

New Hampshire  
Department of Health and Human Services

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*Building Capacity for Transformation Waiver*

*Integrated Delivery Network*

*Semi-Annual Report*

*(January – June 2019)*

*Network4Health (IDN 4)*

*July 26, 2019*



## Table of Contents

<b>1. Project Plan Implementation Narrative</b>	<b>3</b>
<b>2. Project A1: Behavioral Health Workforce Capacity Development</b>	<b>10</b>
a. Narrative Response	10
<b>3. Project A2: IDN Health Information Technology (HIT) to Support Integration</b>	<b>22</b>
a. Narrative Response	22
<b>4. Project B1: Integrated Healthcare</b>	<b>33</b>
a. Narrative Response	33
b. Network4Health Behavioral Health Site Self Assessment Survey Results (Attachment _B1.1)	45
<b>5. Projects C: Care Transitions-Focused</b>	<b>60</b>
a. Narrative Response	60
<b>6. Projects D: Capacity Building Focused</b>	<b>64</b>
a. Narrative Response	64
<b>7. Projects E: Integration Focused</b>	<b>68</b>
a. Narrative Response	68
b. Training Attendance (Attachment_E4.1)	81
c. ITCOD Newsletter (Attachment_E4.2)	89
<b>8. APM Implementation Planning</b>	<b>93</b>
a. Narrative Response	93

## Project Plan Implementation (PPI)

### Narrative

*Provide a detailed narrative to reflect progress made during this reporting period as it relates to the Administration, Network and Governance.*

*Include a narrative which provides detail of Key Organizations and providers that have been off-boarded as well as new partners and the effective date of change.*

Network4Health is pleased to submit this fifth Semi Annual Report outlining achievements during the January 1, 2019 through June 30, 2019 reporting period. Our integrated delivery network remains dedicated to improving the lives and health outcomes of community members who experience behavioral health issues or are at risk of experiencing behavioral health issues. We are now witnessing the tangible results of targeted investments in transforming the care delivery system into one that integrates primary care, behavioral healthcare, and community based social services providers who address the social determinants of health.

Activities designed to operationalize the Network4Health project plans are well underway as described in the following report.

Highlights for the reporting period include:

- Our B1 Integrated Healthcare Project partners continue to demonstrate improvement along the SAMHSA Integrated Care Continuum and are now implementing second year integration enhancement plans.
- NH Department of Health and Human Services (DHHS) has conducted contract re-procurement for the Medicaid Managed Care program. Three Managed Care Organizations (MCO) have been selected and new contracts are intended to be in place by September 1, 2019. Network4Health has been engaged in multiple discussions with each of the MCOs to discuss contract elements relating to integrated healthcare and the NH Transformation Waiver requirements including implementation of local care management entities and alternative payment models.
- As part of the State Opioid Response (SOR) grant, regional substