	Non-FQHC Community Health Partner	A1, A2, B1, D3, E5
Memorial Hospital	Hospital Facility	A1, A2, B1, D3, E5
Huggins Hospital	Primary Care Practice; Hospital Facility	A1, A2, B1, D3, E5
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services	A1
Life Coping, Inc.	Community-based	A1
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
NCH – Androscoggin Valley Hospital	Hospital Facility	A1, A2
Coos County Family Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
NCH – Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	A1, A2, B1, D3, E5

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
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	A1, A2, B1, E5
NCH – Upper Connecticut Valley Hospital	Hospital Facility	A1, A2
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
NCH – Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	A1, A2, B1
Cottage Hospital	Hospital Facility	A1, A2
Rowe Health Center	Rural Health Clinic	A1, A2, B1
North Country Health Consortium (NCHC), NCHC Clinical Services & Friendship House	Substance Use Disorder Treatment (After 10/01/2017), Community-based Organization providing social and support services	A1, A2, B1, D3, E5
Mount Washington Valley Supports Recovery	Peer Recovery, Transitional Housing	A1, D3
North Country Serenity Center	Peer Recovery	A1, D3
Tri-County Community Action Program	Community-Based Organization	A1, C1
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
Visiting Nurse Home Care & Hospice	Skilled nursing, home health, homemaker	A1
Grafton County Nursing Home	Skilled nursing	A1
Hope for NH Recovery	Peer Recovery	A1, D3

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.

During the reporting period of July 1, 2018-December 31, 2018, Region 7 IDN had no new members join the network, and no members leave.

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

Hospital	ADTs sending	Goal Date	PreManage ED Implementation	Goal Date
NCH – Androscoggin Valley Hospital	Yes	n/a	No	05/31/2019
Cottage Hospital	No	03/31/2019	No	05/31/2019
Huggins Hospital	Yes	n/a	Yes	n/a
NCH – Littleton Regional Hospital	No	07/01/2019	No	07/30/2019
Memorial Hospital	No	09/01/2019	No	10/31/2019
NCH – Weeks Medical Center	Yes	n/a	Pending	02/15/2019
NCH – Upper Connecticut Valley Hospital	Yes	n/a	No	05/31/2019

Updates:

Because of the unified manner of the approach to event notification and shared care plan utilities, the updates for hospital agencies are covered in the next section A2-3 Component 12.

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

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

Ammonoosuc Community Health Services: ACHS is currently not working on shared care plan implementation. IDN staff will continue to discuss how this can help the team and clients of ACHS.

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 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 ongoing communications and one meeting with their team that included a demo of the shared care plan, but it has been difficult to gain approval to proceed. As this hospital is near the Maine border and they are now 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 although time and resources has been a constraint. 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 Medical Center 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. NCH – 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 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 to work with the organization on planning for addressing IDN goals. This work is under way and the SCP is part of that discussion. They have also engaged legal help to review contributing ADT feeds to the CMT network.

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 has not been engaged in SCP implementation to date. But at the end of this reporting cycle, IDN staff met with the organization to review progress towards IDN goals and after walking through SCP features and benefits, they agreed to a demonstration with Collective Medical. That meeting has been scheduled and it is expected that the organization will engage implementation steps in the early part of 2019.

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: During this reporting period, NHS met with Collective Medical and IDN staff several times about shared care planning. They have seen a demonstration of the product and completed required pre-implementation paperwork with CM. They identified their initial cohort for using the SCP to be clients receiving services from the ACT team as this a group of complex clients with high utilization of services. NHS completed significant due diligence on consent requirements and related processes. They are working on obtaining written consent from their target population. This is a process that will require time to complete as many consumers have guardians or may not appear for appointments. NHS has also worked to develop best practices for communication about integrated care and shared care planning with staff and clients. In this reporting period they have trained all staff on this process and introduced a brochure for clients that explains collaborative care and addresses common questions asked such as: What is the CMT Network? What are EDIE and PreManage? Who is on my "Care Team"? What does "Treatment" include? Am I required to participate in EDIE/PreManage or can I opt-out? Will signing this Special Consent Form affect other consents or authorizations I have signed? Northern plans to complete an initial census upload early in 2019 and begin live use of the product at some point in the late winter or spring.

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 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.

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

Ammonoosuc Community Health Services: ACHS uses capacity in their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.

Huggins Hospital: The hospital has direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.

Indian Stream Health Center: ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.

North Country Healthcare Hospitals: The North Country Healthcare affiliation includes Littleton Regional Hospital, Weeks Medical Center, Androscoggin Valley Hospital, and Upper Connecticut Valley Hospital. All four organizations are implementing Imprivata as a secure messaging platform. It was originally planned that this would be live by end of 2018. But it was identified that the NCH hospitals had to first finalize implementation of active directory across all four hospitals to support this platform.

This has delayed rollout of the Imprivata which is now targeted for use by the end of the first quarter 2019. The organization also maintains patient portals for communications appropriate for that channel.

Northern Human Services: NHS had previously installed DSM functionality, but vendor issues prohibited them from using the functionality. A new upgrade that is forthcoming for their Netsmart LWSI Essentia electronic record will include a HISP and NHS plans to take advantage of this to engage direct secure messaging. Targeted upgrade completion is February of 2019.

White Mountain Community Health Center: WMCHC has a patient portal that they use to communicate with patients if the patient is registered. They do not currently have other secure messaging technology to provide email communication with other providers or clients.

Saco River Medical Group: The practice is fully functional with patient portal and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with don't have DSM and can't engage them in this form of communication.

Coos Family Health Services: DSM has been in place for a number of years at CFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers. Changes related to NHHIO did require the implementation of a new HISP with MedAllies. The organization can send direct secure messages to anyone in the Surescripts directory or anyone who has some sort of connection to a HISP. They can also use the secure messaging platform to communicate via DSM to anyone with a valid email address. This is done via a process where the end user receives a generic notification that they have a secure message to retrieve from the CFHS Secure Message server. They then log-in to view/retrieve their message.

Memorial Hospital: The hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to perform secure text messaging.

Project Component ¼ 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 has come on sporadically in the intervening months, Region 7 is not ready to initiate a fully study via an HIT Utilization survey. However, the HIT Integration Coach continues to follow up directly with B1 user-organizations in the Region like CCFHS and White Mountains to discuss utilization, challenges, successes and next steps. The Integration Coach also offers support through the coordination of the IDN 7 Webinar Series, newsletter work and Basecamp posting. As the active cohort grows, Region 7 will formalize this follow up and institute a survey as indicated above.

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 pursues a regional data management infrastructure as an HIT project component.

Project Component 2/1: Regional Data Infrastructure Buildout

The most pressing need for data management is to create a regional structure that will accommodate reporting on outcome measures for all 6 DSRIP projects in a regional manner. The period covered by this report (07/01/2018-12/31/2018) contained work on two separate reporting deadlines (the first, which was due in August, and the third which will be due in February 2019) as well as a historical data request from calendar year 2015 on two of the Care.03 measures.

The second reporting period, covering the six-month period 01/01/2018 to 06/30/2018 was successfully completed by 8 of our B1 partners, up from 5 in the first reporting period. In addition to Huggins Hospital, Ammonoosuc Community Health Center, White Mountain Community Health Center and Indian Stream Health Center, the following newly engaged partners submitted at least denominator data in the second period: Northern Human Services, Coos County Family Health Services, Saco River Medical Group, and Cottage Hospital/Rowe Health Center. Memorial Hospital was the only partner to report in the first period but not the second.

The historical data request was fulfilled by all 7 of the 8 partners who reported in the second reporting period, with only Huggins unable to fulfill this request due to a lack of staff availability for some unavoidable manual extraction for this request. Memorial Hospital was also unable to engage on this request due to an ongoing I upgrade.

The remaining providers (North Country Healthcare, Friendship House, White Horse Addition Center) did not engage because of administrative hurdles, which have since been cleared and all are engaging with MAeHC and IDN Region 7 in pursuit of reporting in the third period.

Additionally, Region 7 is pleased to note that Memorial has completed their I upgrade and has re-engaged, bringing Region 7 to a full participation in reporting by appropriate partners for the first time in the project.

Please see the list below for the snapshot status of partners regarding the reporting requirement. More details are provided in the partner by partner updates later in this same section.

Provider	First Reporting Period Status	Second Reporting Period Status	Historical File Submission 10/15	Projected Status for Third Period
Ammonoosuc Community Health Services	Complete	Complete	Complete	Complete
NCH – Androscoggin Valley Hospital	*	*	*	*

Coos County Family Health Services	Did not report (held data back because of 42 CFR Part 2 concerns)	Complete	Complete	Complete
Cottage Hospital/Rowe Health Center	Did not report	Partial	Complete	Complete
Friendship House	Did Not Report	Did Not Report	No patients in sample	Complete
Huggins Hospital	Partial	Partial	Did Not Report	Complete
Indian Stream Health Center	Complete	Complete	Complete	Complete
NCH – Littleton Regional Healthcare	*	*	*	*
North Country Health Care	Did Not Report	Did Not Report	Did Not Report	Partial
Northern Human Services	Did Not Report	Complete	Complete	Complete
Memorial Hospital	Partial	Did Not Report	Did Not Report	Partial
Saco River Medical Group	Did Not Report	Complete	Complete	Complete
NCH – Upper Connecticut Valley Hospital	*	*	*	*
NCH – Weeks Medical Center	*	*	*	*
White Horse Addiction Center	Did Not Report	Did Not Report	No patients in sample	Partial
White Mountain Community Health Center	Complete	Complete	Complete	Complete

*See entry for North Country Health Care

Partner by Partner Updates:

Ammonoosuc Community Health Services:

ACHS has been a model partner in terms of data reporting and has satisfied all requirements on time. They appear to be on track to report successfully in the third period, and we expect numerator performance from them on CCSA, given work they have completed internally to align their screening tools to accommodate this process.

NCH – Androscoggin Valley Hospital

As AVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.

Coos County Family Health Services:

Though CCFHS held back in the initial period due to concerns around 42 CFR Part 2, explaining the process to them cleared the path for them to report successfully in the second and historical requests. Staff shortages have resulted in them using IDN training and technology request funding to engage MAeHC directly for data extraction assistance. It is hoped that through this process CCFHS can create a sustainable process for reporting data to MAeHC in monthly files rather than batch reporting at the end of each reporting period.

Cottage Hospital:

Technical limitations prevented Cottage Hospital from reporting at all in the first reporting period, but through sustained work with MAeHC they have made great strides. They still have a gap in their reporting related to the SUD-Screening component of ASSESS_SCREEN_02 but they have fully reported in depression component and submitted denominators for ASSESS_SCREEN_01 and ASSESS_SCREEN_02. Recognizing that some of these limitations may be due to the configuration of their local I, Cottage Hospital has engaged their I vendor to work directly with MAeHC to build standard fields and reports to ease the reporting burden in the third period and beyond. However, the late institution of these changes may mean that the third period may reflect the historical challenges with Cottage's fields, an issue they share with Memorial and others.

Friendship House:

A wholly covered 42 CFR Part 2 Provider, Friendship House held back reporting in the first reporting period. In the second period, a site move took vital resources away from their ability to report. The state sample for the historical request did not have any Friendship House attributed patients. Now, approaching the third reporting deadline they are engaging with MAeHC with an eye towards reporting all 2018 data at once.

Huggins Hospital:

An early partner who has engaged with the IDN on many levels from day one, Huggins has nevertheless encountered several challenges related to the reporting of data for the statewide outcome measures, all of which have to do with their ability to pull the data in an automated way. They have reported some data for all periods requested, excepting only the historical request, which they were not able to process due to staffing shortages. For the third period they have engaged directly with MAeHC to help solve this issue.

Indian Stream Health Center:

ISHC engaged early on and has reported data in all periods as requested. They are on a monthly flat file submission schedule that allows them to fulfill the requirements without the strenuous last-minute effort.

NCH – Littleton Regional Healthcare:

As LRH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.

Memorial Hospital:

Memorial Hospital engaged with IDN Region 7 early on and was able to report some data for the pilot reporting period covering 07/01/2017-12/31/2017. However, an organization wide migration caused them to disengage for the second and historical request periods. However, in the leadup to the third period's reporting deadline they have engaged their I vendors directly with MAeHC in order to make the ongoing reporting as seamless and automated as possible. This coincides with clinical work to begin to implement the CCSA first in behavioral health providers and then in the totality of their primary care. Though the fruits of both the I modifications and the CCSA implementation occurred well into 2018, we would expect some results to show in their reporting for the latter half of that year. We would also expect much better performance for future reporting periods.

North Country Healthcare (NCH)

An affiliation that combines several partners, including the four hospital Androscoggin Valley Hospital (AVH), Littleton Regional Healthcare (LRH), Upper Connecticut Valley Hospital (UCVH) and Weeks Medical Center (Weeks), NCH accounts for a majority of Region 7 hospital partners and between Weeks and LRH, a large number of primary care patients in Region 7. However, the initiation of reporting the Statewide Outcome measures coincided with the action of affiliation by these partners, meaning that they were unable to engage directly with reporting until just recently. In recognition of their new status they asked to sign their data use agreements and engage as an affiliation rather than as individual partners. With all administrative hurdles cleared, the team assigned, led primarily by Weeks staff, have begun to approach the task of reporting. They are aided in this task by the fact that only LRH and Weeks have primary care arms, meaning that the immediate reporting period of 02/15/2019 they would be the primary focus.

Northern Human Services:

IDN Region 7's sole community mental health center, Northern Human Services represents a key partner for region 7, without whom many of the Behavioral Health goals of the IDN would be difficult or impossible to realize. Their novel proposal to collocate primary care directly in one of their sites (through a partnership with Coos County Family Health Services) was met with the full support of the IDN Region 7 steering committee. Their value to the Region stretches into the reporting of statewide outcome measures as well. Though they held back first reporting period data because of concerns around 42 CFR Part 2, the system modifications by MAeHC and the modifications to the data use agreement by Region 7 allowed them to fully report in the second and historical periods. Region 7 believes they will report fully again in the third period (deadline 02/15/2019).

Saco River Medical Group:

Saco River was unable to engage on the first reporting period, but engaged on the second. Despite being a smaller agency that lacked much in the way of traditional reporting infrastructure they were nevertheless able to report fully in both the second and historical reporting deadlines. They were able to do so because of the tireless support of their staff and their engagement of MAeHC directly in the data extraction process using IDN Training and Technology Funding request. Region 7 is hopeful that the structures set up by this investment will continue in the third period and beyond.

NCH – Upper Connecticut Valley Hospital:

As UCVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.

NCH – Weeks Medical Center:

As Weeks is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.

White Horse Addiction Center (WHAC):

A wholly covered 42 CFR Part 2 SUD-treatment provider, WHAC was not engaged in the first period. IDN Region 7 began outreaching to them over the late summer and fall, culminating in a productive face to face meeting in November that kicked off their involvement in numerous IDN initiatives including statewide outcome reporting. It is hoped that many of the lessons that are being learned working with Friendship House (use of the WITS system) can be applied here, as they are a similar provider. As of the time of this writing, they have a scheduled kickoff call for late January (the earliest time their staff could be available). It is hoped that, despite the short deadline, a small denominator may allow them to report manually for the 02/15/2019 deadline.

Summary:

Overall, Region 7 is very pleased with the progress that has happened in the last six months, seeing engagement from all targeted providers for the first time. Moreover, Region 7 is pleased with the hard work of these partners to catch up and, in some cases, modify their data systems to better interface with the IDN outcome measures. Many of the newly engaged have a long way to go in terms of catching up to the early high-performers (such as Northern Human Services and Ammonoosuc Community Health Services) but Region 7's ability to fulfill the reporting requirement is in a much stronger place now than on 07/01/2018.

Project Component 2/2: Population Health Analytics

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 had targeted implementation of such a tool at one partner agency by 12/31/2018. Region 7 had hoped to leverage relationships with the hospital affiliation and others who have existing ACO commitments to find and leverage population health analytics.

However, challenges based around funding uncertainty and regulatory hurdles to using existing tools like MAeHC's Quality Data Center and CMT's PreManage Community have hampered the ability of the region to move forward in this area – as has lack of desire on the part of partners – who drive the IDN through their proposal process – to engage in a Population Health-focused project.

If funding allows, Region 7 will initiate this process on the regional level by incentivizing participation by a partner or group of smaller partners in a lead-agency initiated Population Health Analytics project.

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

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

Funding for projects is in a delayed state because of uncertainty about availability of funds. HIT Proposals provisionally funded in the reporting period 07/01/2018-12/31/2018 which fall into the general IT categories include:

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

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

Funding for projects is in a delayed state because of uncertainty about availability of funds. HIT Proposals provisionally funded in the reporting period 07/01/2018-12/31/2018 which fall into the general IT categories include:

Partner Organization	Funding Provisionally Allocated	Project Description	HIT Component
Saco River Medical Group	$70,399 (agency total), MAeHC budget will be a subset of this)	As part of a larger collaborative proposal, Saco has requested funding to continue to engage directly with MAeHC (for 45 hours) to shore up their reporting capabilities.	Discrete Electronic Data Capture
North Country Serenity Center	$15,550	Hire and equip 1 full time data admin to assist with the collection of data on clients they are assisting with recovery.	Electronic Data Capture, Secured Data Storage, Discrete Electronic Data Capture
Northern Human Services	$2558.86	Equip technology needs (laptop, connectivity, etc) for second of two integrated Clinics – this time located in Littleton's Ammonoosuc Community Health Services location.	Electronic Data Capture, Secured Data Storage, Discrete Electronic Data Capture, Internet Connectivity
Tri-County Community Action Program	$1500	Equip connectivity needs (phone and mobile hotspot) for Critical Time Intervention-implementing staff to allow them to communicate and record encounters.	Internet Connectivty, Electronic Data Capture, Discrete Electronic Data Capture

NCH – Weeks Medical Center	$66365 (entire salary line item, medical assistant position not broken out)	As part of a proposal to expand MAT services at Weeks, a medical assistant position will be funded. One of this person's primary responsibilities will be entry into the EMR of all relevant screening and encounter data for MAT patients.	Electronic Data Capture, Discrete Electronic Data Capture
Mount Washington Valley Supports Recovery	$850	Purchase of a laptop and internet connectivity to support staff engaged in a 24x7 emergency response service for people experiencing addiction crisis in their area.	Internet Connectivity, Electronic Data Capture, Discrete Electronic Data Capture
White Horse Addiction Center	$2550	Purchase of 3 laptops and internet connectivity to support staff engaged in a 24x7 emergency response service for people experiencing addiction crisis in their area.	Internet Connectivity, Electronic Data Capture, Discrete Electronic Data Capture
Total	$23008 + some portion of the $136,764		

In addition to the traditional request for proposal process, IDN 7 has also offered its partners access to Training and Technology Request of amounts of up to $5000 for training and technology needs related directly to the goals of IDN 7. In the last reporting period, the following agencies requested and received

Partner Organization	Funding Provided	Project Description	HIT Component
Saco River Medical Group	$4680	Saco requested and was granted funding to engage directly with MAeHC to complete requirements for the second reporting period ending August 15th.	Discrete Electronic Data Capture
Tri County Community Action Program	$779	Tri-CAP requested and was granted funding to provide a newly hired community health worker with a laptop.	Electronic Data Capture, Discrete Electronic Data Capture
Coos County Family Health Services	$4900	CCFHS requested and was granted funding to engage directly with MAeHC to complete requirements for the third reporting period due in February 2019	Discrete Electronic Data Capture

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	3*
Number of Participants Exchanging Information Via Shared Care Plan Tool	13	0	0	3*
Hospitals Sending Event Notifications To PreManage ED	7	1	4	4**
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	15 (presence of capabilities only)	16 (presence of capabilities only)	10
Reporting Periods Successfully Completed (By 2020)	11	0	1	3
Pilot Participants Using Population Health Tool (By 2020)	5	0	0	0***
Region 7 Patient Lives In PreManage Primary (By 2020) – includes any patient on the census upload	19601	0	0	15,273
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	0	5 (11 funded)	8 (22 funded or provisionally 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.

Region 7 IDN is still working with IDN partners regarding use of direct secure messaging (DSM). The idea behind the DSM exchange measure was that it could be a standalone solution that could be used to connect partners that lack other methods to securely receive and transmit necessary information. When the region's implementation plan was submitted the plan was to cast a wide net over the entire IDN membership because it was unknown which agencies would be key to DSRIP projects. Now that there has been further definition of who are considered B1 partners are and who is involved in the various community driven projects, and potentially need to exchange protected health information, the target for this measure may not be appropriate. IDN staff has been working to find out which agencies have direct secure messaging capabilities, and during the recent reporting period key agencies were asked about actual use of direct secure messaging, versus only capabilities. The IDN team will continue to ascertain the use of direct secure messaging across IDN partners in the region during the next reporting period and use this information to adjust targets ahead of the 2020 deadline if appropriate.

The region 7 IDN team initially had a target of 20 "reporting periods successfully completed by 2020" in the region's implementation plan which also included the implementation plan and semi-annual reports. The target for this measure has been revised to more accurately reflect the data reporting required under project A-2. The target for this measure is 11: 7 half year measurement periods for 2nd half 2017

through 2nd half 2020; plus 3 full year measurement periods for 2018-2020; plus 1 historical look in October 2018. As of December 31, 2018, Region 7 IDN completed 2 reporting cycles plus 1 historical look back.

*Shared Care Plan rollout has been slower than expected due to a variety of factors including: concerns about the shard care plan impacting provider time, staff resources needed to implement, competing projects and re-alignment of current consent processes to cover the inclusion of 42 CFR Part 2 covered data. However, those partners which have moved on this have responded very positively and the region has worked to amplify their voices by providing them a platform to discuss successes at our quarterly meetings. The reception from these presentations has been positive and several other partners are now in the process of adopting the shared care plan.

**Event notification (send) rollout has been slowed by extensive legal reviews taking place at NCH – Littleton Regional Healthcare and Cottage Hospital. The adoption of the event notification (send) functionality by 4 other hospitals in Region 7 within compliance with legal framework should help move this process along. Memorial Hospital implementation was delayed because of an EMR migration which was completed early this year. Additionally, as they are a member of the Maine Health affiliation, they have concerns that CMT currently does not have data for Maine hospitals which makes the system less useful to them.

***After an initial discovery process for the population health tool, IDN Region 7 has temporarily suspended activity in this area because of the expenditure of resources involved in such a tool and the and uncertainty around DSRIP funding.

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	1
HIT Integration Coach	1	0	0	1	1
Data Specialist at NCHC	1	0	0	0	1*
Data Aggregator specialists in the community through the RFP process	Up to 3	0	0	0	3**

*After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT Lead.

**In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coos County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coos County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

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	07/01/2018-12/31/2018	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	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	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	$1,612	$138	$127	$14,660	$14,660	$7,330
6. Travel	$1,235	$613	$482	$24,085	$24,085	$12,043
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	$71,433	$154,693	$154,693	$77,347
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$738	$0	$1,011	$1,011	$505
10. Marketing/Communications	$1,809	$1,509	$2,993	$156	$156	$78
11. Staff Education and Training		$862	$987	$29,971	$29,971	$14,985
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$2,722	$1,541	$705	$4,525	$4,525	$2,262
Support Payments to Partners	$109,551	$99,342	$72,176	$9,796	$9,796	$4,898
TOTAL	**$116,929**	**$255,065**	**$148,903**	**$238,896**	**$238,896**	**$119,448**

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

IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training

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
NCH – 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

Organization Name	Organization Type
Huggins Hospital	Primary Care Practice; Hospital Facility
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services
Life Coping, Inc.	Community-based
NCH – 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
NCH – Upper Connecticut Valley Hospital	Hospital Facility
Visiting Nurse Home Care and Hospice of Carroll County	Home and Community- Based Care Provider
NCH – 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/A
Ammonoosuc Community Health Services	Y
Androscoggin Valley Home Care Services	N/A
NCH – Androscoggin Valley Hospital	Y*
Carroll County Coalition for Public Health	N/A
Carroll County Department of Corrections	N/A
Central New Hampshire Visiting Nurse Association & Hospice	N/A
Children Unlimited	N/A
Coos County Family Health Services	Y
Cottage Hospital	Y
Crotched Mountain Foundation	N/A
Family Resource Center	N/A
Grafton County Department of Corrections	N/A
Grafton County Nursing Home	N/A
Granite State Independent Living	N/A
Hope for NH Recovery	N/A
Huggins Hospital	Y

Indian Stream Health Center	Y
Life Coping, Inc.	N/A
NCH – Littleton Regional Healthcare	Y*
Memorial Hospital	Y
MWV Supports Recovery	N/A
National Alliance on Mental Illness	N/A
North Country Healthcare	Y
Northern Human Services	Y
Rowe Health Center	Y**
Saco River Medical Group	Y
ServiceLink Resource Center of Carroll County and Grafton County	N/A
Tri-County Community Action Program, Inc.	N/A
NCH – Upper Connecticut Valley Hospital	Y*
Visiting Nurse Home Care and Hospice of Carroll County	N/A
NCH – Weeks Medical Center	Y*
White Horse Addiction Center	Y
White Mountain Community Health Center	Y

N/A: As a partner for whom no data for the statewide reporting measures is gathered (because of their type), these partners do not need a data use agreement.

*Included in the overarching North Country Healthcare data use agreement

**Included in the overarching Cottage Hospital use agreement

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				

Project B1: Integrated Healthcare

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

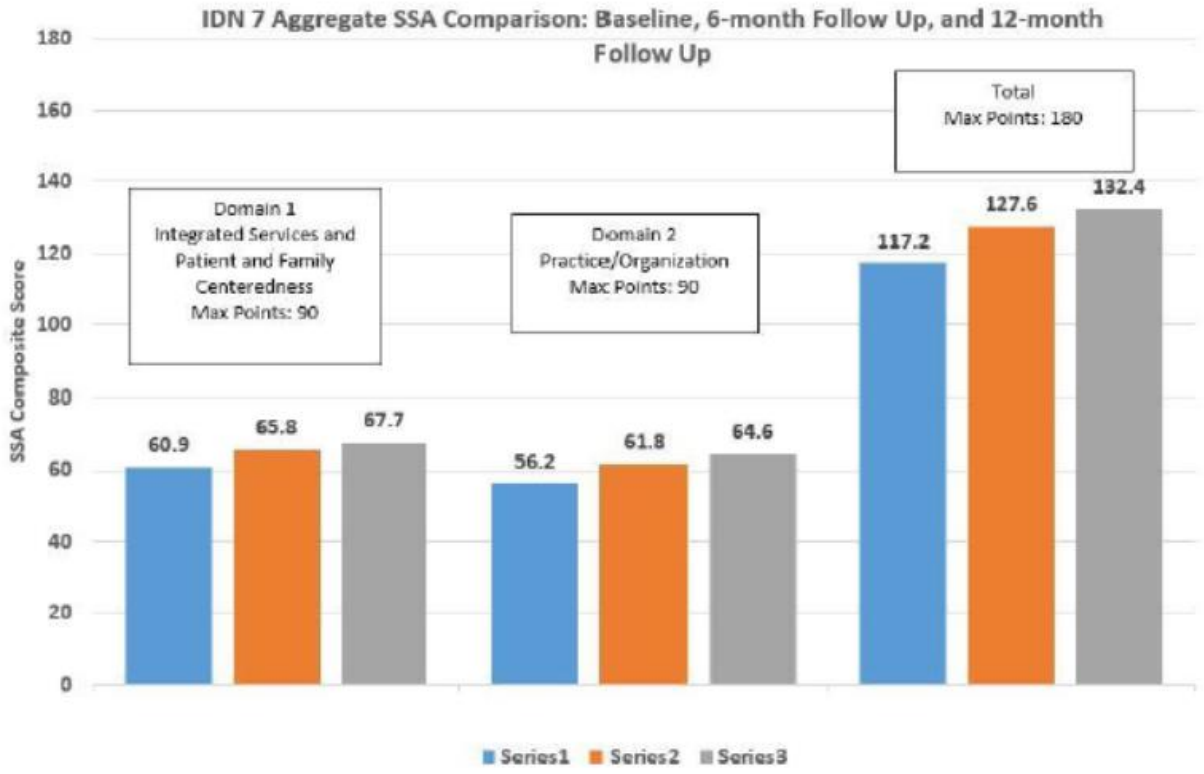
Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners.

During the reporting period of 07/01/2018-12/31/2018 Region 7 IDN had no members join or leave the network.

Maine Health Access Foundation Site Self-Assessment:

Partner agencies in Region 7 IDN have made significant progress as they have worked to advance along the continuum of integrated healthcare during the reporting period of July-December 2018. The region has a contract with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to administer a Site Self-Assessment (SSA) Survey to the behavioral health and primary care practices within the region to assess their level of behavioral health integration. The survey is based on the on the Maine Health Access Foundation Site Self-Assessment. To date, practices have completed a baseline survey in June 2017, a follow up survey in December 2017, and a second follow up survey in June 2018. The region's implementation plan states that moving forward the survey will be administered on a yearly basis, so the partners in the region are not expected to complete another survey until June 2019, and then one more in 2020. The region's SSA score results through June 2018 are reflected below. According to

SAMSHA's Six Levels of Integration the region is at a level 5 out of level 6. As agencies continue to refine workflows, develop written protocols, and incorporate additional technologies into their systems, these scores should continue to rise over the remaining DSRIP period. When the IDN team met with CHI to discuss the June 2018 SSA results they suggested that Region 7 IDN explore using Tanya Lord's skills to increase patient/family input to integration management. Ms. Lord was the main speaker at NCHC's annual meeting in November 2018 and the IDN team will continue to strategize on how to best incorporate her information to help improve patient and family engagement within the region.



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

Quality Improvement Team:

The region's Quality Improvement team has evolved based on the needs of the region. NCHC continues to leverage the expertise of one of the organization's Practice Transformation Network (PTN) Facilitators to serve as a part-time IDN Quality Improvement Coach. She bills some of her time to the IDN and works with a few of the IDN partners directly to help them develop and implement workflows and protocols designed to improve integration of behavioral health and primary care services. These resources are shared with the IDN team who then shares the tools with the remaining IDN partners in the region and encourage the agencies to adapt the tools to meet the needs of their agencies. In addition, the IDN Quality Improvement Coach serves as the regions' Care Advocate Supervisor by offering training and technical assistance for care coordinators. During this reporting period she has created a number or draft workflows and protocols, presented at the regional care coordination training, delivered a webinar on risk stratification, and delivered a webinar on the region's available protocols.

The IDN team has seen significant progress from the agencies that the IDN QI Coach works directly with and is excited that they have been able to hire an addition part-time QI coach who will work with additional practices in the region. The new QI coach previously worked for the Practice Transformation

Network and has strong ties in the region so she will be an asset to the region when she joins the team in January 2019. The part-time QI coach will work closely with the region's HIT Integration Coach to offer technical assistance to IDN partners.

The IDN team lost a full-time coordinator during the reporting period but was able to transition an existing IDN team member into a full-time coordinator role. The IDN Program Manager transitioned to a Director level position at NCHC during the reporting period but will continue to work with the IDN team on an ongoing basis. This will ensure a seamless transition for the new IDN Program Manager who will be starting in February 2019. The new manager has a lot of experience in quality initiatives and is a Certified Professional in Healthcare Quality which is great for the IDN. NCHC will be looking at the skill sets of all the IDN team members and relying on those skills and expertise to advance the region along the continuum of integrated healthcare.

Three-pronged approach to help transform the delivery of behavioral health care in the region:

The IDN team has continued using 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; and focus on transitional services. Each of these areas are discussed in more detail in the sections that follow in the report, starting with training. Below is a table depicting the region's comprehensive master training plan for the core competency project and the 3 community-driven projects. The trainings were placed in one table because there is so much overlap in training needs among the various DSRIP associated projects.

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 7^{th} & 8^{th} 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, 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	C1

	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	D3

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

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

	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

Region 7 IDN held numerous trainings during the reporting period of 07/1/2018-12/31/2018 based on the suggested trainings in the region's master training list. There were two quarterly meetings held during this period to bring the region together to discuss the IDN projects, partner progress, and collaborate to develop strategies to meet deliverables in 2019. Approximately 39 people attend the September 2018 to participate in the following presentations:

- *XY Exercise (Collaboration team building activity)* – Facilitated Joe Viger, IDN HIT Integration Coach, North Country Health Consortium
- *IDN Updates & Incentive Funding Process* – Nancy Frank, CEO, North Country Health Consortium
- *Data Aggregation & Shared Care Plan Update* – Drew Brown, Management Information Systems Administrator, North Country Health Consortium & Joe Viger, IDN Integration Coach, North Country Health Consortium
- *Trauma Informed Care* – Linda Douglas, M.Ed., CTSS, Trauma Informed Services Specialist, NH Coalition Against Domestic & Sexual Violence

The December 2018 Quarterly meeting served as a partner forum to prepare agencies for the shift to pay for performance and strategize on meeting deliverables in 2019. Approximately 31 people were in attendance to discuss the following topics:

- *Funding, Alternative Payment Models, Granite Advantage Healthcare Program* – Henry D. Lipman, Medicaid Director, New Hampshire Department of Health and Human Services
- *Vision for Integrated Care* – Joe Viger, IDN HIT Integration Coach, North Country Health Consortium
- *IDN and Partner Updates* – Nancy Frank, CEO, North Country Health Consortium and IDN Partners

Other trainings for Region 7 IDN during the reporting period 07/01/18-12/31/18 include:

- 7/25/2018: Ethical Considerations for Recovery Coaches trained 13
- 8/9/2018: HIV/AIDS Training trained 13
- 8/23/2018: Suicide Prevention trained 16
- 8/23/2018: Critical Time Intervention Train the Trainer trained 2
- 9/13/2018: CCAR Recovery Coach Academy trained 8
- 9/13/2018: Trauma Informed Care Training (Quarterly Meeting) trained 39
- 9/17/2018: Introduction to Management of Aggressive Behavior trained 10
- 9/17/2018: Introduction to Managing Physical Confrontation trained 6
- 9/20/2018: Addiction 101 trained 9
- 9/27/2018: Co-Occurring Medical and Psychological Conditions trained 23 total and 16 from IDN 7
- 10/1/2018: Introduction to Management of Aggressive Behavior trained 14
- 10/1/2018: Introduction to Managing Physical Confrontation trained 14
- 10/11/2018: Recovery Coach Academy Train the Trainer trained 6
- 10/24/2018: Motivational Interviewing trained 11
- 10/26/2018: Mental Health First Aid –Huggins Hospital trained 21
- 10/31/2018: Stigma and Language Webinar trained 10, 46 views of YouTube recording
- 11/1/2018: Critical Time Intervention trained 17
- 11/5/2018: Ethical Considerations for Recovery Coaches Training trained 13
- 11/7/2018: Ethics Train the Trainer trained 4
- 11/14/2018: Suicide Prevention Training trained 26
- 11/16/2018: NCHC Annual Meeting: Patient and Family Engagement Training
- 11/28/2018: Risk Stratification Webinar trained 7, 12 views of YouTube recording

- 11/28 – 11/29/2018: Regional Care Coordination trained 6
- 12/4 – 12/5/2018: Motivational Interviewing trained 12

The North Country Health Consortium held their Annual Meeting in November 2018, at which Tanya Lord, Director of Patient and Family Engagement at Foundation for Health Communities presented about the importance of engaging the patient and family during care. She explained that collaborative patient and family engagement is a strategy to build a patient and family centered health care system. In a patient and family centered health system, patients and families are encouraged and supported as essential members of the health care team and there are meaningful opportunities for them to serve as advisors and partners in quality improvement efforts, patient safety initiatives and health care design. The presentation was very well received by NCHC staff, board members and community members.

The Region 7 IDN team has developed a Peer Recovery Coach training plan that will continue into 2019, along with multiple other trainings listed below:

- Policy & Protocol Clearinghouse Webinar: January 16th, 2019
- 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 has multiple trainings which will be offered on an as needed or recurring basis including:

- Mental Health First Aid
- Community Health Worker Training
- Introduction to Management of Aggressive Behavior
- Introduction to Managing Physical Confrontation
- Critical Time Intervention
- Regional Care Coordination

In addition to the training plan above IDN staff have engaged in conversations with the Managed Care Organization, New Hampshire Healthy Families (NHHF), to potentially deliver additional trainings to the region using the partner connections the MCO currently has in place. NHHF staff are routinely prepared to train in multiple areas including, SBIRT, social determinants of health and social supports, integrated care for healthcare providers, cultural competence, and other topics based on identified needs. IDN staff have continued conversations with the New England Addiction Technology Transfer Center to learn more about their training opportunities and potentially partnering with them to bring some of the these to the IDN region.

The IDN team has been working closely with the other IDN regions across the state to sponsor an IDN training track at the December 2018 NH Behavioral Health Summit entitled*, "Alignment of Systems: Improving Behavioral Health Outcomes*." There were six sessions created as part of the track to help participants meet the training requirements of the DSRIP project. The sessions were recorded and will be available as webinars with continuing education options in early 2019. The sessions were as follows:

- *Community Care Team: A Model Strategy for Systems Alignment*: Tory Jennison PhD, RN and Sandi Denoncour BS, ASN, RN
- *Understanding and Addressing Substance Use Disorders as Chronic Medical Conditions*: Mary Brunette, MD and Seddon R. Savage MD, MS

- *Enhanced Care Coordination for High Needs Population from Multiple Perspectives*: Jennifer Seher, B.S., CIRS A/D; Glenn Lawrence, MA; Maryann Evers, LICSW; Marie Macedonia, MS Psychology, PsyD; Annette Carbonneau
- *Core Competencies for Primary Care Behavioral Health Integration: Knowledge, Skills & Attitudes*: William Gunn PhD
- *Chronic Disease Information for Behavioral Health Providers*: Tracy Tinker, RN, MSN, CDE, CNL
- *Facilitated Integrated Care Success with Co-Occurring Disorders: A Case Study*: David Ferruolo, EdD., LICSW, MLADC

IDN staff have been working to promote the newly developed Region 7 IDN webinar series that has brought two trainings to the region in October and November 2018. The webinars included, *Reducing Stigma in SUD Treatment* and *Risk Stratification to Drive Care Coordination.* Both were recorded for participants to have access to the material on their own time and to assist in addressing training of new staff. The team plans to deliver a webinar monthly addressing topics germane to the IDN and partner feedback. The January 2019 webinar will be focused on policy and protocol development.

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

Region 7 IDN has not engaged in new memorandum of understandings with IDN partners in this reporting period due to the IDN funding uncertainties associated with the county funding methodology. The region did receive 15 new proposals in October but has not been able to execute agreements until final DSRIP funding levels are solidified. The following agencies submitted proposals to help their agencies improve the integration of primary care and behavioral health and are anxiously waiting to receive agreements and subsequent funds.

- *Memorial Hospital* submitted a proposal on behalf of four organizations in Mount Washington Valley (Memorial Hospital, Saco River Medical Group (SRMG), Children's Unlimited (CU) and Visiting Nurse Home Care & Hospice (VNHCH)) to expand their Collaborative Community Program Addressing Behavioral Health & Substance Use in Carroll County project;
- *Huggins Hospital* submitted a proposal to expand their "Huggins Health Neighborhood Care Coordination and Integration Services" project. The project would expand Huggins Hospital's integration of behavioral health and primary care and address the social determinants through expanded care coordination, adoption of assessment and screening related to the IDN project, and support for expanded MAT services;
- *Northern Human Services* submitted a proposal to partner with Ammonoosuc Community Health Services to develop an Integrated Health Home, to be located at White Mountain Mental Health Center in Littleton and operated by ACHS.

Region 7 IDN Core Competency Integration Toolkit:

The Core Competency Integration Toolkit remains available to partners as they work to implement new systems and B1 deliverables into their agencies. The toolkit has proven to be an effective and valuable tool to the partners. The IDN team continues to encourage the use of the toolkit and updates the content as necessary.

CCSA implementation:

Region 7 IDN has made significant progress towards all B1 partners implementing the Comprehensive Core Standardized Assessment (CCSA). The Sample CCSA Protocol drafted by the IDN Quality Improvement Coach, and submitted in the last reporting period, was pivotal to the momentum the region experienced during this reporting period.

The IDN team prepared for multiple meetings over the past six months where the focus was the implementation of the CCSA. The Strategic Funding Meeting with all workgroups held in July 2018 provided a great opportunity to discuss the importance of meeting IDN deliverables, and how they equate to incentive payments. The CCSA was a major agenda item that was discussed at length between the IDN team and partners in attendance. The two quarterly meetings in September and December were strategically planned to continue helping partners understand the value and importance of the CCSA. Partners were very receptive at these meetings and many agencies are now capturing domains they had not before.

B1 partners have been working to embed the 12 domains into their EMR and create systems to gather the information from patients. Multiple partners have been successful in launching this technique, while others continue to adjust a process to fit their internal needs. The IDN team plans to continue working with all partners to finalize protocols and procedures relating to the CCSA. Partners who do not currently capture all domains will be the focus of the IDN team moving into the next 6 months. The providers of multiple agencies have begun to see value in gathering this data and are more comfortable with how to address positive screenings.

Multi-disciplinary core team:

The IDN team has worked with partner agencies to encourage them work with a multi-disciplinary core team which meets DSRIP requirements. Some of the partner agencies had a system in place which could be adapted to meet the requirements, while other agencies didn't have the staffing needed to form these teams. The IDN team helped the agencies assess what was in place and worked to make connections to psychiatrists for those agencies who didn't have access. This is still a work in progress for some of the agencies in the region, but the IDN team will focus efforts on these agencies to help connect them to a multidisciplinary core team. The IDN team will research more on telepsychiatry services to support the multi-disciplinary teams in the region. Additional efforts will be made to ensure partner agencies are using the multi-disciplinary team meetings to discuss high risk patients versus talking about system level concerns.

Standardized Workflows and Protocols:

Members of the IDN team have worked diligently to research and create draft workflows and protocols for partners in the region to adapt to meet their needs. These draft protocols have been shared in the region's toolkits and have been posted in Basecamp. In addition, the team has scheduled a webinar for January 2019 to have open discussions related to these workflows and protocols.

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 Region 7 IDN partners have worked closely with IDN staff toward capturing all 12 CCSA domains and putting a protocol in place for the assessment process. Multiple partners have made excellent progress and continue to adapt the sample CCSA protocol to meet their specific needs. Saco River Medical Group is still in the process of developing ways to implement tools and workflows to capture missing domains. Coos County Family Health Services is still working to capture all 12 domains and the IDN team continues to provide workflow and protocol templates to assist CCFHS with the implementation process. Whitehorse Addiction Center and Friendship House have been focusing on building capacity to treat SUD patients. Memorial Hospital has been working to build the CCSA domains into their new EPIC platform. The IDN team will continue to focus efforts on assisting partner agencies to capture the 12 domains and implement a CCSA protocol, including the identification of specific barriers and realities, and implementing PDSA's as needed to hone workflows.	13 as of 2018	0	0	8
# of partner agencies using shared care plan (care guidelines feature) While Region 7 IDN does not have any organizations using care guidelines at this time, there has been continued expansion of all other areas of CMT utilization. This includes White Mountain Community Health doing additional census work as part of their go-live (it is anticipated they will use care guidelines in the next quarter), Northern Human Services starting implementation, Huggins Hospital starting to receive faxed event notifications in the ED and presentations to Indian Stream Health Center.	13 as of 2018	0	0	0
# of partner agencies using multi-disciplinary core team	5 as of 2018	0	0	7

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of partner agencies using standardized workflow and protocols: The IDN engaged consulting and education resources to develop and implement a Protocol Clearinghouse on the IDN Basecamp site. Here, partners can see examples of all required protocols that they can either adopt or use as guideline to develop their own version. Region 7 IDN team ha2 communicated this to partners and will also be doing a webinar in January to review the platform and specific policies. IDN staff are working to develop a new partner reporting tool which will help address gaps in workflow and protocol development.	13 as of 2018	0	0	7
# of partner organizations which have implemented MAT services	5 as of 2018	2	6	7
# of psychiatric nurse practitioners	3 as of 2018	2	5	6
# of MLDACs Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 IDN has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.	16 as of 2018	16	19	20

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 Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.	23 as of 2018	18	16	9
# of Peer Recovery Coaches	6 as of 2018	22	59	67
# of Community Health Workers	4 as of 2018	11	13	13
# CTI Workers	15 as of 2018	11	24	37
# CTI Supervisors	3 as of 2018	3	3	3

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Care Advocates The region initially planned to train 5 Care Advocates in each of the 3 subregions by December 31,2018. As the project moved into the implementation phase it became apparent that it would be beneficial to combine Coos and northern Grafton County agencies together for the regional care coordination training. The reasoning behind this decision was due to the structure of North Country Healthcare, and their efforts to coordinate care across the region. Due to North Country Healthcare's regional care coordination approach they only sent 2 staff members to the training versus one from each of the 5 affiliate agencies. NCHC plans to offer additional care coordination training modules via webinar to reach additional care coordinators moving forward.	15 as of 2018	0	7	11
# Care Advocate Supervisors	1 as of 2018	0	1	1
# Community based clinicians (staffing from first round of capacity)	1 as of 2018	1	1	1
# Physician assistant clinicians (staffing from first round of capacity)	1 as of 2018	1	3	3
Community nurse coordinator clinicians (staffing from first round of capacity)	1 as of 2018	1	1	1
Behavioral health assistant clinicians (staffing from first round of capacity)	1 as of 2018	1	2	3
Behavioral health case managers clinicians (staffing from first round of capacity)	5 as of 2018	4	5	11
LICSW clinicians (staffing from first round of capacity)	3 as of 2018	2	2	4
IDN QI Coach	1 as of 2018	0	1	2 (both part-time)
HIT Integration Coach	1 as of 2018	1	1	1
IDN Data Specialist (NCHC)	1 as of 2018	0	0	1
Data Specialists for IDN partners	Up to 3 as of 2018	0	0	3

After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT lead at NCHC. In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coos County Family Health Service) have elected to use IDN funds to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coos County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

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 Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the	16 by 2018	11	16	18	19

transition between school and actual practice.					
Licensed Mental Health Professionals Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.	23 by 2018	14	18	16	9
Peer Recovery Coaches	6 by 2018	2	22	59	67
CTI Workers	15 by 2018	0	11	27	37
CTI Supervisors	3 by 2018	0	3	3	3
Community Health Workers	4 by 2018	0	13	13	13

Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2	5	7
Care Advocates Region 7 IDN held two Regional Care Coordination trainings during 2018. This was a shift from the original 3 planned for each county. Northern Grafton and Coos County training were combined into one fall training to allow partners to prepare staff. Due to staffing transition and lack of staff time the measure was missed by 2. The Carroll County training had two individuals who were partially trained during the 2-day training that were not counted in this measure, however they received valuable content from the day they attended. The Region 7 IDN team is exploring more efficient ways to train current care coordination staff throughout the region. The Region 7 IDN webinar series seems to be a good platform to achieve this goal.	15 by 2018	0	0	7	13
Other Front-Line Provider	1 by 2018	0	10	16	52
Care Advocate Supervisors	1 by 2018	0	0	0	1
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Physician assistant (round 1 funds)	1	1	1	3	3
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	4
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	7
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	4
IDN QI Coach	1	0	0	1	2
HIT Integration Coach	1	0	1	1	1
IDN Data Specialist (NCHC)	1	0	0	0	1
Data Specialists for IDN partners	Up to 3	0	0	0	3

After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT lead at NCHC. In lieu of hiring additional staff to handle data

aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coos County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coos County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

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	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Core Competency Actual Funds Spent	Core Competency Actual Expense (6 months)				
Core Competency	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	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	$4,650	$341	$365	$14,575	$14,575	$7,288
6. Travel	$3,560	$1,767	$1,391	$29,827	$29,827	$14,914
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	$0	$1,011	$1,011	$505
10. Marketing/Communications	$5,218	$4,351	$8,635	$22,414	$22,414	$11,207
11. Staff Education and Training		$2,487	$2,848	$27,796	$27,796	$13,898
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	$2,034	$4,054	$4,054	$2,027
Support Payments to Partners	$315,939	$290,152	$208,250	$852,584	$852,584	$426,292
TOTAL	**$337,218**	**$305,695**	**$223,524**	**$952,262**	**$952,262**	**$476,131**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
(Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)

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
NCH – Littleton Regional Healthcare	Y
Friendship House/North Country Health Consortium	Y
Northern Human Services	Y
Ammonoosuc Community Health Services	Y
White Mountain Community Health Center	Y
NCH – 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

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
Monika O'Clair	Vice President of Strategy & Community Relations	Huggins Hospital	Y
Caleb Gilbert	Public Health Advisory Council Coordinator	Carroll County Coalition for Public Health	Y
Rona Glines	Director of Physician Services	NCH – Weeks Medical Center	Y
Ken Gordon	Chief Executive Officer	Coos County Family Health Services	Y
Suzanne Gaetjens-Oleson	Regional Mental Health Administrator	Northern Human Services	Y
Jeanne Robillard	Chief Operating Officer	Tri-County Community Action Program	Y

Name	Title	Organization	Sign Off Received (Y/N)
Bernie Seifert	Coordinator of Older Adult Programs	NAMI NH	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	Y

Region 7 IDN has seen changes to the membership of the region's Steering Committee due to staffing turnover, but NCHC has worked to ensure the composition still encompasses the required participating agency representation and has a broad geographic distribution. All current Steering Committee members have signed charters for the DSRIP project.

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.

B1-8a: All of the following domains must be included in the CCSA:

Site	Demographic	Medical	Substance Use	Housing	Family & Support	Education	Employment	Legal	Risk assessment including suicide risk	Functional Status	Universal Screening	SBIRT
Saco River Medical Group	Y	Y	Limited	N	N	N	N	N	Y	N	Y	Used for adolescents
NCH – Littleton Regional Healthcare	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Memorial Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Huggins Hospital Behavioral Health	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Huggins Primary Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Limited use
White Mountain Community Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NCH – Weeks Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Coos County Family Health Services	Y	Y	Y	Y	Y	N	Y	N	N	N	Y	Y
Rowe Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	y
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
Whitehorse Addiction Center	Gathering data											N
Friendship House	Y	Y	Y	Y	Y	Y	Y	Y	Y	unknown	Y	Unknown

Region 7 IDN partners have worked closely with IDN staff towards capturing all 12 CCSA domains and putting a protocol in place for the assessment process. Multiple partners have made excellent progress towards this deliverable and continue to adapt the sample CCSA protocol to meet the agencies specific needs.

NCH – Littleton Regional Healthcare has worked to add the domains that were lacking during this last reporting period. Currently the CCSA is fully templated and live in their ambulatory clinics' EMR. Staff and providers are receiving education on its use, and they have recently shared a Primary Care staffing plan with the head of the Physician Practices that includes a deeper care coordination bench including, among other things, a Population Health Coordinator whose role encompasses monitoring care gap reports, assisting patients in completing assessments like these and coordinating referrals to the appropriate community resources for the most needy patients with multiple comorbidities. The agency is hopeful that in early 2019, they will have the staffing plan finalized and begin the hiring process so that they see this and other assessments charted at least annually on most of their primary care patients.

White Mountain Community Health Center has fully implemented the CCSA survey process with their Medicaid population of 18 years and older and are tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes. The care coordination team is responsible for tracking compliance and ensuring patients with identified needs are addressed with care coordination follow up. They have implemented ASQ-3 developmental screenings as part of their CCSA process as well. The agencies protocol was submitted during the last reporting period.

Saco River Medical Group continues to work toward implementing the CCSA however does not currently capture all 12 domains. They are still in the process of developing ways to implement tools and workflows to capture the missing domains. SRMG does use SBIRT routinely for adolescents with positive screens during well checkups. They do not use it in the older population however they do have templates written. Currently, there is no written process for CCSA patient completion. SRMG will continue to seek out guidance from IDN team to work toward CCSA implementation.

Indian Stream continues to capture all 12 domains through the nurses and provider in the exam room. Currently there is no formal process however the subject has been discussed with the team. ISHC has entertained the idea to have patients answer questions on paper before the visit that can then be transcribed into the EMR. Currently, when domains are collected the SDoH are flagged in the EMR.

Huggins Hospital made significant progress around the CCSA, now capturing all domains and piloting the assessment with a small sample of patients; one patient completed the CCSA during the reporting period. Due to the pressure of the rapid implementation, Huggins is planning to use PSDA to massage the process. The agency has been using SBIRT in their behavioral health department, however providers do not use it routinely. One primary care provider has only used it in a limited way. Huggins staff has expressed the need of SBIRT training as the project moves forward.

Cottage Hospital/Rowe Health Center has made exceptional progress in implementing the CCSA. Currently, they have a documented protocol in place that was adapted from the sample protocol released to the region. They now capture all 12 domains and use SBIRT regularly. The PCP does have an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services.

NCH – Weeks Medical Center made great strides to implement the CCSA in September 2018. To capture the 12 domains, they have put the process on tablets to give to patients at annual visits. Weeks has also developed a formal protocol for collecting the domains. Overall it is going well, however there is some pushback from patients who don't want to provide certain information. To mitigate this, Weeks adapted

the questionnaire to allow a patient to opt out of a specific question versus skipping the survey entirely. Providers feel that they are getting some useful information from this process.

Memorial Hospital conducts an Assessment for Appropriateness for Office Based Buprenorphine Treatment, found in the IMAT clinical guidelines distributed by MaineHealth, that could be considered a form of SBIRT. Coos County Family Health Services has experienced some barriers to capturing all 12 domains and developing a protocol to implement the CCSA process. The IDN team will continue to work with CCFHS as they work towards full CCSA implementation. Whitehorse Addiction Center and Friendship House have been focusing on building capacity to treat SUD patients, resulting in slow progress towards CCSA implementation. The treatment centers will continue to enhance services and work with the IDN team to capture the 12 domains and implement a CCSA protocol.

Northern Human Services and Ammonoosuc Community Health Services continue to capture all domains within the CCSA. ACHS has implemented the process within tablets given to patients before visits. While processes are active and clear for staff, written protocol for CCSA has not yet been finalized. Protocol for follow-up is in place and guides the role of the Patient Navigators. NHS has embedded the 12 domains into their EMR and are moving toward using the Columbia for a suicide risk assessment. The agency has completed a CCSA protocol and plans a mass roll-out to all open and incoming patients to be assessed by the end of January 2019. While NHS does not follow SBIRT protocol and the table above shows a "No" response, they do perform significant screening on substance use disorder that likely exceeds the requirements as defined by SBIRT given the nature of their organization as a behavioral health provider.

The table below reflects what NCHC currently knows regarding comprehensive core standardized assessments for pediatric providers in the region.

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
NCH – Weeks Medical Center	Y ASQ:3	Y	Y (MCHAT)
White Mountain Community Health Center	Y ASQ:SE	N	Y (MCHAT)
Huggins Hospital	Y	Y	Y (Teen screen)
Memorial Hospital	Y	N	Hoping to integrate ACEC
NCH – 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

B1-8b: List of multi-disciplinary core team members that includes, at minimum: PCP, Behavioral Health Providers (including a psychiatrist), assigned Care Managers or Community Health Workers

In the early stages of the demonstration, Region 7 IDN B1 partners expressed a preference for developing site-specific multi-disciplinary care teams over the development of a regional multi-disciplinary care team. Several partners have been successful in implementing a multi-disciplinary care team within their agencies, while others have struggled to formalize this process. In future reporting periods Region 7 IDN will explore alternatives that ensure that all B1 partners have access to a multi-disciplinary care team. Alternatives to be explored include, but are not limited to, the possibility of leveraging existing multi-disciplinary care teams as consulting bodies for partners in need of a multi-disciplinary care team, as well as revisiting the possibility of convening a regional group to hold monthly case conferences in a virtual setting.

Huggins Hospital

Provider Type	Position
Primary Care Provider	Huggins Primary Care Provider (DO)
Behavioral Health Provider	LICSW, Huggins Hospital
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital
Psychiatrist	Northern Human Services

White Mountain Community Health Center

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

Ammonoosuc Community Health Services

The table below shows MDCT members that attend monthly patient care case conferences at ACHS.

Provider Type	Position
Primary Care Provider	Primary Care Provider (MD), ACHS
Behavioral Health Provider	LICSW, ACHS
Care Manager or Community Health Worker	Behavioral Health/SUD Case Manager, ACHS
Care Coordination	RN Care Coordinator, ACHS Behavioral Health Community Health Worker, ACHS Patient Navigator, ACHS
Psychiatrist	Pathways Psychiatric Consulting, Dr Erinn Fellner & Dr Stacey Charron
Additional Members	
Pharmacist	RPh, ACHS

Cottage Hospital/Rowe Health Center

The partner has an Integrated Care Team (ICT) and a Multi-disciplinary Care Team (MDCT) which consists of similar staff members on both teams as shown below.

Provider Type	Position
Primary Care Provider	Internal Medicine Provider Primary Care Provider, Rowe Health Center (ICT)
Behavioral Health Provider	Licensed Social Worker Behavioral Health Providers, Rowe Health Center (ICT)
Care Manager or Community Health Worker	Chronic Care Management RN Certified Medical Assistant, Rowe Health Center (ICT)
Psychiatrist	Ray of Hope Psychiatric Department, Cottage Hospital Behavioral Health APRN with access to psychiatrist consultation, Cottage Hospital

NCH – Weeks Medical Center

Weeks employs multiple forums to communicate about patients. Behavioral Health is embedded in daily interdisciplinary team meetings that involve real time review of all inpatients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP, as needed. If psychiatric input is needed the patient is put on the psychiatrist schedule. In the monthly provider meetings, BH is also present for case discussion.

Provider Type	Position
Primary Care Provider	Rotating Primary Care Providers, NCH – Weeks Medical Centers 4 DOs 2 MDs 5 APRNs 3 PA-C
Behavioral Health Provider	BH Providers, NCH – Weeks Medical Center 2 Psych NP 2 LDACs 2 Social Workers 2 LICSW
Care Manager or Community Health Worker	1 BH Case Manager, NCH – Weeks Medical Center 5 Care Coordinators (RNs & Mas)
Psychiatrist	Available if necessary with consulting psychiatrist, Erin Fellner

Indian Stream Health Center

ISHC has a long-standing integrated provider meeting with providers from across disciplines where a variety of issues are discussed including patient issues. The organization is working on developing this meeting to address MDCT requirements including case conference. They have recently transitioned a staff person to be a behavioral health care manager and as of the end of 2018, staffing is in place for the MDCT.

Provider Type	Position
Primary Care Provider	Rotating Primary Care Providers, ISHC 1 DO 1MD 1 PA-C 1 APRN
Behavioral Health Provider	LICSW, ISHC MSW, ISHC
Care Manager or Community Health Worker	Behavioral Health Case Worker, ISHC
Psychiatrist	Contracted psychiatrist

Northern Human Services

Northern Human Services actively participates on Huggins and WMCHC teams. They have also agreed to provide psychiatric consultation for agencies in the region to support the multi-disciplinary core team approach.

Provider Type	Position
Primary Care Provider	Huggins and WMCHC primary care provider
Behavioral Health Provider	LICSW, Huggins Hospital and APRN, WMCHC
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital and Community Health Worker and social worker from WMCHC
Psychiatrist	Northern Human Services

Memorial Hospital

Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum that has primary care providers, psychiatrists and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary care pods at the agency, which gives primary care providers direct access to behavioral health staff. The agency has access to psychiatrists through MaineHealth.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

NCH – Littleton Regional Healthcare

LRH does not have a structured team in place. Currently, their level of integration is collegial interaction with providers through a shared EMR. Behavioral health notes are integrated with primary care records. PCPs can refer to psychiatric APRN or psychiatrist who provide co-located services when they are at LRH.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

Saco River Medical Group (SRMG)

Saco River Medical Group does not currently have a multi-disciplinary core team in place, however they are searching for a psychiatrist to consult on difficult cases, once per month as a start. They have been communicating with Northern Human Services to address this need and plan to craft a solid team moving forward. The IDN team will continue to follow up with SRMG to see how they can support these efforts.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

Coos County Family Health Services

Coos County Family Health Services does not currently have a MDCT or case conference in place, but staff does participate in care transition meetings which includes several provider agencies from across the region. The IDN team will work closely with this partner to offer assistance in finding a solution to which meets DSRIP requirements.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

Friendship House and White Horse Addiction Center

Friendship House and White Horse Addiction Center continue to build capacity to deliver services to the region's SUD population and will work closely with the IDN team to develop a process and structure for their MDCT's.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

B1-8c: Multi-disciplinary core team training

Master MDCT Training Tracking Table						
Staff	**Target**	**Mental Health**	**Substance Use Disorder**	**Diabetes**	**Dyslipidemia**	**Hypertension**
Cottage Hospital/Rowe Health Center	7	0	0	0	0	0
Huggins Hospital	4	2	0	0	0	0
ACHS	8	2	0	0	0	0
Indian Stream Health Center	8	0	0	0	0	0
Weeks Medical Center	28	0	0	0	0	0
White Mountain Community Health Center	4	1	0	0	0	0
Northern Human Services	2	-	0	0	0	0

The table above reflects the five DSRIP required training topics for multi-disciplinary core team members. Region 7 IDN has worked diligently to develop a comprehensive training plan to target the MDCT members and other essential staff involved in patient care. Despite the team's best efforts, it has been evident that the consistent barrier to training the MDCT members is directly related to lost billable hours for providers to attend; workforce shortages so staff cannot get time off to participate in required trainings; and provider hesitancy to take trainings they feel are unnecessary for re-licensure. The Region 7 IDN team will continue developing a strategy to reach the MDCT members specifically, potentially using their monthly case conference schedule as a platform to deliver trainings.

Region 7 IDN is working to offer trainings on diabetes/hyperglycemia and hypertension to meet DSRIP requirements. The region partnered with the other IDNs in the state to sponsor an IDN training track at the Behavioral Health Summit in December 2018. Chronic Disease Management for Behavioral Health Providers was one of the sessions offered, and the session was approved for continuing education credits. The Region 7 IDN team will work to promote this training over the remaining course of the DSRIP program. The Region 7 IDN webinar series will also be used as an option to bring additional required trainings to the MDCT members in an efficient way to avoid lost staff time. Multiple trainings have been held over the past year that relate to mental health and SUD including; Stigma & Language Webinar, Addiction 101, Co-Occurring Medical and Psychological Conditions, Ethical Considerations, Suicide Prevention and Mental Health First Aid.

The Region 7 IDN team will expand this training table once it is determined how the six remaining B1 partners in the region will be connected to a MDCT. The team will continue working to connect the MDCT members to these webinars and available trainings throughout the state to help meet the DSRIP training requirement.

During the July-December 2018 reporting period IDN Region 7 held several other trainings for IDN partners including MDCT team disciplines, non-direct staff, and many other staff. The Peer Recovery Coach Academy training track began in July of 2018 and provided multiple trainings, mostly to

community service partners and recovery community organizations. The region also sponsored one Critical Time Intervention Training, two Management of Aggressive Behavior trainings and Managing Physical Confrontation were offered, along with one Mental Health First Aid training which has been determined as one training that meets the mental health topic required by DSRIP. The region also developed two webinars during this period; one focused on Stigma and Language and the other on Risk Stratification. The Stigma and Language training addressed the Substance Use Disorder topic required by DSRIP. These trainings and webinars reached a variety of partners and are now available on demand for the MDCT team members in the region**.** The second Regional Care Coordination training was delivered to partners from Coos and Northern Grafton, training key members of partner MDCTs.

Region 7 also held two quarterly meetings for IDN partners, with a Trauma Informed care training at the September meeting; this trained a portion of the 39 people that attended the meeting and was very valuable to the region. The December quarterly meeting focus on informing the partners on funding updates, reporting requirements, Medicaid programs, and workforce policy movements. Region 7 IDN is working diligently to train the team members of all partner multidisciplinary core teams and plans to develop another strategic training plan for 2019.

Multiple Region 7 IDN partners were trained over the July-December 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		1			17	12
Northern Human Services	2	1	3		2	2
Family Resource Center	8				2	1
Huggins Hospital				21		
Saco River Medical Group						
White Mountain Community Health Center			1			
Carroll County Department of Corrections						
Tri-County Community Action Program	4		1			
Crotched Mountain						
Whitehorse Addiction Center						

North Country Health Consortium			3			
NCHC Friendship House			5			
Memorial Hospital						
Carroll County Coalition for Public Health						
Granite State Independent Living						
NCH – Littleton Regional Healthcare	2	2	1			
NCH – Weeks Medical Center		1				
Cottage Hospital/Rowe Health Center		1	1		2	1
Mount Washington Valley Supports Recovery			2			
Grafton County Department of Corrections			2			
North Country Serenity Center			3			
Town of Conway			1			
GCNH					1	1
Coos County Family Health Services						
Indian Stream Health Center						

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		

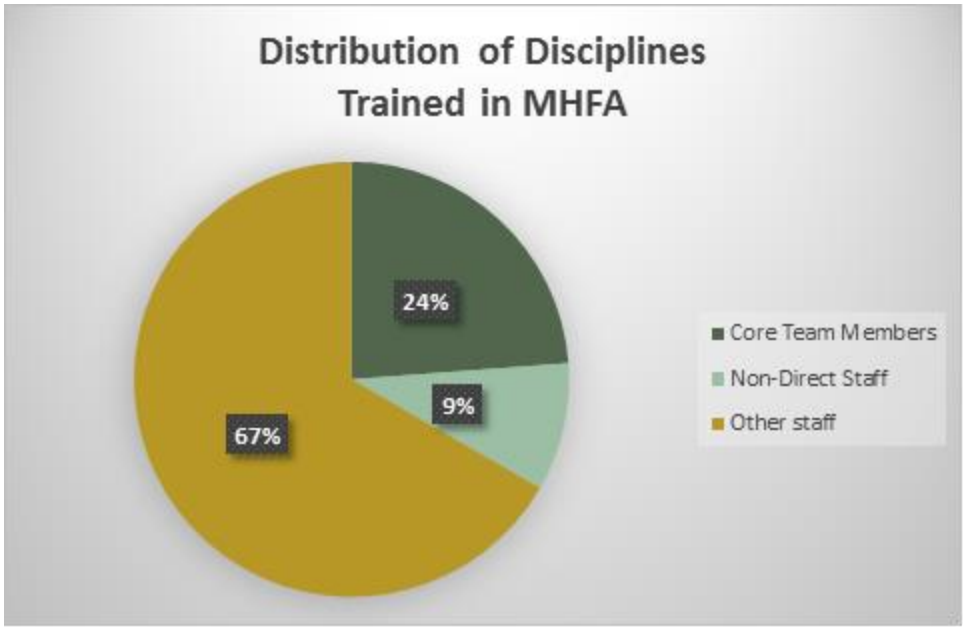
MA		Any staff member who is indirectly involved with a patient's care.	
Psy.D.			
LICSW			

B1-8d: Training for non-direct staff

The region used the two trainers embedded at NCHC to deliver the last MHFA training for 2018, totaling 4 trainings for the year. This training was held at Huggins Hospital in Wolfeboro for 21 staff members on October 26th. Region 7 IDN staff will work to coordinate at least four Mental Health First Aid trainings for 2019 to meet the 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 members 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, one training was offered on 10/26/18. A variety of Huggins staff members participated in this training, reaching a wide range of disciplines. Below is a table reflecting the regions progress regarding number of front-line staff members trained in Mental Health First Aid. Region 7 IDN team is working with the remaining partners that have not met their target for this training to schedule opportunities during 2019. It is anticipated to offer 4 more Mental Health First Aid trainings with a focus on Northern Grafton, Coos County and all other partners who still require the training.

Mental Health First Aid Training Plan	Target based on need	Trained as of 12/31/18
Saco River Medical Group	3 (reception, phone support, medical records)	0
NCH – Littleton Regional Healthcare	35 (medical secretaries, facility directors, administration and hospital registrars)	11
Cottage Hospital	N/A	11
Memorial Hospital	8 (front desk, medical records, registration)	18
Huggins Hospital	19 (front desk, PATH, billing, medical records)	64
White Mountain Community Health Center	5 (front desk, billing, medical records)	0
NCH – **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 109 individuals, as of December 31st, 2018. The "Core Team" and "Other" categories consist of a variety of disciplines that are in the Mental Health First Aid Training table above.

Additionally, ACHS has been encouraging all its staff to attend de-escalation training. Currently 12 ACHS employees have attended the Introduction to Management of Aggressive Behavior Series sponsored by IDN 7, more will be scheduled for 2019. ACHS also plans to participate in a 42 CFR Part 2 training in early 2019.

B1-8e: Monthly Core Team Case Conferences

This section should include a schedule of case conferences for the, minimally monthly, MDCT.

The partners of the Region 7 IDN have worked very hard to expand integrated and coordinated care in the region. Many partners have developed the capacity to deliver primary care and behavioral health care under one roof. They enjoy staff relationships that are fluid and collegial. In the words of staff at Memorial Hospital, "we're in each other's offices all the time". Teams at many partner organizations work together every day, crossing disciplines to address patient centered goals.

As a result, structured and scheduled case conferences are not occurring in some organizations. But Region 7 IDN is still seeing a high level and growing amount of collaboration between primary care and behavioral health staff. In some cases, this results in more case specific discussion albeit less formal. And some providers feel this is done more efficiently and at a lower cost than convening a full monthly case conference.

In the early stages of the demonstration, Region 7 IDN B1 partners expressed a preference for developing site-specific multi-disciplinary care teams over the development of a regional multi-disciplinary care Team. Several partners have been successful in implementing a multi-disciplinary care team within their agencies, while others have struggled to formalize this process. In future reporting periods Region 7 IDN will explore alternatives that ensure that all B1 partners have access to a multi-disciplinary care team. Alternatives to be explored include, but are not limited to, the possibility of leveraging existing multi-disciplinary care teams as consulting bodies for partners in need of a multi-

disciplinary care team, as well as revisiting the possibility of convening a regional group to hold monthly case conferences in a virtual setting.

Northern Human Services: Northern Human Services actively participates on Huggins and WMCHC teams and meet with these agencies on a monthly basis. They have met with Huggins Hospital 4 times during the reporting period and with WMCHC 5 times. They have also agreed to provide psychiatric consultation for agencies in the region to support the multi-disciplinary core team approach.

Indian Stream Health Center: ISHC has a long-standing integrated provider meeting with providers from across disciplines where a variety of issues are discussed including patient issues. The organization is working on developing this meeting to address MDCT requirements including case conferencing. They have recently transitioned a staff person to be a behavioral health care manager and as of the end of 2018, staffing is in place for the MDCT. The ISHC team is now working on developing protocols and policy that will structure the MDCT meeting. They hope to roll this out in 2019. The Team has agreed to begin a more formal process for case conferences during their scheduled integrated provider meetings (both BH and medical). ISHC will be looking into executing BAAs with other local organizations such as NCH – Upper Connecticut Valley Hospital and Northern Human Services to be able to include them in those discussions. The organization is familiar with meetings facilitated by NHS with school health, and ISHC will reach out about releases for their staff. The monthly partner reporting tool will help to focus the effort to implement regular monthly meetings of the MDCT.

Ammonoosuc Community Health Services: ACHS has held four MDCT meetings during this reporting period, including contracted psychiatric representation. Roles and responsibilities have been written for MDCT members, and these along with the purpose of the team has been documented. The agency has held a structured meeting to strategize the most effective way to continue using the MDCT. In response, it has been arranged for providers to have a 15-minute block to participate in the care planning case conference in person or by phone. Cases presented are high utilizing or complicated patients selected at provider discretion. A barrier to implementation of the MDCT has been provider buy-in due to lack of time, referral processes, and the uncertain benefit for patients. Evidence-based articles have been provided to the team to support the MCDT process. At their last case conference, the team discussed 2-3 referrals which was proven to be helpful for providers. In addition to this progress, roles and responsibilities have been written for MDCT members, and these along with the purpose of the team has been documented. Below is an example of MDCT Purpose, Roles and Responsibilities developed by ACHS:

> **Purpose**: Multidisciplinary care involves a team approach to planning treatment and providing care for patients as they move along the pathway of services they need. The Multidisciplinary Core Team (MDT) provides improved patient care and outcomes through the development of an agreed treatment plan, streamlined treatment pathways and reduction in duplication of services, improved coordination of care, and educational opportunities for health professionals.
>
> **Roles and Responsibilities:** The multidisciplinary team includes providers, Case managers, nurses, pharmacists, and patient navigators. Other members may be present as appropriate to the patient group. All members of the team should have the opportunity to actively interact as part of the MDT process. Possible roles for each team member on a multidisciplinary round are outlined below:
>
> - **Integrated Behavioral Health (IBH) Director-** Is the primary leadership for MDT. Is the focal point for MDT related issues. Schedules and facilitates MDT meetings. Ensures all team members are resourced to perform MDT functions. Makes recommendations pertaining to Behavioral issues.
> - **Psychiatrist-** Provides psychiatric recommendations on referred patients

- **Primary Care-** Leads the round and introduces patient to the team. Provides update of recent history, clinical examination, and review of the patient. Reviews medications.
- **Medical Case Manager-** Case Manager for patients whose primary needs are medical in nature. Ensures patients are prepared for next care setting. Coordinates transitioning the care plan from one setting to a next setting. Case manager works during the health care encounter with the patient/family and next level of care. Case manager should advise care coordinator of potential care coordination needs in the home setting.
- **Pharmacist-** Plays a key role in medication management, with the goal to minimize patient attrition (going without a needed medication) and to minimize to the extent possible prescriber and pharmacy disruption.
- **Behavioral Health Case Manager-** Case Manager for patients whose primary needs are behavioral in nature. Ensures patients are prepared for next care setting. Coordinates transitioning the care plan from one setting to a next setting. Case manager works during the health care encounter with the patient/family and next level of care. Case manager should advise care coordinator of potential care coordination needs in the home setting.
- **Community Health Worker (CHW)-** Ensures patients get needed care services to keep health stable and reduce risk of further expensive care services. Coordinates health-related needs for patients at home. CHW works with patient prior to and after any given health care encounter.
- **Patient Navigator-** Reviews and makes recommendations on social determinants of health.

Huggins Hospital: Huggins Hospital has scheduled multi-disciplinary core team (MDCT) meetings on a monthly basis since August. A psychiatrist from Northern Human Services (NHS), attends as the psychiatric consultant. They have limited the primary care involvement at this time, due to capacity of care coordination at this time. They are unable to handle large volumes of complex case management at this time due to staffing constraints but are evaluating how IDN funding opportunities can assist in expanding capacity. As the CCSA process implementation is spread throughout the organization, it will be imperative to have dedicated care coordination staff for this purpose.

White Mountain Community Health Center: WMCHC had their first case conference with their established MDCT in June 2018. The team meets monthly and has discussed five cases in this reporting period. All meetings have included WMCHC's provider team, social worker/care coordinator and contracted psychiatrist. The team explains that the meeting is very beneficial in caring for the patient and developing a care plan. They found the toolkit forms exceptionally valuable for/ during the planning process and execution of the meeting.

Cottage Hospital/Rowe Health Center (RHC): RHC has a weekly Integrated Care Team meeting with primary care, care coordinator, social worker and behavioral health APRN to discuss patients. The behavioral health APRN then takes any patient cases that need additional consideration by the psychiatrist to a meeting between the APRN and psychiatrist. Once this consult is complete the APRN brings feedback to the next weekly meeting. All providers necessary are involved in this process. They also have a more formal MDCT that will meet quarterly, guided by the ICT, to discuss targeted high-risk patients experiencing significant barriers, challenges and/or complex situations requiring a larger discussion. The MDCT consists of Rowe Health Center providers from Internal Medicine, Rowe Health Center Behavioral Health, Rowe Health Center Chronic Care RN, and the Cottage Hospital Psychiatric Department (Ray of Hope). Goals of this team are to support patients at high risk for or diagnosed with high risk behavioral health conditions and/or chronic health conditions. The partner has a documented Integrated and Multidisciplinary Care Team Protocol that explains each team's purpose, members, roles, communication, format, and logistics.

NCH – Weeks Medical Center: Although Weeks Medical Center does not currently schedule regular case conferences with a structured MDCT behavioral health is embedded in daily interdisciplinary team meetings for real time review of all inpatients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP as needed. The patient cases that need psychiatric input are specifically put on the psychiatrist schedule. BH is also present for case discussion at monthly provider meetings. The IDN team will continue to work with Weeks to identify a standard case conference format and monthly schedule for the MDCT to discuss complex patient cases.

Saco River Medical Group: SRMG does not currently have a Multi-disciplinary Core team in place or case conferences scheduled. The IDN team plans to facilitate discussion between SRMG and NHS to help them build a team that will include a psychiatrist. The IDN team will also continue to provide SRMG the tools to develop the team and schedule monthly case conferences moving forward. The first step in this process is to connect with the Practice Transformation Facilitator at SRMG to ascertain work currently in progress through the Transforming Clinical Practice Initiative ending in September 2019 and create a plan for next steps.

Memorial Hospital: Memorial does not have a structured MDCT in place however, BH staff is imbedded in primary care and involved in the staff meetings with primary care. The BH staff are in a "specialty pod" within the same practice and both share MA's and nursing. They have a seamless system in place to help transition patients from primary care to BH services and discuss complex cases as necessary.

Memorial also participates in a learning collaborative as part of their I-MAT program that regularly meets with representation from primary care providers, psychiatrists and any other necessary staff. They discuss difficult patients, changes in protocols, difficulty in implementing new protocols, and also solicit insight and guidance from other providers as necessary.

Coos County Family Health Services: As previously mentioned, Coos County Family Health Services does not currently have a MDCT or case conference in place. The IDN team will work continue to engage with this partner related to this deliverable.

NCH – Littleton Regional Health Care: LRH does not have a structured team in place. Currently, their level of integration is collegial interactions with providers through a shared EMR. The IDN will continue to work with LRH to determine an effective way to formalize monthly case conferences

Friendship House and White Horse Addiction Center: As mentioned previously, Friendship House and White Horse Addiction Center continue to build capacity to deliver services to the region's SUD population and will work closely with the IDN team to develop a process and structure for their MDCT's and be part of monthly case conference schedule.

B1-8f: Secure Messaging

The narrative should speak to the progress made with Secure Message Exchange that was not already in place prior to the IDN. If participating partners already have the technology, the narrative should speak to what the IDN is doing to enhance the use of Secure Messaging to promote Integrated Care.

Ammonoosuc Community Health Services: ACHS uses capacity in their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.

Huggins Hospital: The hospital has direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the

future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.

Indian Stream Health Center: ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.

North Country Healthcare Hospitals: Littleton Regional Healthcare, Weeks Medical Center, Androscoggin Valley Hospital, and Upper Connecticut Valley Hospital are all implementing Imprivata as a secure messaging platform. It was originally planned that this would be live by end of 2018. But it was identified that the NCH hospitals had to first finalize implementation of active directory across all four hospitals to support this platform. This has delayed rollout of the Imprivata which is now targeted for use by the end of the first quarter 2019. The organization also maintains patient portals for communications appropriate for that channel.

Northern Human Services: NHS had previously installed DSM functionality, but vendor issues prohibited them from using the functionality. A new upgrade that is forthcoming for their Netsmart LWSI Essentia electronic record will include a HISP and NHS plans to take advantage of this to engage direct secure messaging. Targeted upgrade completion is February of 2019.

White Mountain Community Health Center: WMCHC has a patient portal that they use to communicate with patients if the patient is registered. They do not currently have other secure messaging technology to provide email communication with other providers or clients.

Saco River Medical Group: The practice is fully functional with patient portal and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with don't have DSM and can't engage them in this form of communication.

Coos County Family Health Services: DSM has been in place for a number of years at CCFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers. Changes related to NHHIO did require the implementation of a new HISP with MedAllies. The organization can send direct secure messages to anyone in the Surescripts directory or anyone who has some sort of connection to a HISP. They can also use the secure messaging platform to communicate via DSM to anyone with a valid email address. This is done via a process where the end user receives a generic notification that they have a secure message to retrieve from the CCFHS Secure Message server. They then log-in to view/retrieve their message.

Memorial Hospital: The hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to perform secure text messaging.

NCH – Littleton Regional Healthcare: LRH uses a peer-to-peer protocol in the clinics EMR and has consolidated clinical document architecture documents in the hospital EMR. This is a standard for the creation of electronic documents that facilitates data sharing in healthcare. These documents are sent by DSM services that are also part of the EMR; the system meets HIPPA guidelines and scores high in meaningful use evaluations. The partner also uses patient portal to communicate with patients which is unidirectional.

Cottage Hospital/Rowe Health Center: The hospital and health center have a system in place for provider-to-provider and staff-to-provider communication. Their EHR is utilized to develop patient cases, to outline patient needs, concerns, etc. These are assigned to staff/providers as appropriate and all

documentation/responses are timestamped and e-signed. These cases can be marked as urgent. The partner has not reported capability to use DSM with patients however the IDN team will continue to work with them to implement this feature into their practice.

Friendship House: The IDN team will work to assess for the availability of direct secure messaging at Friendship House.

White Horse: The IDN team will work to assess for the availability of direct secure messaging at White Horse Addiction Center.

B1-8g: Closed Loop Referrals

The narrative should speak to the progress the IDN has made with participating partners for a closed loop referral process and the movement to electronic closed loop referrals.

Ammonoosuc Community Health Services: ACHS has an approved policy and procedure for tracking outstanding test orders and referral orders. They have an electronic means of creating referrals and a monthly report that tracks all open referrals for follow-up. The organization has a procedure for closing referrals which is as follows, but does not have a formal protocol:

Huggins Hospital: Huggins utilized orders tracking functionality in their electronic record as the basis of their closed loop referral process. Referrals are entered as orders. Once a referral is complete and a patient has been seen, Huggins receives a note from the specialty provider which is attached to the order in the EMR. The order status is modified to returned. This information goes back to Huggins referring provider for review and the referral loop is closed. Huggins staff also update the "visit date seen" in referral management which provides additional tracking that the referral loop has been closed. Below is the Huggins internal and external referral workflow they have documented.

Indian Stream Health Center: ISHC has a formalized protocol and workflow regarding closed loop referral. Referrals are handled by the care management staff that includes two referral coordinators and they work towards a goal of never closing a referral without patient contact. They recently introduced a new algorithm that ensures closed loop process. This includes tracking reports for referrals with no patient contact with-in seven days and reaching out to the specialty provider to see why. If they cannot establish patient contact, then the organization sends the patient a certified letter to inquire about why the referral wasn't fulfilled before closing out the referral. ISHC has multiple protocols to explain the process, procedure and tracking of their referrals.

NCH – Littleton Regional Hospital: LRH has a dedicated group of staff work that referrals. They are responsible for sending medical records via DSM and manage reminders in the EMR to look for referral reports coming back to LRH and the loop being closed. This process is all part of their EMR managed through orders functionality for the referral and direct messaging. The EMR manages the responsibility for follow-up.

Northern Human Services: NHS uses a referral workflow to describe how referrals are processed. Policies are in place on how to transfer to another mental health center. Depression Management protocol is outlined in multiple documents with eligibility assessment protocol guides to define needs and to specify level of service.

White Mountain Community Health Center: WMCHC operates a closed-loop referral process that is based on their EMR's order entry system. The process includes a written protocol.

Memorial Hospital: Referrals are made through the Hospitals new Epic EMR. Referrals are entered and tracked via the systems order entry feature. The hospital has a staff person who works to help manage the referral process. Memorial will be working to adjust workflows and protocols as the agency continues with the adoption of the Epic platform.

Cottage Hospital/Rowe Health Center: Cottage/RHC currently has an Internal Medicine to Behavioral Health Referral Process documented at their agency. Below is the documented process followed by the agency, and the IDN team engage with the partner to see how the plan to close the loop for external partner agencies.

The organization's closed loop referral procedure relies on their electronic medical record's ability to enter the required referral with appropriate information about the identified need and relevant dates of entry and follow-up. This data is the basis of tracking performed by staff in the EMR and related reporting to ensure a closed loop process.

NCH – Weeks Medical Center: WMC has a comprehensive referral protocol and referral policy flow in place to direct providers and staff through the referral process. This protocol and policy acts as a guide for both internal and external referrals, with directions for each referral type. Weeks' EMR, eClinicalWorks, is utilized to record referrals to WMC specialists and non-WMC specialists, at which time actions related to the referral are tracked. Once the referral is entered into the system it is labeled as "referral, scheduled" to await the receipt of report; once this report is received the referral is marked as reviewed. The protocol has instructions on how to manage referrals which include processing requests, managing pending referrals and managing pending report.

Coos County Family Health Services: CCFHS has established closed loop referral protocols in place.

Saco River Medical Group: The IDN team will continue to engage with staff at Saco River Medical Group to learn more about their closed loop referral process and aid with protocol development if it is needed.

Friendship House: The IDN team will continue to engage with staff at Friendship House to learn more about their closed loop referral process and aid with protocol development if it is needed.

White Horse Addiction Center: The IDN team will continue to engage with staff at White Horse Addiction Center to learn more about their closed loop referral process and aid with protocol development if it is needed.

B1-8h: Documented workflows

This section should represent the submission of the required workflows/protocols. Minimally, it should represent the IDN's plan to train and disseminate the workflows/protocols that address the requirements.

The IDN has developed a Protocol Clearinghouse that is housed on the Region 7 IDN Basecamp site. This area accessible by any IDN partner and is for the sharing of sample and draft policies and protocols to assist with the educating partners on protocols, defining requirements and promoting efficiency in the development of protocols. The IDN worked closely with IDN Quality Improvement Coach to coordinate

the development a set of sample protocols and policies and these are the basis of the Clearinghouse. The sample set includes:

- Care Coordination Documentation and Plan TCM
- Care Coordination Documentation Referral and Plan
- Collaborative Care Agreement
- Referrals Process Workflow Sample
- Sample Closed Loop Referral Guidelines
- Sample Process for MDCT and Complex Case Management Teams
- Sample Protocol for Comprehensive Core Standardized Assessment
- Sample SBIRT Screening Policy
- Sample Suicide Risk Assessment Procedure
- Sample Transitional Care Management Policy and Procedure
- Transition of Care Spreadsheet

Education on these protocols and the Clearinghouse will be delivered by the IDN Quality Improvement Coach at a Region 7 IDN Webinar in January. The IDN team encourage sharing and ask partners to contribute appropriate sample protocols to the Clearinghouse as they see fit.

IDN 7 partners have done considerable work in implementing multiple documented workflows throughout this reporting period.

White Mountain Community Health Center continues to work with IDN Quality Improvement Coach to develop and revise workflows and protocols. They have a finalized the CCSA protocol during the reporting period.

Cottage Hospital has been progress developing and documenting workflows throughout the hospital and Rowe Health Center. Cottage has made significant progress implementing the CCSA and has a comprehensive protocol similar to the sample protocol drafted by the IDN team in the previous reporting period.

Huggins has also continued to work with NCHC Quality Improvement Program Manager to develop and revise workflows and protocols.

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 • Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal services	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
	• 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 (including a psychiatrist) • Assigned care managers or community health worker	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health 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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	• SUD topics (multiple)	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 can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	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	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
	• Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support service providers • Intake procedures that include systematically soliciting patient consent to confidentially share 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

This section should consist of the progress toward Coordinated Care Practice designation of your partners to include the NH Plus requirements. For example, speak to your rollout of the CCSA.

The current status of IDN partners most likely to adopt the Shared Care Plan is outlined below:
Ammonoosuc Community Health Services: ACHS is currently not working on shared care plan implementation. IDN staff will continue to discuss how this can help the team and clients of ACHS.

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 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 ongoing communications and one meeting with their team that included a demo of the shared care plan, but it has been difficult to gain approval to proceed. As this hospital is near the Maine border and they are now 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 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 Medical Center, Androscoggin Valley Hospital, Littleton Regional Healthcare and Upper Connecticut Valley Hospital, and North Country Home Health and Hospice Agency. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint. Androscoggin Valley Hospital, Upper Connecticut Valley Hospital 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. The IDN team continues to work with Littleton Regional Healthcare to establish ADT connections for that agency.

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. NCH – 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 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 to work with the organization on planning for addressing IDN goals. This work is under way and the SCP is part of that discussion. Cottage is considering contributing ADT information to the CMT network and this is under legal review.

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 has not been engaged in SCP implementation to date. But at the end of this reporting cycle, IDN staff met with the organization to review progress towards IDN goals and after walking through SCP features and benefits, they agreed to a demonstration with Collective Medical. That meeting has been scheduled and it is expected that the organization will engage implementation steps in the early part of 2019.

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: During this reporting period, NHS met with Collective Medical and IDN staff several times about shared care planning. They have seen a demonstration of the product and completed required pre-implementation paperwork with CM. They identified their initial cohort for using the SCP to be clients receiving services from the ACT team as this a group of complex clients with high utilization of services. NHS completed significant due diligence on consent requirements and related processes. They are working on obtaining written consent from their target population. This is a process that will require time to complete as many consumers have guardians or may not appear for appointments. NHS has also worked to develop best practices for communication about integrated care and shared care planning with staff and clients. In this reporting period they have trained all staff on this process and introduced a brochure for clients that explains collaborative care and addresses common questions asked such as: What is the CMT Network? What are EDIE and PreManage? Who is on my “Care Team”? What does “Treatment” include? Am I required to participate in

EDIE/PreManage or can I opt-out? Will signing this Special Consent Form affect other consents or authorizations I have signed? Northern plans to complete an initial census upload early in 2019 and begin live use of the product at some point in the late winter or spring.

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 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.

Friendship House: Friendship House staff have not participated in conversations related to the implementation of the shared care plan to date due to 42CFR Part 2 concerns and their primary focus has been the opening of the new facility to serve patients. The IDN team will continue to engage in conversations with the staff at Friendship House during the upcoming reporting period related shared care plan implementation.

White Horse Addiction Center: White Horse has been active in quarterly meetings and IDN communications. Near the end of this reporting period, the IDN team joined discussions with White Horse leadership about the opportunities that exist for expanding coordinated care efforts with the shared care plan. The IDN team is working with the agency to determine how the shared care plan can work for White Horse and assess readiness for implementation.

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

Ammonoosuc Community Health Services: ACHS captures all required CCSA domains utilizing tablets for patients to answer the assessment questions as well as other admit information. Answers are automatically brought in to the visit note and are looked at by patient navigators. The organization has 4 patient navigators (one per 3 providers) that follow up on patient responses to the CCSA. Tablets are working on a Visual Signature Capture form and linked to their Centricity EHR. The agency is reviewing the appropriateness of this process for adolescents as they feel some aspects of the assessment should be framed differently for that population. The organization uses several assessments in conjunction with the CCSA including the PHQ-2 and PHQ-9. ACHS had planned to finalize their CCSA protocol before the end of 2019. While processes are active and clear for staff, written protocol for CCSA has not yet been finalized because ACHS has chosen to implement the CCSA process and use the PDSA cycle to determine if adjustments need to be made to the process before finalizing their protocol. However, the organization has seen the region's CCSA protocol template and participates in conversations related to workflow and protocol development.

Huggins Hospital: Huggins Hospital has completed a Comprehensive Core Standardized Assessment protocol that has included all required domains for patients 18 years and older. This protocol has been reviewed by appropriate committees and approved for use. The CCSA survey has been reviewed by the forms committee and has been approved for use. The checklist for documentation of completion of each domain will be developed in the health maintenance flowsheet of the EMR. This will allow tracking of completion of the CCSA process. There is a plan to pilot implementation at Wolfeboro Family Medicine with Dr. Jamison Costello's Medicaid patients that started December 18, 2019. Staff have been trained and full implementation continues to be a high priority. A process review will take place early in 2019.

Wolfeboro Pediatric Medicine does complete age appropriate developmental screenings using the Ages and Stages Questionnaire, Third Edition (ASQ-3). They are currently working on documenting that process workflow for consistency in training staff and tracking compliance. They anticipate having that completed by February 1, 2019.

Indian Stream Health Center (ISHC): All CCSA domains have been added to the organization's electronic health record and providers have access to the data as part of medical history. CCSA data fields are also synchronized from the Indian Stream record to the electronic record at their partner NCH – Upper Connecticut Valley Hospital. ISHC is working on finalizing written protocol for the CCSA and confirming process for annual update. The organization will begin the CCSA process via paper utilizing the following process... Patients who are coming in for annual visits will receive the CCSA from the nurse during the "rooming" process. They will be given time to complete the CCSA during their wait for the provider or immediately following the appointment if the provider is running on schedule/early. The provider will briefly examine the CCSA for any "red flags" and refer as appropriate. The nurse will enter the CCSA information into the EMR upon close of the appointment and has an opportunity to catch any "red flags" that the provider may have missed.

NCH – Littleton Regional Healthcare: The CCSA is fully templated and live in the electronic health record used by LRH's ambulatory clinic. Staff and providers are receiving education on its use. A barrier to completion of the CCSA at LRH has been staffing to apply the assessment but also to provide adequate follow-up on identified needs. A new Primary Care staffing plan is under consideration that would deepen care coordination resources including, among other things, a Population Health Coordinator whose role encompasses monitoring care gap reports, assisting patients in completing assessments like the CCSA and coordinating referrals to the appropriate community resources for our most needy patients with multiple comorbidities. The goal is to finalize this plan in early 2019 and begin hiring to facilitate primary care patients getting annual assessment and proper follow-up. The agency has seen the region's draft CCSA protocol and the IDN team will continue to work with staff at LRH to ensure they complete a written protocol.

Northern Human Services: NHS has adopted a full roll out of the CCSA format. They are moving through the administration of this tool to all clients and anticipate completing that process by the end of January 2019. Based on the nature of their population, NHS is updating this information quarterly. They use a variety of supplemental assessments in conjunction with the CCSA including the CANS/ANSA, PHQ-9 and the Columbia lethality assessment.

White Mountain Community Health Center (WMCHC): WMCHC has fully implemented the CCSA survey process with their Medicaid population of 18 years and older and are tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes. The care coordination team is responsible for tracking compliance and ensuring patients with identified needs are addressed with care coordination follow up. They have implemented ASQ-3 developmental screenings as part of their CCSA process as well. The agencies protocol was submitted during the last reporting period.

NCH – Weeks Medical Center: Weeks Medical Center implemented the CCSA in September of 2018. They have developed a formal protocol for collecting the data which is captured during the patient's annual visit and completed by the patient on a tablet. Staff report that this process is going well although they do have a challenge that sometimes patients do not want to provide the information.

Saco River Medical Group: This practice does not collect all domains of the CCSA at this time. They do not have a structured process to complete this task.

Coos Family Health Services: CFHS is currently collecting a majority of the CCSA domains including: Demographic, medical, substance abuse screenings/referrals, housing, education, employment, and depression screening. They are not collecting Family & Support services, Legal (other than advance directives & power of attorney), risk assessment and functional status. CFHS has communicated that will continue to evaluate the implementation of the CCSA and IDN staff will remain in communication with them on this.

White Horse Addiction Center: White Horse Addiction Center has had a very active year which included opening a new treatment location in North Conway. Near the end of this reporting period, the IDN team joined discussions with White Horse leadership about the opportunities that exist for expanding coordinated care efforts by implementing the CCSA, and the team will continue to engage in additional conversations with agency regarding this deliverable. The agency does create care plans for clients and part of this care plan address social determinants of health. The IDN team will work to learn more about this process to see what questions are asked of clients, and if those meet the DSRIP requirements for the CCSA process.

Memorial Hospital: Memorial Hospital went live with a new Epic EMR in this reporting period. They report all domains of the CCSA are captured in the system. They do not currently have a CCSA reporting procedure in place but are working to address that.

Cottage Hospital/Rowe Health Center: RHC and Cottage hospital have made significant progress in implementing the CCSA. As mentioned previously they have a documented protocol in place that was adapted from the sample protocol released to the region. They now capture all 12 domains and use SBIRT regularly. The PCP does have an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services.

Friendship House: Staff at Friendship House use the Continuum Narrative Report during the intake process for clients at Friendship House. Patients are asked questions related to medical, employment, alcohol, drug, legal, family/social and psychiatric involvement and/or problems. The answers to these questions assist in the development of the client's treatment plan. The IDN team will continue to engage with the agency to learn more about this intake process and to see if it meets DSRIP requirements for the CCSA.

The current status of IDN partners working with a Multidisciplinary Core Team is outlined below:
Huggins Hospital has continued to build their MDCT and conduct regular case conferences. They have been scheduling multi-disciplinary core team (MDCT) meetings on a monthly basis since August. A psychiatrist from Northern Human Services (NHS) attends these meetings as the psychiatric consultant. At this time, they have limited the primary care involvement, due to capacity of care coordination. They are unable to handle large volumes of complex case management but are looking to bolster their staffing in the near future with IDN funding opportunities.

White Mountain Community Health Center has also had success in implementing their MDCT. WMCHC had monthly case conferences with a psychiatrist from NHS and primary care providers for approximately 10 years. During the last reporting period the MDCT meet 4 times, one each month and as of June 2018, they have now included the care coordinator who is presenting shared cases and/or complex cases that need assistance with development of the plan of care. WMCHC has 2 psychiatric nurse practitioners that are on staff who participate in the MDCT meetings as well.

Ammonoosuc Community Health Services: ACHS has made progress in developing their MDCT during this reporting. They have a structured team with psychiatric consultation in place and have documented roles and responsibilities written for MDCT members, along with the purpose of the team. ACHS has held four MDCT meetings during this reporting period, including contracted psychiatric representation. The agency has held a structured meeting to strategize the most effective way to continue using the MDCT. In response, it has been arranged for providers to have a 15-minute block to participate in the care planning case conference in person or by phone. Cases presented are high utilizing or complicated patients selected at provider discretion. A barrier to implementation of the MDCT has been provider buy-in due to lack of time, referral processes, and the uncertain benefit for patients. Evidence-based articles have been provided to the team to support the MCDT process. At their last case conference, the team discussed 2-3 referrals which was proven to be helpful for providers.

Indian Stream Health Center: ISHC is working on developing a long-standing integrated provider meeting into a meeting to address MDCT requirements including case conference. This meeting has been conducted with providers from across disciplines where a variety of issues are discussed including patient issues. They have recently transitioned a staff person to be a behavioral health care manager and as of the end of 2018, staffing is in place for the MDCT. The ISHC team is now working on developing protocols and policy that will structure the MDCT meeting and hope to roll this out in 2019. The ISHC team has agreed to begin a more formal process for case conferences during their scheduled integrated provider meetings (both BH and medical). The agency will look into executing business associate agreements with other local organizations such as Upper Connecticut Valley Hospital and Northern Human Services to be able to include them in those discussions. The organization is familiar with meetings facilitated by NHS with school health, and ISHC will reach out about releases for their staff.

NCH – **Weeks Medical Center:** Currently Weeks has Behavioral Health embedded in daily interdisciplinary team meetings that involve real time review of all inpatient patients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP, as needed. Weeks does not currently schedule regular case conferences with a structure MDCT. If psychiatric input is needed the patient is put on the psychiatrist schedule. In the monthly provider meetings, BH is also present for case discussion. Weeks does not currently schedule regular case conferences with a structure MDCT. BH is also present for case discussion at monthly provider meetings. The IDN team will continue to work with Weeks to identify a standard case conference for the MDCT to discuss complex patient cases.

Cottage Hospital/Rowe: Cottage Hospital and Rowe Health Center have made significant progress in standing up a MDCT. The partners have developed and Integrated Care Team and a standard multi-disciplinary core team to provide effective and efficient collaboration of treatment interventions and care for those patients identified as experiencing behavioral health and/or complex chronic medical needs compounded by social determinants of health issues. The teams have similar staff attend as described in previous sections with the Integrated Care Team meeting weekly as part of the broader Provider Meeting. This meeting focuses on the following:

- New Patients: Risk Stratification and Concerns
- Existing Patients: Specific Goals for resolution through the discussion
- Anticipated BH and/or CCM Discharges in the next 1-2 months.

All patient cases which are discussed are documented via a new patient case or complex care management documentation protocol within the EHR.

Memorial Hospital: Memorial does not have a structured MDCT in place or hold monthly case conference however, BH staff are imbedded in primary care and involved in staff meetings with primary

care. As part of their I-MAT program, Memorial participates in a learning collaborative that regularly meets with representation from primary care providers, psychiatrists and any other necessary staff to discuss difficult patients, change in protocols or difficulty in implementing new protocols, and soliciting insight and guidance from other providers as necessary.

NCH – Littleton Regional Healthcare: Currently, LRH's level of integration is collegial interactions with providers through a shared EMR with behavioral health notes integrated with primary care records. PCPS can refer to psychiatric APRN or psychiatrist who are co-located. LRH does not have a structured MDCT team in place or case conferences to discuss complex patients. The IDN will continue to work with LRH to determine an effective case conference schedule and solidify their MDCT.

Saco River Medical Group: As mentioned previously throughout B1, SRMG does not currently have a multi-disciplinary core team in place, however they are searching for a psychiatrist to consult on difficult cases, once per month as a start. They have been communicating with Northern Human Services to address this need and plan to crafting a solid team moving forward. The IDN team plans to help facilitate discussion with SRMG and NHS to help them build a team that will include a psychiatrist. The IDN team will also continue to provide SRMG the tools to develop the team and schedule regular case conferences moving forwards.

Northern Human Services: Northern Human Services continues to sit on Huggins and WMCHC MDCT's, as well as the early childhood team at CCFHS.

Coos County Family Health Services: As previously mentioned, Coos County Family Health Services does not currently have a MDCT or case conference in place. They do however hold meetings for their early childhood team that Northern Human Services attend regularly and participate in care transition meetings which are attending by numerous provider agencies in the region. The IDN team will continue to engage CCFHS in conversations related to a MDCT.

Friendship House and White Horse Addiction Center: Friendship House and White Horse Addiction Center continue to build capacity to deliver services to the region's SUD population and will work closely with the IDN team to develop a process and structure for their MDCT's.

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

This section should speak to protocols for MAT and treatment of mild to moderate depression.

Medication-assisted treatment (MAT)

White Mountain Community Health Care: WMCHC has an active MAT program that is at capacity. And despite this growth of the service, they still feel demand is significant. The organization has written protocols in place for the program that are highlighted in the D3 project.

Saco River Medical Group: SRMG continues to expand their capacity to deliver MAT with their agency. SRMG added one new MAT certified prescriber who is performing SUD treatment as part of her regular schedule; this is a total of 2 MAT providers with a third contracted to start April 15, 2019. The agency reports a current total of 97 active MAT patients, 30 of which are new patients that have started treatment between 7/1/18-12/31/18. The partner has multiple protocols and documents in place to ensure program success.

Coos County Family Health Services: CCFHS has an active MAT program that started in 2018 with a focus on prenatal patients. They have started to reach out to their primary care patients and now serve 25 individuals with a wait list of 32. They are working towards an expansion of 50 MAT patients in a very

structured program that includes group sessions. CCFHS has 5 waivered prescribers and the program also includes the work of an RN, Recovery Coach and Women's Health staff. CCFHS using a comprehensive MAT Policy & Procedure document that explains the population eligible for treatment, the purpose of the program, enrollment requirements, referral management, provider training requirements, and several other detailed sections to ensure 42 CFR Part 2 compliance. CCFHS using multiple assessment strategies including the CAGE assessment for alcohol abuse and the Drug Abuse Screening Test DAST-10 for the program.

Ammonoosuc Community Health Services: ACHS continues to build capacity to deliver MAT services to internal patients with hopes to expand outside their walls in the future and attained their Drug Enforcement Agency credentialing in September 2018. Policies and workflows are continually being executed and assessed using the Plan, Do, Study, Act cycle (PDSA).

Huggins Hospital: Huggins has worked to build capacity for MAT in this reporting period. They have been working with consultants who have been on site multiple times assisting them with assessment tasks. The hospital has two waivered providers, this is an addition of 1 provider during this period. They have not seen a patient yet and will continue working to develop workflows and protocol specific to their MAT program.

Memorial Hospital: Memorial Hospital has continued to offer SUD services through their Integrated Medication Assisted Treatment Program (I-MAT) and the "A New Life" Prenatal Program. The I-MAT program served 45 new patients during the reporting period, making a total of 97 active patients between the 3 providers. In addition, Memorial's "New Life" Prenatal Program treated 4 patients during the reporting period.

NCH –Weeks Medical Center: WMC has continued to enhance and expanded their MAT program throughout the region. Weeks currently has two MAT waivered providers and two more completing certification. Their current estimate is a total of 60 patients enrolled in the program. The partner continues to use multiple workflows and protocols (new documents shown below) to ensure program success and quality care.

Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model) :

Northern Human Services: NHS is a community mental health center and does not have a formal MAT program although they do have a waivered prescriber on staff. NHS has positioned itself to be a behavior health provider working to integrate care in support of other providers who provide MAT. They don't do significant amounts of this work as frequently, health centers and other providers with MAT programs have developed their own behavioral health services.

Saco River Medical Group: SRMG does not have a formal depression workflow or protocol in place however they have a draft outline of a depression screening protocol shown below. The IDN team will continue working with SRMG to provide information on the IMPACT model and other model options.

The IDN team will continue to work with the remaining partners designated to adopt evidence-based treatment of mild-to-moderate depression by utilizing the Policy and Protocol Clearinghouse to share sample templates of common models, specifically the Collaborative Care Model which is discussed in detail under the joint service provider protocol session.

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

This table should include all partners at the practice level and their progress on the Use of Technology for At-risk, Plan of care, Monitor care and Closed loop referrals. If the provider already has the ability, speak to the IDNs plan to enhance the use of technology to promote Integrated Care.

Provider List		**Process Details**			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Northern Human Services	Community Mental Health Center	Alert system in EMR	Mass roll-out of SCP info to staff, clients. Initial census upload 1/2019 Goal all clients in system Need CMT-specific training High PHQ-9: staff now to do suicide assessment (Columbia in mid-January)	Focus on honing work flows, referral tracking and closing referral loop.	DSM in mid January, will ease burden of calling to determine patient status and place in the referral process.
White Mountain Community Health Center	Community Health Center	Event notifications being sent from Memorial, shared throughout office for cross coverage/care management.	Fully implemented the CCSA survey process with their Medicaid population of 18 years and older.	Tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes	The basis of CLR tracking is the order entry system of their EMR.

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Memorial Hospital	Hospital	Implementation of new EMR, Epic this past year featuring significant provider alerts at the point of service and care documentation. These prompts alert providers to situations that present risk for the patient and protocols that may assist or additional documentation to be completed. Has enabled closed loop referrals on patients who are part of the hospital primary care practices.	MaineHealth standard protocols for its system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment. 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.	Internal patients to MaineHealth, through EMR	Shared EMR assures closed loop referral for in-system Mainehealth patients only. Working on CLR for patients referred from outside the system.
Huggins Hospital	Hospital	The checklist for documentation of completion of each CCSA domain will be developed in the health maintenance flowsheet of the EMR. This will allow tracking of completion of the CCSA process and referencing for risk factors.	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.	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 has implemented monthly case conferences	*Focus on building Care Coordination staff, hopefully with IDN funds to assure f/u. MDCT meets with BH staff, seek to engage PCPs next as capacity to support complex cases allows.
Coos County Family Health Services	Community Health Center	* CCFHS collects majority of domains in CCSA, not yet risk assessment domain. * MAT services expanding to include new moms and partners.	*Completed installation of the shared care plan through CMT, use to track patient movement through other users of CMT system. *Patient transitional info from NCH-AVH Care Management team sends discharge plan and	Strong care coordination for high risk patients. Care managers access ADT information as part of their follow-up of high utilizers and complex/chronic care patients on CMT portal every day.	2 nurses and care coordinator on CMT are shared positions by CCFHS and NCH-AVH. Actively exploring community care

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
		*Continue work with NHS on a co-located BH and PCP. *Transitions of care tracked by care mgmt team as indicator of risk, through EMR.C	care plan to CCFHS for follow-up. Enhanced care management also through private insurance companies.		plan with local partners, would better communications, timeliness, assure closed loop.
Rowe Health Center	Community Health Center	Rowe and Cottage Hospital demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers.	Major step taken in conjunction with Cottage Hospital was to adopt and implement the same EMR.	Working to finalize how they will best utilize shared care plan going forward. IDN metrics examined for integration into processes.	
Saco River Medical Group	Community Health Center	*Use technology to identify at risk patients, plan their care, monitor their goals and ensure a closed loop referral thro patient registries on EHR. This is monitored by MAT providers and our Care Coordinator	Decision support built into EMR; using as conditional logic model for patients who should have specific followup at next appt. Working to stratify COPD, CHF.	Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring	Using EMR to check on referral out information (once back in record).
White Horse Addiction Center	Substance Use Disorder Treatment	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
NCH – Weeks Medical Center	Hospital	*Implemented the CCSA in September of 2018, formal protocol in place for collecting the data. Patient completes with annual visit using a tablet.	Weeks hospital emergency department to begin implementing SCP, the first hospital in the NCH network. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. Active use by the end of the next reporting cycle, Also work to capture all CCSA domains, aligning with NCH – Littleton Regional Healthcare on pilot.	Able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network Strong care coordination department and technology to identify high risk patients and document care	Formal written protocol in place for closed loop referral process.
NCH – Littleton Regional Healthcare	Hospital	EMR, eClinical Works, has built in registries for diabetes, heart failure, COPD. Await SUD. Chronic care management. CCSA seen as critical to risk ID. Opioid risk assessment tool. Screen for PPD in new moms.	Weeks hospital emergency department to begin implementing SCP, the first hospital in the NCH network which includes LRH. After the approach is modeled at Weeks, a rollout will occur to the other affiliation hospitals, with active use by the end of the next reporting cycle. Working to capture all CCSA domains Littleton Regional Healthcare will partner with Weeks on second phase of pilot.	Initiated project with IDN/CMT to establish ADT connections for Littleton Hospital, expect work completed next cycle. Open EMR system between BH and PCP to monitor and manage care	Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.
Indian Stream Health Center	Community Health Center	The AAFP model is used and 6 levels of risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically indicate needed care management.	Exploring SCP implementation in early 2019 with demonstration of the product and articulated next steps.	Collecting all domains in the CCSA, with access of this information available to all providers for their care planning with patients and care management. BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process.	CLR is currently tracked using a speadsheet with reports indicating needed follow-up.

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
				EMR documentation to montior	
NCHC Friendship House	Substance Use Disorder Treatment	Not sure her IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information
Ammonoosuc Community Health Services	Community Health Center	CCSA used for adult patients, all domains on a tablet while pt waits for appt. Synch'd into EMR for reference and use by patient navigator. BMI, Suicide Risk, Lead in children, Hypertension, Tobacco, Depression screens and assessments/followup.	Not yet addressed shared care plan priority, though IDN focus on how to assist in next reporting cycle.	Rigorous attention to MAT service development and provision. Electronic EMR system used to document patient treatment plans Policies and workflows are continually being executed	Electronic order sent out for referrals, clinical summary or note scanned into chart. Reports out of EMR can track whether loop generate a followup form to work on closing the loop.

The three agencies (Carroll County Department of Corrections, Life Coping Inc., Crotched Mountain) included in this table as it is shown in the implementation plan are not required B1 partners so Region 7 IDN team will continue to talk with them as necessary. The IDN team decided to focus on required B1 partners to highlight their progress towards coordinated and integrated care.

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

Submit all workflows for Joint service protocols and communication channels. At a minimum, provide a narrative describing the IDN's plan to develop/train partners and a timeframe for completion.

Further movement with joint service protocols and communication channels continues with several partners throughout the region to improve integration of behavioral health and primary care.

Ammonoosuc Community Health Services has been working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUDs since August 2018. During the last reporting period, ACHS proposed formalizing agreements and procedures with North Country Serenity Center (NCSC) to provide medical, dental, vision, behavioral health, substance misuse, nutrition, and patient navigation services, while utilizing NCSC's peer support and recovery support services for ACHS patients. ACHS will gain the ability to provide complete wrap-around services for persons with behavioral health and substance use disorders, and by using its internal capacities, in addition with NCSC for persons that exit corrections' institutions, residential programs, or hospitals. This formalized agreement will enable ACHS to provide services that will ultimately reduce recidivism, relapse rates, and expand behavioral health services.

Currently the proposed formal agreements and procedures or written protocols are not in place with NCSC. ACHS leadership has been encouraged to construct a Qualified Service Organization Agreement (QSOA) with no success. ACHS is currently reviewing its HIPPA and CFR 42 Part 2 compliance and has decided to have their lawyers present to the staff compliance education and training meeting in early 2019. It was decided to discuss specific relationships such as NCSC at that presentation. In the meantime, the partners have been using Release of Information (ROI) as authorization to discuss patients and have case management meetings bi-weekly to discuss mutual client goals and progress.

ACHS also has a comprehensive feedback loop documented with NCH – Littleton Regional Healthcare ED to allow them to track high utilizers within their patient population. This relationship is explained in greater detail within the D3 project including a snapshot of their feedback loop workflow.

The Region 7 IDN team is also excited to help partners develop joint service protocols and communication channels using a newly developed Collaborative Care Agreement. The IDN Quality Improvement Coach worked throughout the reporting period to draft the agreement for partners to use as templates to provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers. White Mountain Community Health Center and Northern Human Services have adapted this template to fit the needs of the communications they currently have between each other and plan to use this system to improve care across both agencies. All IDN 7 partners have access to this document through the new Policy and Protocol Clearinghouse folder on Basecamp. The complete draft is included below.

Collaborative Care Agreement

The primary care practice of (Primary Care Practice Name) and (Specialty Practice Name) has developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

Collaborative Guidelines

I. Purpose

- To provide optimal health care for our patients
- To provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers

II. Principles

- Safe, effective and timely patient care is our central goal.
- Effective communication between primary care and behavioral health care is essential to providing optimal patient care and to eliminate the waste and excess costs of health care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- A high functioning medical system of care provides patients with access to the 'right care at the right time in the right place'

III. Definitions

Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients.
Specialist (Psychiatrist) – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.
Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.
Care Manager – An APN who uses evidence based guidelines and assessment tools to identify high risk
patients in the primary care practice. The CM then facilitates patient care through the complex health system according to PCMH principals including but not limited to:

i. Whole person orientation
ii. Coordinated and/or integrated care
iii. Quality and safety
iv. Enhanced access

Behavioral Health Navigator – a social worker who works as a team member with a Nurse Navigator and the patients primary care provider to assist the patient in negotiating the complex health care system
Nurse Navigator – an RN who works as a team member with the Behavioral Health Navigator and the patients primary care provider to assist the patient in negotiating the complex health care system
Patient-Centered Medical Home –a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.
Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment options, and expectations taking into consideration the patient's psychosocial and personal needs.
Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

IV. Types of Transitions of Care

- *Pre-consultation exchange* – communication between the PCP and Health Options Social Worker to
  - i Answer a clinical question and/or determine the necessity of a formal consultation.
  - ii Facilitate timely access and determine the urgency of referral to specialty care.
  - iii Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.

Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.

Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient's health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources.

Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.

- i *Co-management with shared management for the disease* – the specialist shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the primary care and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.
- ii *Co-management with Principal Care for the Disease (Referral)* – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The primary care practice continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.
- iii *Co-management with Principal Care for the Patient (Consuming illness)* – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The primary care practice remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.
- iv *Emergency Care* – medical or surgical care obtain on an urgent or emergent basis.

Primary Care – Behavioral Health Compact

V. Mutual Agreement for Care Management

Review tables and determine which services you can provide.

The *Mutual Agreement* section of the tables reflects the core element of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.

- The *Expectations* section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or Behavioral Health.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.

When patients self-refer to Behavioral Health, processes should be in place to determine the patient's overall needs and reintegrate further care with the primary care practice, as appropriate.

The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.

- Each provider should agree to open dialogue to discuss and correct real or perceived breaches

of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

Primary Care – Behavioral Health Compact

Transition of Care	
Mutual Agreement	
• Maintain accurate and up-to-date clinical record. • When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record (CCR) or Continuity of Care Document (CCD). • Ensure safe and timely transfer of care of a prepared patient.	
Expectations	
Primary Care	Behavioral Health
- PCP maintains complete & up-to-date record including demographics - Transfers information as outlined in Patient Transition Record - Orders appropriate studies that would facilitate the Behavioral Health visit - Provides patient with Behavioral Health contact information & expected time frame for appointment - PCP Care Manager facilitates the Transition of Care by communicating directly with the Behavioral Health Social Worker to plan a strategy for the transition. - Patient/family are in agreement with the referral, type of referral & selections of specialist	- Determines &/or confirms insurance eligibility - Identifies a specific referral contact person to communicate with in the PCP office - Assist PCP prior to the appointment regarding appropriate pre-referral work-up - Informs patient of need, purpose, expectations & goals of transfer

Addendum
Additional Agreement/Edits

Primary Care – Behavioral Health Compact

Access
Mutual Agreement

- Be readily available for urgent help to both the physician and patient
- Provide adequate visit availability
- Be prepared to respond to urgencies
- Offer reasonably convenient office facilities and hours of operation
- Provide alternate back-up when unavailable for urgent matters
- When available and clinically practical, provide a secure email option for communication with established patients and/or providers

Expectations	
Primary Care	Behavioral Health
☐ Communicate with patients who miss appointments to Behavioral Health ☐ Determines reasonable time frame for specialist appointment	☐ Notifies PCP of missed appointments or other actions that place patient jeopardy Schedule patient's first appointment with requested provider Provide PCP with a list of practice physicians who agree to agreement principles

Addendum
Additional Agreement/Edits

Primary Care – Behavioral Health Compact

Patient Communication	
Mutual Agreement	
• Consider patient/family choices in care management, diagnostic testing & treatment plan • Provide information to & obtain consent from patient according to community standards • Explore patient issues on quality of life in regards to their specific medical condition & shares this information with the care team	
Expectations	
Primary Care	Behavioral Health
☐ Explains, clarifies, & secures mutual agreement with patient on recommended care plan ☐ Assists patient in identifying their treatment goals ☐ Engages patient in the PCMH concept and identifies whom the patient wishes to be included in their care team	☐ Informs patient of diagnosis, prognosis & follow-up recommendations ☐ Provides educational material & resources to patient when appropriate ☐ Recommends appropriate follow-up with PCP ☐ Be available to the patient to discuss questions or concerns regarding the consultation of their care management ☐ Participates with patient care team

Addendum
Additional Agreement/Edits

Primary Care – Behavioral Health Compact

Collaborative Care Management	
Mutual Agreement	
• Define responsibilities between PCP, Behavioral Health, and patient • Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up • Maintain competency and skills within scope of work & standard of care • Give & accept respectful feedback when expectations, guidelines or standards of care are not met • Agree on type of care that best fits the patient's needs	
Expectations	
Primary Care	Behavioral Health
Follows principles of PCMH Manages Behavioral Health problem to the extent of the PCP's scope of practice, abilities & skills Follows standard practice guidelines related to evidence-based guidelines Resumes care of the patient as outlined by Behavioral Health & incorporates care plan recommendations into overall care of the patient Shares data with Behavioral Health in a timely manner including data from other providers	Review information sent by PCP; address provider & patient concerns Confer with PCP & establish protocol before ordering additional services outside of practice guidelines Confers with PCP before referring to other specialists; uses preferred provider list Sends timely reports to PCP; shares data with care team Notifies PCP of major interventions, emergency care, & hospitalizations

Addendum
Additional Agreement/Edits

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 atient progress oward 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.

B1-10 Table 1: B1 partners who have achieved Coordinated Care designation to include NH Plus requirements or partners who have achieved Integrated Care designation

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	7
Integrated Care Practice	9	0	0	0	0

The Region 7 IDN team feels that 7 out of 13 agencies in the region have achieved Coordinated Care Practice Designation as reflected by their progress above and in the documents below: Northern Human Services, NCH – Weeks Medical Center, Huggins Hospital, White Mountain Community Health Center, Indian Stream Health Center, Ammonoosuc Community Health Services, and Rowe Health Center. Coos County Family Health Services, Memorial Hospital, and Saco River Medical Group are still working on processes to capture all of the domains of the CCSA for a variety of reasons. For example, Memorial Hospital has the ability to capture the domains in their new Epic platform but has not created the processes to do so yet. Friendship House and White Horse Addiction Center have had to work around 42CFR Part 2 which has delayed some of the engagement with these 2 agencies. Littleton Regional Healthcare was able to get a system in place to capture all of the required CCSA domains, but the agency is still working to get formal protocols in place and a formal system in place for a multi-disciplinary core team.

B1-10 Table 2: Progress Toward Coordinated Care Practice Designation

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

Agencies with an asterisk are the ones that Region 7 IDN feels have achieved Coordinated Care Practice designation

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
***Northern Human Services**		CCSA & SCP including NH Plus: • Actively engaged in shared care plan conversations Multi-Disciplinary Core Team: • Finalizing a contract with NCHC to provide psychiatric	CCSA & SCP including NH Plus: • Developed best practices for communication about integrated care and shared

		services for developing MDCT's across the region • Finalizing CrossRoads clinic, a co-located site with CCFHS supplying primary care providers • Part of a multi-disciplinary core team meeting with WMCHC and soon to be with Huggins Hospital • Staff member attended Regional Care Coordinator training <u>Information Sharing:</u> • Working on consent requirements and related processes relating to the shared care plan	care planning with staff and clients • CCSA now in EMR, expect all patients to be using by end of January • Use Dartmouth SDoH assessment, like it <u>Multi-Disciplinary Core Team:</u> • Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care. • Can opt for on-site to FQHC's, see patients, then bill • Practice transformation work addressing MDCT work done by psychiatrist with Huggins and WMCH • Participates on MDCT at WMCHC and Huggins Hospital <u>Information Sharing:</u> • On site mtg with IDN HIT coach and CMT demonstration for SCP; First client population to be Assertive Community TX clients • To complete an initial census upload early in 2019 and begin live use early spring • Opt-out and consent/authorizations explained • Event notifications soon, up and running in some locations • Mid-January, upgrade with Esscentia for DSM • Consent requirements being finalized <u>Workflows & Protocols:</u> • Workflow chart sent on referrals • Risk stratification built into procedures
***White Mountain Community Health Center**		<u>CCSA & SCP including NH Plus:</u> • Developed a CCSA assessment process • Actively working to install shared care plan <u>Multi-Disciplinary Core Team:</u> • Hired a care coordinator	<u>CCSA & SCP including NH Plus:</u> • Developed an assessment process • Developing protocols for care guidelines in SCP • Fully implemented CCSA with Medicaid population 18 yo and

		• Staff member attended Regional Care Coordination Training <u>Information Sharing:</u> • Held first case conference June 2018, and establish a MDCT process • 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 <u>Workflows & Protocols:</u> • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	over; tracking through Health Maintenance Flowsheet on EMR, use for reporting by Care Coordination Team. <u>Multi-Disciplinary Core Team:</u> • Established a multidisciplinary team process • Hired a care coordinator • MDCT monthly case conference with NHS psychiatrist and WMCHC primary care, behavioral health, and care managers • MDCT case conferences in grand rounds style, care coordinator began presenting complex cases and consults for med prescribing. <u>Information Sharing:</u> • Implemented CMT PreManage • Receiving Event Notifications, circulated to all staff to assure coverage of patient follow-up; see this as critical to care coordination and decreasing ED use <u>Workflows & Protocols:</u> • Working on risk stratification models using PDSA approach on CCSA protocol
Memorial Hospital		<u>CCSA & SCP including NH Plus:</u> • 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 <u>Multi-Disciplinary Core Team:</u> • nurse practitioners have received certification in MAT and have a robust behavioral health integration project underway through MaineHealth • Looking into connecting to psychiatric services through MaineHealth; • Staff attended a Mental Health First Aid training <u>Information Sharing:</u>	<u>CCSA & SCP including NH Plus:</u> • Six standardized assessments used across the system for SUD and BH <u>Multi-Disciplinary Core Team:</u> • Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum that has primary care providers, psychiatrists and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary, the agency has access to

		• Taken the lead on a four-agency collaborative proposal in Region 7 IDN to improve care coordination in the North Conway area	psychiatrists through MaineHealth. <u>Information Sharing:</u> • SCP and ADT feeds to CMT next priority for IDN <u>Workflows & Protocols:</u> • Epic EMR migration focus, so IDN team will continue to engage on CCSA protocol. Domains being built within EPIC • Closed loop for internal patients, look to expand and focus on this for external referrals they receive • Focused on behavioral health integration, and MAT expansion
***Huggins Hospital**		<u>CCSA & SCP including NH Plus:</u> • 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 • Plans to roll out the CCSA for their entire patient population, not just the Medicaid population <u>Multi-Disciplinary Core Team:</u> • 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 <u>Information Sharing:</u> • Hospital is contributing ADT feeds to the CMT network • Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in the Clinic • Neither location is actively using the SCP yet as they work through adoption and	<u>CCSA & SCP including NH Plus:</u> • CCSA protocol reviewed and approved, includes all domains per DSRIP • Piloting CCSA at Wolfeboro Family Medicine starting Dec. 18th; staff trained, patients to pilot chosen, results to be documented to inform upcoming full implementation <u>Multi-Disciplinary Core Team:</u> • Hosted 1 more Mental Health First Aid training • Care guidelines in process, as is consent process for contributing to patient goals and treatment plan • MDCT meets monthly, with NHS psychiatrist, only limited PCP involvement due to care coordination capacity issues • Hope to bolster staffing with IDN funding for care coordination of CCSA identified issues <u>Information Sharing:</u> • Pre-Manage ED in both hospital and clinic completed • Hospital sending ADT's to the CMT network • Event notifications being sent to ED via dedicated printer

		workflow as well as a fix to the ADT process	• Outpatient SW staff using CMT portal Workflows & Protocols: • CMT-Related workflows created • Sample policies and consents being amended for Huggins format
Saco River Medical Group		CCSA & SCP including NH Plus: • Saco River Medical Group is looking at the CCSA process and is working to address the IDN domains Multi-Disciplinary Core Team: • Staff attended Regional Care Coordinator training Information Sharing: • Saco River and IDN staff have met twice to discuss the SCP; resources to install and provider workflow and productivity impact have been concerns Workflows & Protocols: • Staff are working on care coordination processes	CCSA & SCP including NH Plus: • SCP discussions continue but there are concerns because Memorial Hospital is not yet submitting ADT feeds Multi-Disciplinary Core Team: • IDN team will continue to engage with Saco River Medical Group regarding MDCT Information Sharing: • Continue to engage on Coordinated care initiatives with local partners and shared care plan implementation Workflows & Protocols: • IDN team will continue to engage on protocol development
Coos County Family Health Services		CCSA & SCP including NH Plus: • CCFHS addresses most of the domains in the CCSA and conversations continue about the CCSA process and shared care plan Multi-Disciplinary Core Team: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services Information Sharing: • 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	CCSA & SCP including NH Plus: • Assessing some of the CCSA domains, but not consistently • Shared care plan work continues, the additional DSRIP deliverables considered in this context Multi-Disciplinary Core Team: • No MDCT currently in place but do hold meetings for their early childhood team that Northern Human Services attend regularly and participate in care transition meetings which are attending by numerous provider agencies in the region. The IDN team will continue to engage CCFHS on MDCT Information Sharing: • Implemented event notifications, working to

			understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT Workflows & Protocols: referral protocols in place. IDN team will continue engagement on CCSA protocol
***NCH – Weeks Medical Center**		CCSA & SCP including NH Plus: • Weeks plans to move forward to implement a CCSA during the next 6 months and use lessons learned to share with NCH – Littleton Regional Healthcare as they implement the CCSA Multi-Disciplinary Core Team: • 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 Information Sharing: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network • NCH has also agreed to begin implementing the shared care plan; this will occur first at the Weeks Emergency Department Workflows & Protocols: • 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	CCSA & SCP including NH Plus: • CCSA implemented in September, use tablet to collect info from patients • Patient opt out possible question by question, rather than for whole survey Multi-Disciplinary Core Team: • Registries run based on real time data, e.g. diabetes • MDCT is embedded in IDT daily meetings • Working closely with LRH and AVH to help staff NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 Information Sharing: • BH team meets regularly and as needed for case conferencing • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Workflows & Protocols: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers
***Indian Stream Health Center**		CCSA & SCP including NH Plus: • ISHC is engaged in conversations related to CCSA and are currently revising their assessment process	Multi-Disciplinary Core Team: • MDCT meets weekly, includes psychiatry;

		• Staff is interested in shared care plan and IDN staff will engage them in additional conversations in the next 6 months <u>Multi-Disciplinary Core Team:</u> • 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	• Care management process now inclusive of BH and Primary care, recruiting for 3rd Social Worker <u>Information Sharing:</u> • Many changes, including interim and new CEO's, EMR upgrade, new QI Director, loss of IT Director, have slowed progress this period • Care coordination remains paramount; IDN HIT Coach met with team early December, slating SCP implementation early Jan 2019 • Project engagement pending <u>Workflows & Protocols:</u> • Referrals tracked, honing closed loop referral process and form • Structured case review protocol pending
***Ammonoosuc Community Health Services**		<u>CCSA & SCP including NH Plus:</u> • Creating a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets • The agency plans to finalize their CCSA protocol once they have finished embedding a form into their tablets/EMR and anticipate they will have this completed before the end of 2018 • Modifying CCSA for adolescents <u>Workflows & Protocols:</u> • ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed • Working on development of various protocols required	<u>CCSA & SCP including NH Plus:</u> • Continue to capture all domains within the CCSA. ACHS has implemented the process within tablets given to patients before visits. • Written protocol for CCSA has not yet been finalized but is in process. Protocol for follow-up is in place and guides the role of the Patient Navigators. <u>Multi-Disciplinary Core Team:</u> • Structured team with psychiatric consultation in place • Documented roles and responsibilities written for MDCT members, along with the purpose of the team. • ACHS has held four MDCT meetings during this reporting period <u>Information Sharing:</u> • Working with North Country Serenity Center to provide

			Recovery Support Services for 24 patients/clients with SUDs since August 2018 <u>Workflows & Protocols:</u> • Implemented feedback loop to increase identification and timeliness of appointments for patients seen in ED for BH related issues. 7% of ED pts were there for BH reasons, 5% were seen by ACHS for follow-up
NCH – Littleton Regional Healthcare		<u>CCSA & SCP including NH Plus:</u> • LRH will work to capture domains required in IDN CCSA and will work closely with NCH – Weeks Medical Center to help with this process • 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 on implementation. <u>Information Sharing:</u> • ADT feeds should be live in next reporting period	<u>CCSA & SCP including NH Plus:</u> • CCSA templated in EMR, including all domains for adults and pediatric patients • EMR captures SBIRT • Protocol not finalized <u>Multi-Disciplinary Core Team:</u> • Six days a month, two contracted psychiatrists are on site for diagnostic and medication management services; they recommend care plan to PCP via a shared EMR • Two social workers, one fully licensed and the other finalizing supervision requirements, provide full time counseling services to patients in the primary care practice • Practice also leases space to Weeks so that their Psychiatric APRN can provide satellite services to LRH patients one day per week (records are kept in WMC EMR) • 3 waivered MAT providers at LRH, no MAT program yet • OB/GYN providers working with Dartmouth using CARPP to support moms that are addicted • Plans to work on implementation of MDCT when care coordination staffing filled out <u>Information Sharing:</u>

			• Co-located PCPs and BH providers work within a shared EMR so BH notes are readily available to PCPs; psychotherapy notes are not part of record per HIPAA rules, but the full BH consult note is available to PCP and Care Coordinators Workflows & Protocols: • Focus on written work flows and protocols for CCSA and closed loop referral tracking
***Rowe Health Center**		CCSA & SCP including NH Plus: • Conversations continue around the CCSA and shared care plan Multi-Disciplinary Core Team: • The health center continues to build capacity to implement integrated healthcare	CCSA & SCP including NH Plus: • Documented protocol in place adapted from the sample protocol released to the region. • Capture all 12 domains and use SBIRT regularly. T • PCP has an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services. • IDN team still engaging agency on SCP implementation Multi-disciplinary core team: • Weekly Integrated Care Team meeting with primary care, care coordinator, social worker and behavioral health APRN to discuss patients. • Behavioral health APRN then takes any patient cases that need additional consideration by the psychiatrist to a meeting between the APRN and psychiatrist. APRN brings feedback to the next weekly meeting. • Documented Integrated and Multidisciplinary Care Team Protocol that explains each team's purpose, members, roles, communication, format, and logistics. Information Sharing:

			• Significantly advanced care coordination efforts by unifying EMR between hospital and health clinic Workflows & Protocols: • CCSA, MDCT and referral protocols in place. Agency working with IDN team to adapt regional protocols
White Horse Addiction Center		CCSA & SCP including NH Plus: • Not engaged in active work on the shared care plan – IDN staff will engage with White Horse about the shared care plan in the next reporting period; Multi-Disciplinary Core Team: • Working with a consultant to build capacity and implement processes to work toward coordinated care	CCSA & SCP including NH Plus: • Discussing opportunities that exist for expanding coordinated care efforts by implementing the CCSA. • The IDN team will work to learn more about this process to see what questions are asked of clients, and if those meet the DSRIP requirements for the CCSA process. • IDN team is working with the agency to determine how the shared care plan can work for White Horse and assess readiness for implementation. Multi-disciplinary core team: • IDN team will engage White Horse Addiction Center leadership to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this Workflows & Protocols: IDN team working with agency staff to determine protocols and workflows in place

NCHC Clinical Services – Friendship House		CCSA & SCP including NH Plus: • 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; Workflows & Protocols: • Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders.	CCSA & SCP including NH Plus: Multi-disciplinary core team: IDN team will work with Friendship House staff to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this • Agreements with ACHS and CCFHS for preadmission physicals Workflows & Protocols: • IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • CARF accreditation in progress

B1-10 Table 3: Progress toward Integrated Care Practice Designation

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

Region 7 IDN has identified 9 agencies to work towards Integrated Care Practice Designation: Ammonoosuc Community Health Services, Memorial Hospital, Weeks Medical Center, Coos County Family Health Services, Northern Human Services, Friendship House, White Mountain Community Health Center, Huggins Hospital, and Saco River Medical Group.

Providers Progressing toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
Northern Human Services		Technology for at-risk patients: • Have been working on consent requirements and related processes relating to the shared care plan; • Actively engaged in shared care plan conversations	Coordinated Care Practice Designation met according to Region 7 IDN Technology for at-risk patients: • On site mtg with IDN HIT coach and CMT demonstration for SCP; first client population to be Assertive Community TX clients

			• To complete an initial census upload early in 2019 and begin live use early spring • Mid-January, upgrade with Esscentia for DSM • Event notifications soon, up and running in some locations • Risk stratification built into procedures <u>Collaboration with Community Based Supports:</u> • Developed best practices for communication about integrated care and shared care planning with staff and clients • Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care • Consent requirements being finalized
White Mountain Community Health Center		<u>Evidence Based Interventions:</u> • 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 <u>Technology for at-risk patients:</u> • Actively working to install shared care plan; • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	<u>Coordinated Care Practice Designation met according to Region 7 IDN</u> <u>Evidence Based Interventions:</u> • Provides comprehensive MAT services; active MAT program at capacity, working to expand and prescriber waiver increased to 100 to accommodate <u>Technology for at-risk patients:</u> • Working on risk stratification models
Memorial Hospital		<u>Evidence Based Interventions:</u> • New nurse practitioner has received certification in MAT • Have a robust BH integration project underway through MaineHealth	<u>Coordinated Care Practice Designation in progress according to Region 7 IDN</u> <u>Evidence Based Interventions:</u> • Provides comprehensive MAT services • Focused on behavioral health integration, and MAT expansion • Six standardized assessments used across the system for SUD and BH <u>Technology for at-risk patients:</u> • SCP and ADT feeds to CMT next priority for IDN <u>Collaboration with Community Based Supports:</u> • Closed loop for internal patients, look to expand and

			focus on this for external referrals they receive
Coos County Family Health Services		Evidence Based Interventions: • MAT program in place Technology for at-risk patients: • 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 Collaboration with Community Based Supports: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services	Coordinated Care Practice Designation in progress according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Expansion MAT program to accept referrals from primary care providers; 5 waivered prescribers and the program includes an RN, Recovery Coach and Women's Health staff • Seven BH staff attended Cherokee training and agency is working to implement BH services in a similar fashion to the Cherokee model Technology for at-risk patients: • Implemented event notifications, working to understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT
NCH – Weeks Medical Center		Evidence Based Interventions: • Weeks has a robust MAT program Technology for at-risk patients: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. • NCH has also agreed to begin implementing the shared care plan; this will occur first at the WMC Emergency Department	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Working closely with AVH and LRH to stand up NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Technology for at-risk patients: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers

Ammonoosuc Community Health Services		Coordinated Care Practice Designation in progress according to Region 7 IDN Evidence Based Interventions: • Provides MAT services Technology for at-risk patients • 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 once they have finished embedding a form into their tablets and anticipate they will have this completed before the end of 2018; Collaboration with Community Based Supports: • Agreements in place with North Country Serenity Center • Agreements in place with NCHC Friendship House to provide medical care to residential patients as needed	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • Provides MAT services Collaboration with Community Based Supports: • Implemented feedback loop to increase identification and timeliness of appointments for patients seen in ED for BH related issues (7% of ED pts were there for BH reasons, 5% were seen by ACHS for follow-up) • Working with North Country Serenity Center (NCSC) to provide Recovery Support services for 24 patients/clients with SUD since August 2018 while ACHS provides medical, dental, vision, BH, SUD, nutrition and patient navigation services with a goal to reduce recidivism, relapse rates, and expand BH services
NCHC Clinical Services – Friendship House		Evidence Based Interventions: • Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders. Technology for at-risk patients: • 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	Coordinated Care Practice Designation in progress according to Region 7 IDN Evidence Based Interventions: • IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • Barriers to patient fidelity are transportation and lack of resources • CARF accreditation in progress • Agency working to implement MAT program Collaboration with Community Based Supports: • Agreements with ACHS and CCFHS for preadmission physicals • Working with agency staff regarding SCP implementation

Saco River Medical Group		Coordinated Care Practice Designation in progress according to Region 7 IDN Evidence Based Interventions: • Saco River Medical Group has a MAT program in place	Coordinated Care Practice Designation in progress according to Region 7 IDN Evidence Based Interventions: • Provides MAT services and has multiple protocols and documents in place to ensure program success. • Does not have a formal depression workflow or protocol in place however they have a draft outline of a depression screening protocol and are working with IDN team to explore IMPACT model and other models Technology for at-risk patients: • Decision support built into EMR; using as conditional logic model for patients who should have specific follow-up at next appt. and Working to stratify COPD, CHF • Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring • Using EMR to check on referral out information (once back in record).
Huggins Hospital		Coordinated Care Practice Designation in progress according to Region 7 IDN Evidence Based Interventions: •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;	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • MAT program under development Technology for at-risk patients: • 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. • Works closely with the IDN Quality Improvement Coach to address the DSRIP deliverables, has created a multi-disciplinary core team, supported by a

			psychiatrist as previously mentioned, and has implemented monthly case conferences • Focus on building Care Coordination staff to assure f/u. MDCT meets with BH staff, seek to engage PCPs next as capacity to support complex cases allows.
White Horse Addiction Center		<u>Coordinated Care Practice Designation in progress according to Region 7 IDN</u> IDN team will continue to gather additional information on required aspects of integrated care destination.	<u>Coordinated Care Practice Designation in progress according to Region 7 IDN</u> IDN team will continue to gather additional information on required aspects of integrated care destination.
Littleton Regional Healthcare		<u>Coordinated Care Practice Designation in progress according to Region 7 IDN</u> • IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan. • 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	<u>Coordinated Care Practice Designation in progress according to Region 7 IDN</u> <u>Evidence Based Interventions:</u> • January 2019 NH Doorway will open at LRH <u>Technology for at-risk patients:</u> • CCSA in place. Need additional care coordination staff to address social determinants of health • EMR, eClinical Works, has built in registries for diabetes, heart failure, COPD. Await SUD. Chronic care management; CCSA seen as critical to risk ID; Opioid risk assessment tool; Screen for PPD in new moms • Open EMR system between BH and PCP to monitor and manage care • Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.

Rowe Health Center		Coordinated Care Practice Designation in progress according to Region 7 IDN •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	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • IDN staff will continue to engage with Rowe Health Center on evidence based interventions Technology for at-risk patients: • Demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers. • Major step taken in conjunction with Cottage Hospital was to adopt and implement the same EMR.
Indian Stream Health Center		Coordinated Care Practice Designation in progress according to Region 7 IDN	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: Technology for at-risk patients: • The AAFP model is used and 6 levels of risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically indicate needed care management. • Exploring SCP implementation in early 2019 with demonstration of the product and articulated next steps. • BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process. • EMR documentation to monitor • CLR is currently tracked using a spreadsheet with reports indicating needed follow-up.

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.

During the reporting period of 07/01/2018-12/31/2018 Region 7 IDN had no members join or leave the network.

Region 7 IDN chose Care Transition Teams as the C1 Community Project and has been consistently making progress to grow the Critical Time Intervention (CTI) network in the region. CTI's evidence-based approach to serving vulnerable populations when supports are critical by providing focused care at staged levels of decreasing intensity is helping clients overcome barriers as they make major transitions. Region 7 has been working to implement CTI Teams to address many different transitions and currently has teams for homelessness to housing, incarceration to community, and SUD issues to treatment. Plans are in the works to stand up teams for discharge from both medical and psychiatric hospitals to the community. This comprehensive approach of embedding CTI Teams in agencies to address many different transitions is taking longer to implement than the approach of utilizing one team that grows larger; however, it is setting the region up well for sustainability. Region 7 IDN was also faced with another setback after losing their NCHC project coordinator whose main focus was convening the CTI partners to move the project forward.

The five IDNs that are working on the C1 project held a CTI Train-the-Trainer training in August 2018 in Plymouth, NH for 14 participants and 2 facilitators from the Center for the Advancement of CTI (CACTI). Two of those participants were from Region 7. NCHC, as the Region 7 IDN lead agency, took responsibility for planning the location, travel details, and registration process for the event. The training objectives stated that participants would be able to 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, and enhance skillfulness as a trainer through practice with feedback. This training now allows all five regions to adapt the training to their needs; whether it be a one-hour presentation to partners, a one-day training within an agency, or a two-day training for people from agencies who are new to CTI.

Trainers from IDN Region 6 & 7 worked closely with staff from CACTI to plan and conduct a 2-day CTI Worker Training for 23 participants at the beginning of November 2018. One CTI Worker from Region 1 and one from Region 4 were able to join the other two regions on Day 1 at Plymouth State University. The topics included CTI Model & Essentials, Practical Strategies useful in CTI, and Getting Started with CTI – Case Scenarios. On Day 2, Region 6 met in Dover to continue with training specific to their region while the 15 participants from Region 7 met in Littleton. Topics for Region 7 were Community Partners Activity, CTI Team Structure & Team Work, Fidelity Monitoring & Quality Assurance, and How to Implement a New Team/Strengthen an Existing Team. The day also included a virtual visit from Kim Livingstone of CACTI for technical assistance and additional questions. Evaluation from both days were very positive.

The CTI-NH Community of Practice continued with monthly virtual meetings and quarterly in-person meetings with logistical support from Region 7 IDN. These meetings provided the five regions an opportunity to share new information about CTI work including successes and challenges with the contribution of feedback from others with similar experiences. Some commonalities that arose were issues with receiving timely and appropriate referrals, thoughts of moving to electronic tracking and documentation, problems with finding housing, and feelings of gratification when clients made gains. Participants have expressed that the collaboration and knowing they are not alone in their experiences has been beneficial. The September in-person meeting in Concord included the updates from each region as well as a Harm Reduction Training for 19 participants, 3 of whom were from Region 7 IDN. Due to scheduling complications, all regions agreed that the December in-person meeting would be postponed until January. The plan is to widen the scope of experiences beyond NH by reaching out to the CTI Global Network and inviting their participation in the CTI-NH Community of Practice in the coming year. New and updated materials are continuously being added to the CTI Project on Basecamp for new and existing CTI Workers to access. Basecamp is a platform managed by Region 7 IDN as a vehicle for communication and documentation sharing; an updated distribution list for CTI-NH CoP is also stored there.

The five IDNs working on CTI agreed to extend the contract with Hunter College for another year to include the following tasks; supervisor training, Community of Practice meeting facilitation, program level coaching support, fidelity training, and fidelity consultation to assist local staff to carry out fidelity assessments. Every region expressed the value of this relationship and looks forward to continued guidance from the Center for the Advancement of Critical Time Intervention (CACTI). Region 7 IDN had planned to have a supervisor training in 2018, but after discussions with the other IDNs participating in the project, the decision was made to postpone the supervisor training until 2019 to maximize the number of participants across the state.

Region 7 IDN currently has 37 trained CTI Workers and 3 CTI Supervisors. Four CTI Workers left their positions in the last reporting period leaving 20 in the region of the 24 previously trained. One of the attendees at the CTI Training in November had previously attended a training, so that leaves 14 newly trained CTI Workers for this reporting period. The previous 20 added to the 17 newly trained brings the total to 37. One previously trained CTI worker left one agency but joined another one in the region which did not affect the total. It did increase the number of agencies in the region with trained CTI Workers by 1. The training in November increased the number by an additional 1 bringing the total of agencies with CTI Workers and/or CTI Supervisors to 11. These agencies will be referenced below.

Carroll County Department of Corrections (CCDoC) still has 2 CTI Workers one of whom is also a CTI Supervisor. In September 2018, CCDoC had their first client (and the first for Region 7) complete all 3 phases of the CTI program (9 months total) and get discharged. CCDoC served 5 clients with CTI services and connected all 5 to community resources during this reporting period. This agency does not have a need for outside referrals since their clientele come directly from the incarcerated individuals who are transitioning to the community. The CTI workers at CCDoC have expressed that transportation remains a barrier because they are not able to transport individuals in their own vehicles. Having the extended time for Pre-CTI helps to build relationships and encourage client engagement. The partner does not have agreements in place between collaborating organizations because the region is still working to get additional agencies to participate. CCDoC continues to have challenges with regards to executing the CTI model with fidelity. Region 7 IDN team plans to engage with CCDoC more during this next reporting period to help enhance their program further.

The Family Resource Center at Gorham (FRC) is using CTI with their clients engaged in their new Strength to Succeed program. The agency has 11 staff trained as CTI Workers. One previously trained worker left the agency in the last reporting period, but 6 were newly trained in the same time frame. The clients in Strength to Succeed are involved with the Division of Children, Youth, and Families (DCYF) and have a substance use disorder. Originally, it only included those who already had children removed from the home but has since expanded to include those at risk of having children removed. Parent partners who have lived experience similar to the referred population work with the clients using the Critical Time Intervention approach. The focus is on connecting the parents to SUD treatment along with linking them to other community services that will support them in recovery. FRC served 10 clients with the CTI model during this last period, connecting all 10 clients to community resources. The agency does not currently have agreements in place between collaborating organizations. They do have a LICSW who is the clinical supervisor to oversee CTI fidelity. FRC hired a Program Administrator and Recovery/Prevention Specialist who will be managing the expansion of the Strength to Succeed program and enhance the implementation of CTI.

Tri-County Community Action Program (TCCAP) has experienced unexpected staff turnover which has slowed the implementation of CTI. However, they have taken that opportunity to restructure job roles and assign responsibilities to complement skill sets creating capacity to fully execute the CTI program to fidelity. All positions (see the staffing chart below) have now been filled bringing their total number of trained CTI Workers to 7 including one who is also trained as a CTI Supervisor and one as a CTI Trainer. Of the four employees that left during this reporting period, two had not yet attended a training and one moved to Huggins Hospital which is another partner in Region 7. Four of the five new employees from this reporting period attended the CTI Worker Training in November while the fifth employee had attended the training in November of 2017.

TCCAP is positioned in all 3 counties included in Region 7 IDN and addresses the homeless or at risk of homelessness to housing transition. They had been providing Pre-CTI services prior to this reporting period but are now moving eligible clients into the other 3 phases of CTI. During this period, they have provided CTI services to 10 clients, 8 with Pre-CTI and 2 in Phase 1, all of which were connected to community resources. This soft roll-out will allow for process improvement prior to accepting referrals from partner agencies. The agency has obtained verbal commitments from outside referring agencies and will fully execute MOU's upon the approval of continuation of program funding. The plan was to finalize agreements with area providers and begin accepting referrals from external partners beginning 1/3/19. Due to the uncertainty of funding to reimburse for the period of 12/17/18-6/30/19, the agency has postponed execution of agreements until continuation of funding for the program is confirmed.

TCCAP is also proactively exploring future options for delivery of some components of the program through secured teleconferencing equipment. As caseloads increase the ability to utilize technology to

reduce the burden of travel time and expense will be vital. They are currently researching programs located in rural US, one specifically in New Mexico, utilizing technology and evaluating whether the model would meet the unique needs of Region 7 while preserving program fidelity.

TCCAP created quality assurance tools to test and monitor both the fidelity of the model and staff competency. Supervision is conducted weekly through both individual sessions and group-peer collaboration. Current Pre-CTI and CTI clients are discussed during supervision. Client level data, including transition and review dates are tracked and monitored on an internal spreadsheet; with reminder notifications set using Microsoft outlook shared calendars.

The manager of the Homeless Intervention Program Manager and the Director of Compliance will be conducting monthly QA reviews beginning the third week of January and monthly thereafter; this coincides with the initial 30-day period following enrollment of our initial CTI Phase 1 client. Non-compliance to the fidelity of the model or necessary alterations will be addressed during the monthly QA reviews accompanied by a plan of correction when necessary. These staff members are also working to develop a 6-week follow-up survey for clients that graduate from the program to capture outcomes.

Northern Human Services (NHS) lost a staff member during the last reporting period that was trained in CTI but was able to get two employees trained in November. Littleton Regional Healthcare (LRH) also sent two people to the same training. As mentioned earlier, Huggins Hospital hired a new employee who was previously trained. The remainder of agencies also have workers who were previously trained; one at NCH – Weeks Medical Center, five at Crotched Mountain (statewide partner), one at White Mountain Community Health Center, one at White Horse Addiction Center, and one at North Country Health Consortium. Many of these agencies plan to implement CTI once IDN funds are secured for the region. Staff from these various agencies have been engaging in CTI meetings throughout this period and plan to continue participating as the project moves forward.

The 5 IDN Regions plan to meet with CACTI staff at the end of January to develop a 2019 training plan and discuss the best use of resources to increase the adoption of CTI throughout the state.

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	As of 4/15/2019
# of individuals served by CTI	120 by 12/31/2018	0	12	~~37~~ 196	280
# of partner organizations implementing CTI	3 by 12/31/2018	2	2	3	

Performance Measure Name	Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 4/15/2019
# of CTI workers positioned in Region 7 IDN	15 by 12/31/2018	11	24	37	

Members of the Region 7 IDN team conducted calls with each of the Region's three CTI partners (Carroll County Department of Corrections, the Family Resource Center and Tri-County CAP) in March 2019 as part of an effort to reinvigorate the Region 7 CTI Community of Practice. The calls were intended to garner updates regarding program progress and inform a Mini Learning Collaborative plan for the year. During the calls, partner organizations each expressed concern that they had received information at various trainings that suggested their programs were not operating to fidelity. In previous reporting periods, these partners provided limited counts of individuals served by their programs due to these fidelity concerns.

A CACTI facilitator was engaged to review program implementation with the partners in response to these concerns. Following overview of each program's current format, discussion regarding previous feedback that had informed their concerns regarding fidelity and review of a program self-assessment tool, the CACTI facilitator affirmed on April 11, 2019 that, despite serving radically different populations at disparate points of transition, the partners currently appeared to be meeting the minimum program requirements. She stated that, although in early stages of implementation, the three partners should be credited for all persons served by their various CTI programs.

With the validation from CACTI that was received in April 2019, the programs agreed to recalculate their totals to include all individuals served by their programs. Partners were queried for revised counts, both through 12/31/18 and from 1/1/19 through 4/15/19. In particular, Tri County CAP and Carroll County Department of Corrections had previously under-reported the number of individuals served in the Pre-CTI phase of the project, citing information received that led them to believe that individuals who did not follow through all phases of the CTI program could not be counted. Both partners' CTI teams provide the bulk of their services to individuals during the pre-transition (or Pre-CTI) phase. Counting additional persons served in this window has allowed the Region to better depict the number of lives impacted by this service.

The table above has been corrected to reflect that the total number of persons served by CTI programs in Region 7 through 12/31/18 is 196, not the 37 individuals previously reported. Further, partners were able to confirm that an additional 84 individuals have been served by their programs between January 1 and April 15, 2019, bringing the total number of persons served by Region 7 CTI programs to 280 as of this report revision.

Funding delays and staff turnover have made partners hesitant to start and/or expand the CTI model locally. Northern Human Services submitted a proposal to implement the model across the region. Funding delays have now jeopardized the implementation of this project, as well as expansion of TCCAP's program. Despite best efforts, the evolving fiscal picture has created significant challenges in Region 7 IDN being successful at meeting client engagement targets. Of note, The Family Resource Center was able to implement CTI without funding support from the IDN in their Strength to Succeed program, and this agency has contributed significantly to the client engagement numbers reported.

Although the region exceeded the projected number of CTI workers, many agencies have expressed concerns about being able to implement the model to fidelity. There are also concerns about the sustainability of the model after the DSRIP program ends; agencies want to know if CTI will be a Medicaid reimbursable service. Despite having staff trained in the model, the lack of clarity on future reimbursement has left partners hesitant to expend current resources on reaching fidelity of a model that will not be sustainable at the end of the demonstration period. In many cases, partners feel they are now able to address the needs of their patients/clients using a "CTI-informed approach" without the burden of reaching and sustaining fidelity of a program in the context of uncertain reimbursement.

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	37
CTI Field Work Coordinator/clinical supervisor	3 by 12/31/2018	0	3	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	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Care Transition Actual Funds Spent	Care Transition Actual Expense (6 months)				
Care Transition	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	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	$76	$2,550	$2,550	$1,275
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	$0	$1,011	$1,011	$505
10. Marketing/Communications	$1,086	$572	$1,797	$579	$579	$289
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	$1,306	$4,312	$4,312	$2,156
Support Payments to Partners	$65,766	$59,987	$43,338	$181,953	$181,953	$90,977
TOTAL	**$69,454**	**$62,893**	**$46,517**	**$190,405**	**$190,405**	**$95,202**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
(Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)

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
The Family Resource Center at Gorham	Y

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

Protocol Name	Brief Description	Use (Current/Under development)
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.	Is 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.

Project Team Member	Roles and Responsibilities
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 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	B1

	control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	
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	D3

	and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	
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	D3, E5

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

	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 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	D3

	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	
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

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.

During the reporting period of 07/01/2018-12/31/2018 Region 7 IDN had no members join or leave the network.

The information below speaks to the progress that Region 7 IDN has made on the D3 project, Expansion in Intensive Substance Use Disorder (SUD) Treatment Options during the period of July 1- December 31, 2018. IDN Partners involved with this project collaborated with each other to address expansion in intensive substance use disorder treatment options.

NCHC's Clinical Services Program, comprised of in-patient high-intensity and low-intensity services at Friendship House (FH), intensive outpatient services, outpatient services, peer recovery support services and the impaired driver care management has continued to evolve during the reporting period. The most significant event during this time period was the completion and subsequent grand opening of Friendship House, the region's only residential treatment facility within a 65-mile radius. Nearly 80 people attend the October 19th ribbon cutting ceremony at the new facility including Executive Councilor Joe Kenney, U.S. Rep. Annie Kuster, U.S. Sen. Maggie Hassan, and U.S. Sen. Jeanne Shaheen. NCHC staff have been working with a consultant to complete the process for the Commission on Accreditation of Rehabilitation Facilities (CARF®) accreditation process for Friendship House, NCHC's outpatient clinical services, and the agency's Intensive Outpatient Program (IOP). Receiving CARF® accreditation is an important element to the

sustainability of these programs since third-party payers, governmental agencies, and the public at-large recognize CARF accreditation as a demonstration of accountability and conformance to internationally accepted standards that promote excellence in services. The new facility has had an average daily patient census of 23 patients, and often has a wait list for men wanting to receive services at the facility.

Friendship House has contracted with a nurse practitioner who can write medication orders for patients and provide trainings for agency staff. She has a Medication Assisted Treatment (MAT) waiver and will be able to prescribe detox medications once Friendship House moves forward with this part of their program. Friendship House staff have had conversations with staff from NCH – Weeks Medical Center and the North Country Recovery Center related to these services and will continue conversations with partners in the area as the program evolves. In addition, the new facility has a 4-bed detoxification unit which has not opened yet. Staffing transitions have occurred at the Friendship House during this reporting period, the partner lost their operations coordinator and program advisor, along with 5 recovery support staff. However, FH hired multiple positions including a new intake coordinator and 5 new recovery support staff. They currently staff 4 Master Licensed Alcohol and Drug Counselor's, 2 Licensed Alcohol and Drug Counselor's, 2 Licensed Eligible Master's Level Councilors, 1 Certified Recovery Support Worker, 10 Recovery Support Staff currently working toward CRSW certification, and 3 employees enrolled in behavioral health programs – 2 working on a master's in counseling and 1 working on an associate degree in human services.

Friendship House currently operates one Intensive Outpatient Program (IOP) which meets Tuesday, Wednesday, and Thursday mornings from 9:00-12:00 at the Bethlehem location. IOP staff have determined that this time works well and accommodates the client's ability to find and sustain employment while in the program. Since July 1, 2018 there have been 29 participants in IOP. Of those participants 14 completed the program; 5 were discharged for noncompliance with attendance policies; 4 were transferred to higher level of care (at Friendship House); 1 was referred to an outside agency, and 5 are still currently enrolled in the program. The IOP at Friendship House utilizes the Matrix Model which is an evidenced based curriculum in order to provide participants with education and awareness of symptoms related to addiction; develop effective relapse prevention strategies and coping skills; provide insight and connection to community resources; and fulfill other needs as they apply to the individuals. This curriculum is implemented with over 9 clinical group hours and one hour of 1:1 counseling each week over a period of 12 weeks. The program operates under an open enrollment status which allows staff to provide treatment without delay to individuals seeking help, usually within a few days of the initial phone call. Participants are often self-referred however referral sources also include internal referrals from Friendship House, NH Probation/Parole, Division for Children, health care providers, Youth and Families (DCYF), North Country Serenity Center, and various other programs throughout the state.

Current barriers to the IOP program include lack of transportation and lack of choices for participants. Often people are unable to obtain adequate transportation to be consistent to the fidelity of the IOP attendance policy. Although the time change mentioned above has helped with attendance, the lack of a second IOP with differing hours does leave some people with the decision to work or attend IOP. Friendship House staff have been working to incorporate updated evidence-based curriculum into their programming to better meet the needs of clients. In addition, staff continue to look at options of expanding the IOP to additional service areas, especially the Berlin area.

Friendship House has established a relationship with Ammonoosuc Community Health Services to provide physicals and follow up medical appointments for patients staying at the treatment facility. Although it would be helpful to have these services provided at the Friendship House location that isn't currently possible, so clients are transported to ACHS. In addition, Friendship House staff have worked with Coos County Family Health Services to develop a similar relationship so CCFHS can serve their patient population. Friendship House staff have started referring clients from the Berlin area to CCFHS to receive

a physical during the week prior to their admission. The Friendship House case manager instructs the client to call CCFHS and then notifies CCFHS that a client will be calling to schedule the physical. They plan to continue building this relationship to help CCFHS patients remain getting services there if they are already an established patient; referral processes will be enhanced to allow for timely execution of all necessary Friendship House admission procedures.

NCHC has received a *Rural Health Opioid Program* grant from the Health Resources and Services Administration, Federal Office of Rural Health Policy, which will be used in conjunction with the agency's *Rural Health Care Services Outreach Program* grant to expand its portfolio of programs addressing Substance Misuse issues in the North Country. Both of these grants offer 3 years of funding which will jointly be used to design and implement a new "warm handoff" model in Emergency Departments for patients presenting with an opioid use disorder; improve knowledge and understanding by educating clinicians, patients, families, law enforcement and the public about the need for access to unbiased long-term approach to recovery; and to implement care coordination practices by integrating Community Health Workers/Recovery Coaches into opioid use disorder treatment teams. These funds will help to ensure the region is addressing the full the full continuum of care— ranging from prevention, intervention, treatment and recovery.

In addition to these funds, NCHC has received a one-year *Rural Communities Opioid Response Program* – planning grant from the Federal Office of Rural Health Policy to implement a comprehensive planning process that will result in an effective, accessible, coordinated system of service delivery that reduces morbidity and mortality associated with opioid overdoses in Northern New Hampshire. NCHC staff will work closely with provider agencies in the North Country to improve understanding of accessible treatment and recovery options, gaps in services, and feasibility of systematically increasing capacity and care coordination; implement an Opioid Use Disorder Learning Collaborative that enhances cross-sector community partnerships and explores new, innovative, evidence-based models of care; and integrate a model of care which utilizes a comprehensive approach to address overdose reduction, treatment and recovery support, and criminal justice reforms. This planning grant will be used to assess services and resources related to substance misuse treatment and recovery in the region to help ensure collaboration, non-duplicative services, and identify gaps.

Although the federal funds from these programs do not cover agencies in Carroll County, the infrastructure created as a result of these programs will be leveraged to help expand SUD programming is this part of the IDN region. NCHC staff and the IDN team are working diligently to ensure all these programs align with other SUD initiatives in the region, included *The Doorway-NH initiative,* NH's hub and spoke model designed to transform the system serving individuals with a substance use disorder (SUD). NCHC staff meet on a regular basis with the coordinator of the Littleton and Berlin HUBs to discuss collaboration and integration of programs and services in the region. NCH – Littleton Regional Healthcare and NCH – Androscoggin Valley Hospital will both serve as hubs in the region which will greatly expand access to MAT in the region starting in 2019. The strategic level of involvement of NCHC's CEO is pivotal to ensure the alignment of these programs to avoid duplication of services nd utilize resources efficiently.

In July of 2018 NCHC was awarded the contract for the Grafton County Drug Treatment Court (DTC) and added a new LADC to their staff to serve as the Drug Treatment Program Clinician. This program is an Alternative Sentencing Program designed to help adult offenders whose substance use disorder has led to criminal behavior. The mission of the Drug Treatment Court Sentencing Program for Grafton County is to assist criminal offenders in breaking the cycle of crime and substance misuse, while improving community safety, and decreasing financial costs currently incurred by the criminal justice system. Within an 18- to 36-month window, each part of the multi-phase intervention program focuses on key concepts of addiction recovery, from stabilization to continuing care. DTC works with its participants to determine the appropriate level of care needed, collaborating between several agencies to provide substance use

disorder treatment, psycho-educational programs, and consistent supervision—including swift sanctions for violations and rewards for positive behavior— aimed at supporting participants to maintain a drug-free lifestyle. NCHC's involvement with DTC significantly impacts the timeliness of getting participants into the appropriate level of substance use disorder services. On several occasions, Friendship House staff was able to expedite the intake process for DTC participants when the court mandated in-patient services.

Agency staff at Friendship House are currently working to develop a volunteer policy which would then pave the way for recovery coaches from the Recovery Community Organizations (RCOs) to come into the agency and establish relationships with clients. This would provide an opportunity for the clients to learn more about resources available to them upon discharge and help create a smooth transition back to the community. The case manager at Friendship House works diligently to set up client referrals to outside community services agencies before clients are discharged from the agency. This is an important part of the discharge process which can be very time intensive since many of the clients come from areas outside of the Region 7 IDN service area. Once relationships with the RCOs are solidified the peer recovery coaches will be able to assist with connections to other peer recovery coaches outside of the service area.

North Country Serenity Center (NCSC) is one of the four recovery community organizations in the region. The RCO has continued to expand their capacity to deliver an array of recovery services over the past 6 months. The local recovery community has expressed appreciation for the events hosted by NCSC, and this has led to new agencies engaging in peer recovery services and signing on to be active volunteers at the RCO. Examples of community events offered during the reporting period include the Recovery and Community Field Day in September which had approximately 60 participate in the event. The agency now offers 2 evening All Recovery Meetings which average approximately 15-20 people in attendance, and a weekly evening Family Support Group which has an average attendance of 5-7 participants. The center is seeing more individuals come in during the afternoon and engaging in the coloring café and socializing with peers. Moving forward, the agency will continue to offer center activities to meet the needs of the growing recovery community.

NCSC staff have been working hard to expand services, and part of this outreach included a staff person visiting Webster Place and Farnum treatment facilities to discuss peer recovery support services offered by North Country Serenity Center. Individuals living in recovery homes in the region have heard about the services provided by NCSC staff and have started to utilize these services. Due to the expansion of services and staffing, NCSC staff have spent the last several months looking for a larger location for a new center, and just recently found a new location a few short blocks from the current location. The building will undergo renovations and NCSC will share space with an up and coming recovery home.

North Country Serenity Center lost their administrative assistant and volunteer coordinator during the reporting period but were able to rehire the positions within the same timeframe. The agency also hired a Certified Recovery Support Worker. The current staffing level at the agency will provide NCSC with the infrastructure to expand their peer recovery support services to include activities such as meditation groups, creative writing sessions, and coffee after hours to welcome the f recovery community to gather and share experiences to gain strength and hope.

NCSC has 5 staff members, 3 of which are full-time, and 2 which are part-time. The agency also has 9 volunteers filling out paperwork to participate in volunteer activities at the center. Two of the agency's staff are CRSWs and the remaining staff are working towards CRSW certification. NCSC staff attended numerous trainings during this reporting period, including:

- HIV/AIDS Training: 4 attended
- Recovery Coach Academy: 1 attended
- Suicide Prevention: 2 attended

- Recovery Coach Academy Train the Trainer: peer lead attended
- Recovery housing trainings: 2 attended
- Ethics Training 2 attended
- Ethics Train-the-Trainer: 1 attended
- Community Health Worker Training: 4 staff will complete the training in early 2019

NCSC has served approximately 131 unique participants through their Telephone Recovery Support and Recovery Coaching programs since their inception in 2017, 64 of which are new to the reporting period of July 1-December 31, 2018. North Country Recovery Center continues to build relationships with external partners and has developed a closed loop mutual referral process with ACHS. The two agencies refer individuals in need of peer recovery support services and those in need of medical, vision, or dental services to one another as appropriate. During the reporting period of July 1 – December 31 the agencies used this system to refer 17 patients. They have not executed formal agreements for this arrangement yet, but conversations continue about the process and system.

North Country Serenity Center was awarded the Sober Parenting Journey contract which should begin in March 2019. Sober Parenting Journey is a 14-week evidence-based group program specifically designed for parents in recovery. The program is designed to help parents and caregivers in recovery begin to understand and experience healing new and old wounds, address the impact of triggers that lead to relapse, learn about local resources in the area, learn how to effectively communicate with children, become more confident and optimistic about maintaining recovery, learn to overcome emotional shame and guilt and learn to stop justifying consequences related to substance use and create new possibilities for parents/caregivers and their children.

NCSC has been working to foster relationships so they can provide peer recovery support services to individuals in hospitals, the workplace and the community. The agency has seen forward momentum in their work which includes a local hospital contacting them about individuals needing recovery support information and sending a coach to sit and provide information to a patient until the patient was able to make an informed choice. North Country Serenity Center staff provide peer recovery support services for Friendship House's Intensive Outpatient Program, meeting bi-weekly with participants to provide education and information on services offered by the agency. During these sessions participants are encouraged to sign up for telephone recovery support and to work with a NCSC coach to assist in transition from treatment to their home recovery community. The center is accepting referrals from NCH – Weeks Medical Center MAT program and provides MAT support to groups for recovery. NCSC entered into a formal agreement with MAT provider Better Life Partners (BLP) to provide peer recovery support services to clients on the BLP MAT program. In addition to these collaborations, the Executive Director of NCSC has been meeting with the CEO of NCHC to discuss coordination of services for NCHC's warm handoff model program, including opportunities to provide extensive coverage of Recovery Coaches for individuals presenting in emergency departments.

NCSC and White Mt Recovery Homes, a men's sober living home, continue their collaborative partnership. The RCO attends several treatment programs to educate about NCSC and WMRH and WMRH clients attend meetings, receive coaching and participate in community service and volunteer with NCSC. NCSC staff also engage in many other outreach initiatives, including presenting to the local high school to explain and educate students about peer recovery support services. Additionally, the Good Samaritan Network invited NCSC to attend a round table discussion to address the opioid crisis impact in the region. As a result of the Recovery Friendly Workplace initiative NCSC has received a referral from an employer, and the RCO is in the process of developing referral systems and protocols to handle community requests for peer recovery support services.

Ammonoosuc Community Health Services continues to provide primary care and behavioral health/SUD services at Friendship House. ACHS has been meeting monthly with the Friendship House staff to refine services provided by ACHS and documentation required by ACHS. Between April 2018 and December 2018, ACHS has provided physicals and comfort medication to at least 93 patients. ACHS has also worked with Friendship House to provide after care for patients discharged that remain in the ACHS operational area in northern Grafton County, and southern Coos County.

ACHS continues to improve services to provide enhanced behavioral health services to the region. ACHS has proposed to formalize agreements and procedures with North Country Serenity Center (NCSC) to provide medical, dental, vision, behavioral health, substance misuse, nutrition, and patient navigation services, while utilizing NCSC's peer support and recovery support services. ACHS is currently reviewing HIPPA and 42CFR Part 2 regulations to determine the best way to move forward with the formalized agreements, and in the meantime the agencies are relying on Release of Information forms as authorization to discuss mutual patients. These 2 agencies have been meeting biweekly since August 2018, and to date have provided services for 24 mutual patients. The collaborative relationship between these agencies will ultimately reduce recidivism, relapse rates, and expand behavioral health services in the region.

ACHS has worked with Grafton and Coos County Corrections to provide primary care and behavioral health services for individuals. The agency has established relationships with Grafton County Corrections, Grafton County Alternative Sentencing, Grafton County Department of Corrections Focused Intentional Re-Entry and Recovery Program (FIRRM) and Federal Alternative Sentencing (Laser Docket) programs to provide immediate services for those convicted of SUD related crimes. Through these efforts ACHS has provided wrap-around services to 21 individuals exiting Corrections programs since February 2018. Staff from ACHS and Grafton County Corrections meet weekly to conduct treatment team meetings on all patients.

ACHS has formalized a workflow to notify behavioral health staff when clients are seen in an Emergency Department (ED) for behavioral health or substance use reasons. This feedback loop provides ACHS staff the opportunity to provide services to patients in a time appropriate manner. During the period of February 8, 2018 – December 14, 2018 ACHS reviewed 2615 emergency room reports and identified 188 (7%) patients with a behavioral health related diagnosis. ACHS has flagged providers and/or conducted follow up on all of these patients. 108 (4%) of these patients resulted in actual contact with ACHS behavioral health providers.

IDN staff will continue to engage with ACHS staff regarding the utilization of Collective Medical event notifications to potentially help with this process.

The partner has continued providing mental health clinician support to Lafayette Regional school, Bethlehem Elementary school, Profile High School, Lisbon Elementary School, and Blue Mountain Union School in Landaff. ACHS has provided behavioral health support throughout the summer for identified students that desired it. ACHS is in the beginning stages of expanding its behavioral health support to Woodsville and Warren schools. They have attained one intern who will start in January 2019 and hired one LICSW to work within the schools.

ACHS has expanded their MAT program identifying 4 prescribers, 2 LICSWs, and 2 Patient Navigators to become internal resources for SUD matters in the Woodsville and Littleton locations. As of this date 2 additional prescribers have completed MAT waiver training to bring their MAT waivered prescribers to 4. The agency is not actively promoting this service but will treat existing patients as the need arises. ACHS is currently treating one patient in their MAT program. These providers and ACHS support staff have

been attending addictions counseling courses to increase their knowledge about substance use disorder. The agency is working to refine MAT policies and workflows using the Plan, Do, Study, Act cycle (PDSA).

Coos County Family Health Services has expanded their MAT program. When the program first started it focused on prenatal patients and their partners. Now primary care providers can refer patients to the MAT program. They currently have a total of 25 MAT patients and a wait list of 32 and hope to expand their patient capacity to 50. The MAT program currently has an RN coordinator, recovery coach and a Women's Health nurse practitioner working on MAT one day per week. CCFHS has 5 waivered prescribers on staff and will be starting a 4th MAT group session early in 2019. During the period of July 1-December 31, 2018 the agency hired a LCMHC/MLDAC and one LPN who will fill the role of Behavioral Health Clinical Support and will works toward LADC certification. CCFHS is looking forward to collaborating with NCH - Androscoggin Valley Hospital as part of the NH Doorway hub and spoke model once their plan is developed.

NCH – Weeks Medical Center has continued to increase its capacity to treat behavioral health and substance use disorders and has an integrated physical and behavioral health facility operating concurrently. In 2017 Weeks opened the North Country Recovery Center, their medication assisted treatment program for opioid use, offering services in the hospital setting and outpatient services in four office locations. The agency has expanded services to the Littleton area and has a psychiatric mental health nurse practitioner providing behavioral health services for Littleton Regional Healthcare (LRH) and Ammonoosuc Community Health Services (ACHS) every Monday.

Currently, NCH – Weeks Medical Center has 2 prescribers with waivers to deliver MAT services and is in the process of obtaining a waiver for 2 more providers. The North Country Recovery Center enrolled 17 new patients in their MAT program and currently have 59 active participants in the program. NCH – Weeks Medical Center continued to expand their behavioral health department during the reporting period by adding a LICSW, a Psychiatric Nurse Practitioner, an office coordinator for their MAT program, and a Behavioral Health Case Manager. Future plans for the agency include hiring two additional psychiatric nurse practitioners and expanding MAT services to the Colebrook area to allow the underserved area an opportunity to have direct access to MAT services and counseling regardless of their primary care provider. In addition, NCH – Weeks Medical Center will help to provide staff for the 2 NH Doorway hubs in the region starting in 2019 and will be sending staff to the next Peer Recovery Coach Academy starting in January 2019.

White Mountain Community Health Center (WMCHC) continues to offer MAT services based on their capacity. The MAT provider recently got waivered to service up to 100 patients, however the agency does not yet have the capacity to accept that number of patients. The provider is currently capping her services at 35-40 patients. WMCHC served 7 new patients in their MAT program from 7/1/2018-12/31/2018 and currently have 32 total patients enrolled; this makes a total of 62 patients served since its inception in June 2017.

WMCHC uses a comprehensive protocol for MAT intakes to determine patient eligibility for the program. Once the patient is accepted into the program treatment proceeds using a phased system of progress.

During the reporting period of July 1-December 31, 2018 Saco River Medical Group (SRMG) hired a new primary care physician who also has a MAT waiver and sees SUD patients as part of his regular practice. With the addition of this provider the agency now has 2 waivered prescribers. SRMG has recently contracted with a new family practice nurse practitioner who has a MAT waiver and is slated to start in April 2019. This will increase capacity to provide MAT services to the region and reduce the workload of currently providers. During the reporting period they served 30 new patients in their MAT program creating a total of 97 active MAT patients.

SRMG has multiple policies in place to provide information about the program to patients looking to receive their services. The agency utilizes a similar phase system as WMCHC mentioned above. They also use the following documents:

- Explanation of program and patient expectations for prospective patients requesting acceptance into the MAT program
- Informed Consent
- Consent for the Release of Confidential Information
- Understand Opioid Dependence
- Treatment Options for Opioid Dependence
- Patient Consent and Release Form for Buprenorphine Treatment during Pregnancy
- Treatment Agreement for Suboxone Therapy Program Requirements and Patient Responsibilities
- Warning Statement: Suboxone Treatment will Lead to Loss of Tolerance

Memorial Hospital has continued to offer SUD services through their Integrated Medication Assisted Treatment Program (I-MAT) and the "A New Life" Prenatal Program. The I-MAT program served 45 new patients during the reporting period, making a total of 97 active patients between the 3 providers. This is an increase of 1 provider as a new waivered PCP was hired during this reporting period. Memorial also hired a new Psychiatric Nurse Practitioner to work in their Behavioral Health Department, along with a new general PCP. One of the current waivered providers will be leaving the practice in early 2019 resulting in only 2 waivered providers moving forward. The program is currently not accepting new patients due to this transition and the lack of suboxone induction capacity. Memorial has been referring patients to external MAT programs due to this. The hospital is actively recruiting for a nurse practitioner to increase capacity to deliver services. Through MaineHealth, Memorial has access to a Learning Collaborative forum that meets regularly to present cases on difficult patients. This meeting is specifically for I-MAT programs within the Maine Health system for the providers to discuss how their programs are doing and ask for advice on complex patients. The meeting has helped providers illicit insight and guidance on these patients and discuss challenges and barriers to the IMAT program. Memorial sends I-MAT staff to this meeting and has access to the psychiatrists on the line when needed.

Although 2 nurse midwives have left Memorial's "New Life" Prenatal Program the remaining staff are able to maintain the program and the population it serves. The program allows patients to stay in the program for up to a year however some stay longer due to lack of other treatment options. The number of patients enrolled in the program hasn't changed much, but during the July-December reporting period the New Life program was able to transition 3 patients into Memorial's I-MAT program after determining the patients were stable enough to make the transition. The program has 2 providers who are waivered and 1 waivered nurse midwife and has provided MAT services for 4 patients in the reporting period. in 2018 the program delivered 19 opiate exposed newborns out of 221 births. This means that 8.6% of the births were opiate exposed. Of the 19 opiate exposed babies, only 7 of their mothers were involved in New Life prenatally. Memorial was able to enroll 2 additional mothers post-delivery. There were an additional 3 mothers who joined late in 2018 early in their pregnancies and will deliver in 2019. This totals 12 new patients for the entire year of 2018.

Huggins Hospital has spent the last 6 months developing a new MAT program. The agency has been working to change the culture for MAT dispensing by creating a "change team" to help with implementation. Currently, Huggins has 2 MAT waivered providers since hiring a new provider during this reporting period. A system wide MAT training for providers and outpatient staff was held in November 2018, that included a 90-minute overview of the MAT program, including the evidence for incorporating MAT into practice, and case discussions aimed to teach providers that change is possible. Approximately

25 staff people participated in the training. The Change Management team has not created any workflows or protocols yet; however, they will be working on this in early 2019, and they anticipate that patients will be provided MAT services by March of 2019. The team has been working to identify a pilot practice site for MAT services to be implemented and believe they will start offering these services at the Ossipee location first.

In January 2019 Huggins will start a waiver training for providers and will include some ancillary staff in the training so they have education on the MAT program. There is a goal to have 5 additional prescribers trained during this time so Huggins will have capacity of 7 waivered prescribers total. Huggins staff have been able to engage contracted ED provider staff into the MAT conversation and some ED staff are interested in participating in waiver training.

As a result of the multiple new and expanding MAT programs throughout the region IDN 7 was able to serve an impressive number of patients. Among all partners offering MAT services within the region a total of 121 new patients were served during this reporting period.

White Horse Addiction Center (WHAC) continued to provide outpatient treatment services including IOP, individual counseling, LADC evaluation, and DUI aftercare at both their Conway and Ossipee locations in Carroll County. The agency refers to the RCO in North Conway as the Shed North which provides 1-on-1 peer recovery meetings, transportation assistance, and volunteer opportunities. Additional services that have been added include life skills groups, AA and NA meetings, recovery support groups, parenting classes and more. White Horse staff participated in multiple trainings over the past 6 months including:

- Narcan Training: 12 participants
- Parenting Training: 4 participants
- Nami Family Support Facilitators training: 15 participants
- Kingswood Youth Center Prevention training: 50 participants

WHAC continues to provide Intensive Outpatient Programs in the region. During the reporting period of July-December 2018 the agency ran 2 IOP groups in Center Ossipee, one Christian and 1 secular session; and they started a new IOP in the North Conway location in August. The 3 IOPs provided a structure to offer a total of 198 IOP sessions which served 36 new clients. The agency had 11 new clients complete an IOP in the last 6 months.

Peer Recovery Coaches have provided services to 19 new clients, all of which have been assessed to determine level of readiness. There have also been some staff changes during the reporting period including the addition of 2 administration staff to support the RCO and billing, 2 LADC candidates with target licensure of 2019, 3 CRSW candidates, and a Chief Financial Officer/Controller. The agency's Executive director resigned resulting in the restructuring of leadership.

WHAC also spent the reporting period working with a consultant to perform a Strength, Weakness, Opportunity, Threat (SWOT) Analysis. The agency reviewed the results with the Board of Directors and the consultant, as well has held multiple sessions with staff to educate them on executing a more cohesive business approach. The SWOT analysis revealed multiple strengths, weaknesses and threats; however, it came with many opportunities and recommendations to pursue as the agency works to integrate services in the region. The SWOT analysis highlights that organizations in the region are willing to partner with White Horse and they feel that White Horse has passionate and committed staff who work with clients.

As a result of the SWOT analysis, White Horse Addiction Center added a strategic planning committee to the Board of Directors and restructured leadership and management teams to be more proactive and

collaborative within the region. The partner utilized their SWOT results to develop work strategies and communications with outside providers including the IDN and developed a complete marketing strategy for 2019 that will help them to promote their services to partners in the region. WHAC had meetings with Region 7 IDN staff, Memorial Hospital and Mount Washington Valley Supports Recovery to discuss collaborative opportunities. As a result of this new collaboration strategy, WHAC and MWVSR requested funds for a project to provide 24/7 emergency peer recovery support services to Carroll County and plan to partner with Memorial Hospital and surrounding partners, to roll out the proposed model.

Mount Washington Valley Supports Recovery has increased their capacity to collaborate more effectively throughout the region and bring services to the population. In the last 6 months MWVSR hired a Director of Programs using IDN funds to help have more presence at project and community meetings. Since then they have attended DN meetings, two bi-monthly meetings with C3PH, and held a Peer Recovery Support Services meeting at their facility. They continue to meet with WHAC regularly to discuss crisis intervention in the ER and develop a strategy to bring 24/7 emergency peer recovery support services to Carroll County. MWVSR held a provider's discussion meeting in December 2018 to discuss harm reduction. There were 3 nurse practitioners, 1 MLADC, an AA representative, a Licensed Social Worker and a psychologist as well as 5 recovery coaches that were engaged in the conversation.

MWVSR continues to have good relationships with surrounding partners which has led to WMCHC referring their MAT patients to the center for recovery coaching and meetings. Additionally, MWVSR raised $700 at a collaborative fundraiser they held with Memorial Hospital's New Life Program.

The partner currently has 1 full-time employee, 1 part time administrative assistant and 3 part time recovery coaches. During the reporting period the peer recovery coaches engaged 18 new clients for services. MWVSR continues to run 2 weekly peer support meetings that are regularly attended, as well as weekly collaborative/oversite work sessions with their recovery coaches and contracted MLADC. The 2 weekly peer support meetings are known as Medication-Assisted Recovery Anonymous (MARA) and FASTER which is a model that follows the acronym below

- Finished - What has been completed since the last meeting?
- Acknowledgements - Who made their job easier?
- Still outstanding - What are they working on now?
- Trouble spots - What difficulties are they encountering?
- Enlightenment - What have they learned?
- Requests - What do they need?

MWVSR had 63 attendees at these meetings through the reporting period and 48 calls or inquires for services. They had 58 in-person inquires and 127 encounters with recovery phone/in-person check ins. The partner plans to collaborate with local agencies and the other RCO's in the region to build the Peer Recovery Support Network and help provide services.

Hope for NH Recovery, one of the four RCO's in the region, continued to build capacity to expand services throughout the region. In the past 6 months Hope has begun a complete reorganization of the center. They have hired all new staff, including a new center manager, a new peer lead and a recovery coach. The peer lead has had recovery coach training and is now participating in IDN trainings that will help move them towards CRSW certification. In addition, the peer lead has been trained as a Community Health Worker. The agency is looking forward to greatly expanding their capacity and range of services. Hope has been working with the Family Resource Center (FRC) to provide a space for a Parenting Class. They also work with FRC's parent partners to provide a safe supportive environment for their client visits as well as having several supervised visitation sessions. The RCO has been working with

Tri-County CAP's homeless intervention and prevention worker, and collaboration has begun with Coos County Family Health Center to assist with their MAT program.

The center has increased capacity to implement SBIRT by hiring fully trained Recovery Coaches and a Community Health Worker who have been made familiar with the SBIRT practice modules. During this reporting period Hope served 12 new individuals with Peer Recovery Coaching. The agency is eager to participate in the Regional Peer Recovery Support Network and expand their services to those in need.

The four Recovery Community Centers of Region 7 have continued meeting to strategize the most effective way to develop the Peer Recovery Support Network. The group met in August and October to discuss the development of a sustainable peer recovery network. The 4 RCO's have worked to build capacity to create this network together over the past 6 months, which includes increasing staff and adding more services. One model that was suggested was to create two hubs, one for Carroll County and one for Northern Grafton and Coos. Each hub would be comprised of 2 RCOs. The idea is to have an advisory board to provide guidance for all four RCOs which will include help with the development of systems and processes for referrals and establishing a peer recovery workforce that is equipped to be deployed to clients in their time of need. Each hub would have one of the RCOs serve as a lead agency which would have additional reporting and fiduciary responsibilities for the hub. The RCOs felt it was important to leverage existing initiatives as the model is developed. The group plans to reconvene in early 2019 to learn more about the implementation of NCHC's WARM model and the NH Doorway hub model, and then discuss next steps in the implementation of this regional approach.

The Recovery Coach Academy training plan started in July 2018 with the following trainings held throughout the reporting period:

- 7/25/2018: Ethical Considerations for Recovery Coaches; trained 13
- 8/9/2018: HIV/AIDS; trained 13
- 8/23/2018: Suicide Prevention;16
- 9/13/2018: Recovery Coach Academy; 8
- 10/11/2018: Recovery Coach Academy Train the Trainer, trained 6
- 11/5/2018: Ethics Training; trained 13
- 11/7/2018: Ethics Train the Trainer; trained 4
- 11/14/2018: Suicide Prevention Training; 26

The trainings had impressive participation and helped build the region's peer recovery network substantially. Multiple participants have taken all or most of the trainings required to become a Certified Recovery Support Worker, which will help create sustainability in the Region. Currently, 8 partner staff have been trained in 3 out of the 4 topics needed to move forward in becoming a CRSW. Several partner staff have taken more than 1 training to move toward CRSW and 5 recovery coaches have been cross-trained as Community Health Workers. The current Community Health Worker training began in November 2018 and is expected to graduate 10 participants in February 2019.

Region 7 IDN plans to continue the Recovery Coach Academy training plan through 2019 to increase the workforce and more Recovery Coaches toward CRSW certification. The remainder of the original 2018 PRCA Training plan is below:

HIV/AIDS	March 2019
Peer Recovery Coach Academy	April 2019

Peer Recovery Coach Academy	September 2019
Suicide Prevention	October 17, 2019
Ethics	November 2019
HIV/AIDS	December 14, 2019

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	3
# of individuals to be served with new MAT services in Region 7	35 by 12/31/2018	0	10	28
# of new sites offering intensive outpatient (IOP) services	1 by 12/31/2018	0	0	0
# of individuals to be served with IOP services	144 by 12/31/2018	25	66	156
# of existing IOP providers expanding services	3 by 12/31/2018	0	0	1
# trained Peer Recovery Coaches	6 by 12/31/2018	22	59	67
# of individuals served by Peer Recovery Coaches	50 by 12/31/2018	0	109	222

Although Region 7 IDN has seen significant growth in MAT services in the region the metric for "number of individuals to be served with new MAT services"" was not met because currently there are only 3 agencies being included for this measure: Coos County Family Health Services, Ammonoosuc Community Health Services, and Huggins Hospital. These are the three agencies which established MAT programs after the submission of the region's implementation plan and therefore are being considered as new MAT programs for the region. Huggins Hospital is still working to stand up their MAT program and get providers trained to delivery MAT services, which delayed their ability to start seeing patients before December 31st, 2018. Their program is anticipated to be completely stood up within the first few months of the next reporting period, which will help increase these numbers. ACHS hasn't seen much growth to date in their program due to their model of only accept existing patients and push back from these patients related to the MAT program requirements. However, CCFHS has expanded their

program to include prenatal patients, new moms and partners of new moms, and then adding patients referred to the program by CCFHS primary care providers. The region anticipates meeting this metric in the next reporting period due to the 2 NH Doorways at Littleton Regional Healthcare and Androscoggin Valley Hospital.

Due to workforce shortages Region 7 IDN has not been successful thus far with new or expanded IOP services. When the region's implementation plan was submitted it was hoped that Indian Stream Health Center may expand their IOP, but the agency has stopped providing the service due to staff turnover. Friendship House is still working to expand IOP services and will do so once the agency has adequate staffing in place. NCHC will work closely with IDN partners in the region to investigate the feasibility of another agency establishing a new IOP in the region.

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	13
Psychiatric Nurse Practitioners	3	1	2	5	7
Peer Recovery Coaches	6	2	22	59	67
MLADC	3	0	0	3	4
Case Management	2	2	4	6	15

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	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Expansion in SUD Actual Funds Spent	Expansion in SUD Actual Expense (6 months)				
SUD	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	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	$76	$2,550	$2,550	$1,275
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	$0	$1,011	$1,011	$505
10. Marketing/Communications	$1,086	$572	$1,797	$579	$579	$289
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	$1,306	$4,312	$4,312	$2,156
Support Payments to Partners	$65,766	$59,987	$43,338	$181,953	$181,953	$90,977
TOTAL	**$69,454**	**$62,893**	**$46,517**	**$190,405**	**$190,405**	**$95,202**

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

IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

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
Huggins Hospital	Y
Coos County Family Health	Y
White Mountain Community Health Center	Y
Memorial Hospital	Y
NCH – Weeks Medical Center	Y
North Country Serenity Center	Y
MWV Supports Recovery	Y
Hope for NH Recovery	Y
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.

Standard Assessment Tool Name	Brief Description
Mental Health Screening Form	A comprehensive 12-page screening tool designed to gather the client's mental health experiences and screen for symptoms.
(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 mental health problems, and	B1

	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	B1

	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.

During the reporting period of 07/01/2018-12/31/2018, Region 7 IDN had no new agencies join the IDN network and no members leave.

Region 7 IDN continued to make progress on Project E5, Enhanced Care Coordination for the High Needs Population, during the reporting period of July-December 2018. Region 7 IDN partner agencies had opportunities to attend trainings to improve care coordination services, participate in the new Region 7 IDN Webinar Series to learn more about risk stratification, and participate in new multi-disciplinary core team meeting within their agencies to discuss high risk patients.

Region 7 IDN staff repeated the 2-day Regional Care Coordination training in November 2018 for partner agencies in Coos and northern Grafton Counties so staff could learn how to improve care coordination services for the high needs population as these patients transition between agencies. The region's implementation plan focused on training 5 Care Advocates in each subregion in 2018, but it has become apparent that Coos and Northern Grafton are acting as one subregion instead of two in regard to this project, largely due to collaborative relationships within North Country Healthcare affiliation. For example, North Country Healthcare has been working on a regional care coordination approach and only sent 2 staff members to the training versus one from each of the 5 affiliate agencies. As a result, 6 participants attended the training, representing NCH – Weeks Medical Center, NCH – Littleton Regional Healthcare, Northern Human Services, Ammonoosuc Community Health Services, and Rowe Health Center/Cottage Hospital. The training agenda structure was adapted using feedback from the first

Regional Care Coordination training held in March 2018, but the topics of the training remained the same. This was an important aspect of the training since the region is focused on a regional training approach to deliver enhanced care coordination. The agenda for the training is shown below:

Day 1: Thursday, November 29

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

Day 2: Friday, November 30

- Enhanced Care Coordination for High Needs Population
    - Toolkit review and how to utilize it
    - Sample workflows
    - Breakout sessions for workflow development
- Health Literacy
- Connecting with Regional & State Resources
- Risk Stratification Workflows & Multidisciplinary Core Teams
- Closed Loop Referrals and Collaborative Care Agreements

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 team updated participants on the current status of shared care plan implementation throughout the region and what the plan is for moving forward. A focus on the care guidelines feature of the platform was presented to help care coordinators understand their role in using the system. A vital aspect of the care coordination process is sharing of information, but this is challenging due to the variety of providers and organizations involved in the process as patients transition from one agency to another. IDN partners have continued to express 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.* This group of care coordinators were very engaged in this presentation and brought some great questions to the table. They left with knowledge and advice to bring back to their agencies to put into practice. Their understanding of substance use and consent increased, and additional training on the complicated subject will continue to help move the region toward integrated care.

The Region 7 IDN team coordinated a regional resource panel specific to northern Grafton and Coos County to provide participants with an opportunity to make connections with local social service providers and gain an understanding of what services they provide throughout the region. The IDN team recruited 11 agencies to speak on the panel, including representation from Waypoint, North Country Health Consortium, Hope for NH Recovery, North Country Serenity Center, Response, NH Legal Assistance, Affordable Housing Education and Development, Family Resource Center, ServiceLink Coos County, Tri County Community Action Program, and Affordable Housing Education and Development.

The care coordinators enjoyed the networking opportunities and the overview of each agency. The social service agencies provided business cards and brochures for participants to bring back to their organizations and reference when necessary. New relationships were formed during the panel presentation which will help partner agencies as they work to improve the coordination of care across treatment settings.

The care coordinators were also trained on topics such as cultural humility, patient advocacy and health literacy to keep them up-to-date on best-practices. Participants did understand all topics but agreed that it is important to reflect on that knowledge and refresh their skills. The care coordinators were very engaged in each presentation and left with action items to complete while providing services to their patients. The region's E5 toolkit continues to be updated as necessary and shared with partners to allow them to adapt the sample workflows, forms and best practices into their current work. The care coordinators were provided with pieces of the toolkit to bring back to their agency to put into practice and encouraged to access the entire toolkit on Basecamp for additional information.

The IDN team plans to offer additional care coordination trainings as the DSRIP project continues to account for staffing turnover. After debriefing from the most recent training the team has decided to utilize the Region 7 IDN Webinar Series as a platform to replicate presentations from the Regional Care Coordination training. This will allow for partners to have on demand access to the recorded session so they can learn on their own time and reduce the burden of the time needed to attend an in-person full 2-day training. This strategy will help the region reach its goal of training at least 15 care advocates throughout the region. The Care Advocate workgroup that was convened earlier in the year hasn't needed to continue to meet because the region has seen some positive movement in this project thanks to the Regional Care Coordination training and the November 2017 Risk Stratification Webinar which is available as a recording as well.

In addition to the care coordination trainings available within Region 7 IDN there have been other training opportunities addressing this topic during the reporting period. MSLC hosted a monthly learning collaborative in July which focused on care coordination and included a care coordinator panel discussion. The 7 IDNs worked together to sponsor an IDN training track at the December 2018 Behavioral Health Summit and one of the sessions was an enhanced care coordinator panel discussion. These sessions were recorded and will be available as webinars with continuing education credits attached to the them.

North Country Healthcare (NCH) has continued to grow their care coordination program across all five affiliates, Androscoggin Valley Hospital, Littleton Regional Healthcare, Upper Connecticut Valley Hospital, Weeks Medical Center, and North Country Home Health & Hospice. NCH has continued to use the two ACO coordinators from affiliates Littleton Regional Healthcare and Weeks Medical Center who share responsibility for regional care coordination, which is a 40 hour per week position. Coordinator's responsibilities are divided between NCH care management activities and each of their respective affiliate obligations. During the past six months the ACO coordinators have overseen several initiatives mentioned below.

North Country Healthcare also collaborates with three Federally Qualified Health Clinics: Ammonoosuc Community Health Services in Littleton, Coos County Family Health Services in Berlin, and Indian Stream Health Center in Colebrook. All these agencies together form the North Country Community Care Organization (CCO) which meets on a regular basis to address population health and improve the health indicators for all of the residents of the North Country. NCH regional care coordinators leverage these established meetings to discuss:

<u>Methods to reduce ED utilization</u>:

- Recommendation to review ED reports to determine those patients who frequently have ED visits and who may need care coordination support;
- Implementation of ED rack cards explaining appropriate and inappropriate visits to the ED available at each affiliate and FQHC locations;
- Weekend hours offered at NCH – Weeks Medical Center's hospital to help avoid non-emergent visits to the ED;

- Effective use of home health services

Reduction in hospital readmissions:

- NCH-AVH has a Cardiac Rehab Nurse who provides in-depth education to patients admitted with congestive heart failure (CHF). NCH-AVH has zero readmissions for CHF. Other facilities are looking into implementing a similar CHF program and regional care coordinators are currently working with the provider group to standardize the CHF process using best practice;
- Shared processes to improve transitions in care

Annual Wellness Visits (AWV):

- Information sharing from affiliates and FQHC's on effective approaches to increase annual wellness visits.

Diabetes Education:

- Connecting with an endocrinologist interested in providing education to facilities. One of the regional care coordinators will organize diabetic educational sessions.

Behavioral Health:

- The CCO committee was informed that NCH – Weeks Medical Center is providing MAT services in the Whitefield Office as part of its Littleton expansion plan and providing a psychiatric mental health nurse practitioner for behavioral health counseling services at NCH – Littleton Regional Healthcare.
- The CCO group is discussing ways in which to improve services for psychiatric patients. Many affiliates and partners are experiencing a 10 day wait period for psychiatric beds.

The regional care coordinators and CCO committee are working towards standardizing processes among affiliates and partners with the goal of improving transitions of care and ensuring patients are connected to appropriate support services. Monthly meetings are held with representation from partners to discuss concerns and/or share processes that have been proven successful. The leadership of NCH regional care coordinators helps the CCO team effectively develop methods to improve communication across the agencies in the region.

Although still in its infancy, the Regional Care Coordinators and CCO committee have made concerted efforts towards integration, communication, and cost reduction to improve valued-based care spanning Coos and northern Grafton Counties. The team continues to identify high-risk and complex patients and brainstorming ideas to decrease ED and hospital utilization and help improve healthcare outcomes. The CCO has experienced challenges in consolidating data from various reporting systems into one reportable result.

NCH – Weeks Medical Center has made significant progress with their internal care coordination efforts connecting patients within their primary care practice to services offered through their North Country Recovery Center. NCH – Weeks Medical Center behavioral health case manager & care coordination team are working together to reduce expenses through utilization reviews, assessing appropriate cost-effective services, educating patients on self-management skills, and overseeing proper handoffs. The team is helping to improve quality and patient health outcomes with focus on avoiding unnecessary hospital and ED visits.

The development of North Country Healthcare's regional call center, or connection center as they refer to it, is progressing. The Connection Center's development and implementation team will continue to

oversee the Connection Center project to include reviewing system productivity, determining provider/staff/patient satisfaction, developing procedures & policies, etc. The committee is comprised of managers with associated responsibilities in operations, information technology, provider services, and care management. The Connection Center offers an effective method of connecting providers, staff, and patients to available physical and behavioral health care through a direct link. With one 24/7 access directory for affiliates and partners, individuals can quickly be connected to an appropriate provider and/or service within the region. This system will help avoid delays in finding an on-call provider particularly for specialty services.

As with any project of this size managing time between demanding daily schedules and the Connection Center project development/implementation has been challenging. The partner experienced some delays due to a vendor change, information collection for the provider directory, and an integration issue with logins. The regional CCO group members and Connection Center team have worked together over these past several months to create an all-inclusive provider directory. The directory will soon be available on-line.

NCHC's Ways2Wellness Connect program experienced some staffing transition during the last reporting period which included one staff person leaving the agency and another staff person who transitioning to a new program at the organization where they will serve as a CHW/peer recovery coach. NCHC was able to add a new CHW to their Ways2Wellness Connect program, to bring them to a current total of three. The partner is actively looking to fill two more CHW slots to expanded capacity as the program grows. The target population for this program has shifted slightly to be patients over 55 with chronic health problems and no SUD problems. During this reporting period the program served 4 Medicaid clients. NCHC CHW's currently have relationships with all affiliates of North Country Healthcare, Indian Stream Health Center, Coos County Family Health, and Ammonoosuc Community Health Services. ACHS and NCH affiliate, North Country Home Health and Hospice, are two of these 8 referring agencies to have increased their engagement with NCHC CHW's during this reporting period. The CHW team and referring agencies continue to use the same efficient process to provide patients with services and continue to refine processes and add to protocols as necessary. NCH – Weeks Medical Center has begun sending a referral check back sheet once a month to act as a closed-loop referral process. When this sheet is received at NCHC the CHW looks at the patient names to see the status of their care and/or referral. The CHW communicates the status of the referral to Weeks to allow them to manually close the referral in their system. NCHC CHW staff have been attending Weeks' Emergency Room readmission committee meetings that occur twice a month. The CHW's get a list high ED utilizes and high readmission patients who will be discussed at the meeting to allow them to follow up and participate in the discussion. CHW staff also attend process and system meetings and meet with care transitions staff to continue to improve strategies of care. The CHW Program is looking to have a similar relationship with CCFHS when staffing has increased.

Currently, the NCHC CHW team is strategizing on how to get data out of NCH – Weeks Medical Center system to assess impact and prove sustainability and return on investment. The team plans on looking at dollars saved by engaging CHW's in the course of treatment for clients and implementing client surveys to get treatment feedback. NCHC held one community health worker training which started in November 2018 and will end in February 2019; the trainer anticipates graduating 8 participants. The organization will continue to hold one-two CHW trainings per year to expand the CHW workforce.

The CHW Program launched their Brown Bag webinar which includes a presentation by a chronic care transitions team manager at NCH – Weeks Medical Center who explains the positive impact on clients. The 1-hour webinar offers CEU and 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 webinar has been uploaded to NCHC's Moodle platform to be

accessed by community partners on demand, allowing for increased exposure to the content. NCHC CHW's continue to participate in the NH CHW Coalition to work to standardize a Community Health Worker training for the state and educate providers about CHW's. The group elected a steering committee for the first time and are working to develop a strategic plan to explore CHW certification to work towards sustainability. The NCHC CHW program was chosen to present to 22 clinics that are involved in the Breast and Cervical Cancer Screening project across the state to educate providers about CHW's.

The CHW staff held Diabetes Self-Management Education Class series in Lancaster in July and August. The objectives of the class were how to manage diabetes, how to create an action plan and stick to it, how to problem solve, how to deal with stress, how to select healthy choices, and when to contact the doctor. Better Choices, Better Health classes were also held at NCH – Androscoggin Valley Hospital in August & September. Within this class the Chronic Disease Self-Management Program (diabetes, arthritis, high blood pressure, heart disease, COPD, chronic pain, and anxiety) was completed to help participants gain to manage their health.

White Mountain Community Health Center (WMCHC) and Huggins Hospital both made significant progress on services related to enhanced care coordination for the high needs population. The partners have continued working with the IDN Quality Improvement Coach to improve care coordination systems, develop workflows, and document policies and protocols. Care coordination staff at both agencies have been pivotal in the implementation of the CCSA protocol and risk stratification processes. The IDN Quality Improvement Coach presented a draft risk stratification policy and procedure for review.

Huggins staff worked to determine where risk levels will be documented in the new Allscripts EMR platform. The agency is working to have this be embedded in the health maintenance flowsheet with a 1-6 drop down level to select the assigned risk level. The agency worked closely with the NCHC Quality Improvement Program Manager to host a provider training in December that included risk stratification, SBIRT, screening tools, depression screening documentation and other relevant topics.

As mentioned in project B1, White Mountain Community Health Center has fully implemented the CCSA survey process with their Medicaid population of 18 years and older and are tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes. The care coordination team is responsible for tracking compliance and ensuring patients with identified needs are addressed with care coordination follow up. Once the CCSA profile is initiated when the patient arrives it is determined if they need further care coordination, if they are determined a high-risk patient, they are referred to the Social Worker, who then prepares their cases for the multi-disciplinary core team meetings. If they are a low risk patient that only need simple services the Community Health Worker providers community outreach, helps fill out applications for social services and Medicaid and handles the follow-up of these patients. During the reporting period of July-December 2018 WMCHC enrolled 58 individuals with behavior health disorders, with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors into care coordination services. Additionally, WMCHC has 23 prenatal patients who are receiving care coordination, several having substance misuse risks. They do not currently have any children (<18 years) who meet the criteria of having been diagnosed with chronic serious emotional disturbance seeing a care coordinator.

The Memorial Collaborative Project continues to bring four organizations in northern Carroll County together to improve coordination of services and care for the population. Memorial Hospital, Saco River Medical Group, Visiting Nurse Home Care & Hospice, and Children Unlimited, continue to work 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 finalized a short video highlighting services in place and demonstrating collaboration among agencies in northern Carroll County. The video can be found at the link below:

https://www.youtube.com/watch?v=3z2JKm8hzIs&feature=youtu.be

This video was an exceptional example of innovative collaboration and community outreach. The staff from the four organizations and Carroll County Coalition for Public Health spoke about the impact the opioid crisis has had on the region and how they have come together to improve the health of the community. The video was a powerful representation of how collaboration and commitment can change the way people communicate with others. This group intends to create a second video, highlighting testimonials of people receiving services from these agencies in 2019. Each of the 4 agencies participating in the collaboration have made significant achievements to help with the coordination of services in Carroll County:

Children Unlimited: IDN funding has provided support to allow the addition of one staff person who started in Fall 2018. This has given the agency the capacity to increase outreach into the community affected by SUD. The partner has developed 2 series of parent support/education groups on site of the local domestic violence shelter and SUD treatment center.

Memorial Hospital: Care coordination has remained their major focus during this project. Memorial's Patient Care Coordinator has continued to help coordinate services and assist patients in navigating the system and obtain needed services. Community outreach and education to inform the public and other agencies about the services available for patients with SUD and families has been essential during this project. Community education and outreach included presentations with discussion in multiple venues including:

- Carroll County Coalition of Public Health Advisory Committee meeting
- SAU 9 Wellness Committee
- Carroll County Visiting Nurse Association Board of Directors
- Memorial Hospital Strategic Planning Committee
- Memorial Care Transitions Committee
- Mount Washington Valley Community Health Collaborative
- Mount Washington Valley Regional Health Collaborative
- Mount Washington Valley Future Leaders Chamber of Commerce

Visiting Nurse Home Care and Hospice of Carroll County: This partner has worked to expand their Crossings Bereavement service by increasing coordinator hours for program development. The agency has been able to invest in outreach, resulting in the establishment of solid networks for partnering and referrals. There are no other peer support bereavement services for families in Carroll county, and IDN funding is helping to develop these programs.

Saco River Medical Group: SRMG continues to work to secure behavioral health services for their patients and has been having discussions with a local therapist who has significant experience working with SUD patients. The agency continues to work on the development of risk stratification models.

The four organizations working together have been able to share information regarding resources including community supports, availability of counseling, and peers support groups. This project has fostered stronger partnerships and provided a structure to sustain collaboration.

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	127
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	N/A – waiting to receive claims based data information
# 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	N/A - waiting to receive claims based data information
# of sub-recipient proposals received which are related to Enhanced Care Coordination	5 by 12/31/2018	3	5	10
Convene 1 Care Advocate Workgroup	1 by 12/31/2017	1	1	1

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# regional care coordination trainings	3 by 12/31/2018	0	1	2
# Community Health Worker Trainings	3 by 12/31/2018	1	0	2
# of CHW cross trained as Peer Recovery Coaches	8 by 12/31/2018	5	5	7
# of Region 7 IDN agencies with embedded Community Health Workers	5 by 12/31/2018	4	4	5
# of agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3 by 12/31/2018	0	2	11
# of trained Care Advocates	15 by 12/31/2018	0	5	11
# of partner organizations that have agreements in place for referral process	4 by 12/31/2018	0	2	7

Region 7 IDN initially planned to train 15 Care Advocates by December 31,2018. To accomplish this, NCHC hosted a Risk Stratification Webinar and coordinated two Regional Care Coordination trainings during 2018. This was a shift from the original three that were planned, one for each county. The northern Grafton and Coos County training was combined into one training to better fit IDN partner needs, specifically those of North Country Healthcare affiliate organizations. North Country Healthcare only sent 2 staff instead of 1 from each affiliate agency, and other partner agencies chose not to send staff because of the need to serve patients, so the region did not meet metrics for the number of care coordinators trained. The Carroll County training had two individuals who were partially trained during the 2-day training that were not counted in this measure, however they received valuable content from the day they attended. The Region 7 IDN team plans to offer additional care coordination training modules via webinar to reach additional care coordinators moving forward.

The region did not meet targets for the number of CHW trainings offered in 2018 because NCHC did not conduct a Spring 2018 training as originally planned. NCHC did hold a fall 2018 training and has counted that training in the table above because most of the sessions occurred in 2018, despite the course officially ending in January 2019. The region will be holding two more Recovery Coach Academies in January and April 2019 and will use targeted promotion to individuals who have previously completed NCHC Community Health Worker training. NCHC also plans to host two Community Health Worker trainings in 2019.

It has been challenging to capture the number of Community Health Workers trained as Peer Recovery Coaches because there are so many paths to and titles of individuals that can fall within the CHW category. Additionally, many Peer Recovery Coach trainings are offered over and above those hosted/funded/promoted by the IDN. For the purposes of this report, Region 7 IDN counts only those individuals who have completed both the NCHC (or other formal) CHW training as well as the CCAR Recovery Coach Academy in the “CHWs trained as Peer Recovery Coaches” category.

Although IDN staff are working closely with Huggins Hospital and White Mountain Community Health Center to develop Enhanced Care Coordination programs that meet DSRIP specifications, there are other partners in the region at various stages of implementing Enhanced Care Coordination models without additional IDN facilitation.

For example, Weeks Medical Center has a team that meets regularly to review high utilizers of Emergency Department services and helps identified patients establish and maintain better connections to primary care. They also have a core comprehensive standardized assessment process in place and workforce within the primary care clinic that meets the multi-disciplinary core team requirements. Weeks Medical Center also utilizes NCHC's Ways2Wellness CONNECT program, which provides Community Health Workers to patients 55 and older with unmanaged chronic disease such as hypertension, diabetes, CHF, and COPD, for some of their high-risk patients. Weeks Medical Center has also contributed to the development of a universal consent form for patients using the five NCH affiliates, and in late 2018 began implementation of the Collective Medical platform, first within the hospital side of their operations and with a goal to see the primary care side utilizing this technology in 2019.

Indian Stream Health Center is another agency which has done a lot of work on Enhanced Care Coordination. They have a strong risk stratification system in place, and the IDN team will be working closely with the agency over the next reporting period to get Collective Medical implemented. In the North Conway area, Memorial Hospital is working closely with Children Unlimited, Saco River Medical Group, and Visiting Nurse Home Care and Hospice of Carroll County to enhance care coordination services in the area. Funding delays have impacted this work, but these four agencies hope to continue collaborative conversations focused on care coordination systems, and as the DSRIP program continues they will be encouraged to look at shared patients and develop coordinated care plans which will best serve the needs of high-risk patients.

Coos County Family Health Services and Androscoggin Valley Hospital share a community care coordinator, splitting the time of this person equally between the 2 agencies. The community care coordinator looks at risks related to transitions of care, as well as risks identified by the care management team. This information along with care plans and discharge plans are shared with CCFHS to ensure high risk patients are seen in a timely manner, and referrals are made as necessary. CCFHS staff look at the event notifications triggered by Collective Medical daily to determine who has been utilizing services frequently, and address patient needs appropriately.

Northern Human Services is working on enhanced care coordination, especially with their Assertive Community Treatment (ACT) clients. ACT services are customized to the individual needs of identified individuals and delivered by a team of professionals who are available 24 hours/day. ACT helps to prevent psychiatric hospitalizations and is based in the local communities of those who need intensive community support services. Northern Human Services has an identified care team to work with these clients and are utilizing the Collective Medical platform to assist with the care coordination of these clients.

NCHC has received copies of referral protocols from White Mountain Community Health Center, Huggins Hospital, Coos County Family Health Services, Weeks Medical Center, Indian Stream Health Center, Ammonoosuc Community Health Services, and Rowe Health Center. Region 7 IDN staff continue to work with other B1 agencies to ensure they have written referral agreements in place**.**

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	11
Regional Care Advocate Supervisors	1 by 12/31/2018	0	0	1	1

Although Region 7 IDN did not meet the Care Advocate staffing target which was established, the region has had 2 regional care coordinator trainings to date, one in March 2018 for Carroll County agencies and one in November 2018 for Coos and northern Grafton County agencies. Participants felt the trainings were valuable because they provided an opportunity to come together to discuss information sharing and how to improve care coordination services for the high needs population as these patients transition between agencies.

The region initially planned to train 5 Care Advocates in each of the 3 subregions by December 31,2018. As the project moved into the implementation phase it became apparent that it would be beneficial to combine Coos and northern Grafton County agencies together for the regional care coordination training. The reasoning behind this decision was due to the structure of North Country Healthcare, and their efforts to coordinate care across the region. Due to North Country Healthcare's regional care coordination approach they only sent 2 staff members to the training versus one from each of the 5 affiliate agencies. This is, in part, because NCH hospitals and primary care practices belonged to a Medicare Accountable Care Organization at the same time, so care coordinators at each local affiliate were receiving care coordination training under that demonstration project as well. Counts in this table only reflect those care coordinators trained as part of the IDN activities. NCHC plans to offer additional care coordination training modules via webinar to reach additional care coordinators moving forward.

In addition to regional care coordination trainings NCHC has also hosted a risk stratification webinar in November 2018 which was well received by participating agencies. The IDN team scheduled a Policy and Protocol webinar for January 2019.

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	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	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	$76	$2,550	$2,550	$1,275
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	$0	$1,011	$1,011	$505
10. Marketing/Communications	1,086	$572	$1,797	$579	$579	$289
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	$1,306	$4,312	$4,312	$2,156
Support Payments to Partners	65,766	$59,987	$43,338	$181,953	$181,953	$90,977
TOTAL	**69,454**	**$62,893**	**$46,517**	**$190,405**	**$190,405**	**$95,202**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

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)
Northern Human Services	Y
NCH – Weeks Medical Center	Y
White Mountain Community Health Center	Y
Ammonoosuc Community Health Services	Y
Indian Stream Health Center	Y
Memorial Hospital	Y
North Country Healthcare	Y
Huggins Hospital	Y
North Country Health Consortium	Y
Saco River Medical Group	Y
Coos County Family Health Services	Y

Region 7 IDN partners listed in the chart above are also involved with the region's B1 project in some capacity such as having Identified care teams; a systematic strategy to identify and intervene with target population; a comprehensive core assessment and a care plan for each enrolled patient; care coordination services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources; transitional care coordination across settings; technology-based systems to track and share care plans and to measure and document selected impact measures; robust patient engagement process around information sharing consent; and coordination with other care coordination/management programs or resources that may be following the same patient. IDN staff will continue to engage with agencies working to implement enhanced care coordination to ensure these agencies are incorporating the project core components. Other agencies in the region may be actively involved in the enhanced care coordination project but their efforts are not being tracked due to projected cuts in IDN funding.

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.
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 partners and the IDN team continue to participate in conversations related to the Alternative Payment Model. Seven people from the region participated in the August 2018 Myers and Stauffer Learning Collaborative session on Performance Measurement and Quality Outcomes and heard Henry Lipman, NH Medicaid Director, present an update on the alternative payment model. The IDN team also arranged for Henry Lipman to speak at the region's quarterly meeting in December 2018 to address funding uncertainties and alternative payment models. To date, the focus of alternative payment model conversations has been related to the re-procurement process of the managed care organizations because the MCOs have been asked to develop a strategy for moving 50% of their medical expenditures into qualifying APMs to improve cost, quality, and member experience. The MCOs are tasked with implementing cost of care models which include shared savings and align with the existing APM models used in the Medicare and commercial markets. The APMs must improve measures related to unnecessary emergency department and service utilization; preventable admissions and 30-day readmissions; and timeliness of follow-up after mental illness or substance use disorder admission, all important things related to DSRIP goals as well. DHHS expects the MCOs to provide person-centered care which addresses patients' physical health, behavioral health, and social and economic needs, all of which aligns with what the IDNs are doing. The MCOs must conduct local care management or contract with a designated care management entity for at least 50% of high-risk/high-need members. Region 7 IDN will work closely with NH DHHS as conversations evolve defining DHHS certification of IDNs as a local care management entity. In addition, members of the IDN team have had conversations with the existing MCOs and at least one of the new MCOs regarding working together to prevent duplication of services, and these conversations will continue.

The 7 IDNs and staff from NH DHHS have come together to start having conversations related to billing and coding for integration services. These conversations will continue bimonthly, and the information learned will be shared with partners in the region. The IDN team is interested in learning more about the sustainability of the Critical Time Intervention model and finding out if this could be a billable service as it

is now in North Carolina. This has been a stumbling block for implementation of the model and has been brought up by numerous partners across the region and from other IDN regions in the state.

A non-binding Notice of Intent to Apply for NH Value Care has been submitted and accepted by CMS for the following participating member organizations: Catholic Medical Center, Huggins Hospital, Monadnock Community Hospital, NCH – Androscoggin Valley Hospital, NCH – Littleton Regional Healthcare, NCH – Upper Connecticut Valley Hospital Association, NCH – Weeks Medical Center, Ammonoosuc Community Health Services, Coos County Family Health Services, and Indian Stream Health Center. The Region 7 IDN team does not know if all the mentioned agencies will move forward with the submission, but the team will stay in contact with these agencies to learn more about the progress and what it means for the region.

Saco River Medical Group, the 3rd largest independent physician group in NH, has joined VillageMD New Hampshire ACO which is a collaboration with Derry Medical Center and Southern NH Internal Medicine Associates. The ACO is a joint venture among 3 independent physician groups in NH working together to remain viable as independent medical practices.

Dartmouth-Hitchcock Health (D-HH) and GraniteOne Health (GOH) have signed a non-binding letter of intent describing their intent to combine their health systems to better serve the health care needs of patients and communities throughout New Hampshire. As a combined system, Dartmouth-Hitchcock Health GraniteOne will seek to:

- Expand access to high-quality care for individuals and families throughout New Hampshire;
- Respond to growing demand for inpatient, specialty and sub-specialty services, particularly in southern New Hampshire;
- Extend and reinforce health care services in rural communities;
- Coordinate and strengthen efforts to address behavioral health and substance use disorder;
- Improve the health of populations suffering from chronic conditions such as diabetes, asthma, and obesity, leading to better long-term health and lowering long term healthcare costs;
- Address social determinants of health such as nutrition and food security, access to preventative care, and educational opportunity

There are numerous opportunities for systems alignment and potential alternative payment models in the upcoming month. The Region 7 IDN team will look for opportunities to participate in these conversations as they evolve over the coming months and attempt to leverage payer strategies to develop innovative ideas that meet IDN metrics and measures.

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	Yes
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		No	No
Develop the financial, clinical and legal infrastructure required to support APMs		No	No

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
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	No

DSRIP Outcome Measures for Years 2 and 3

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

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

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

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**
		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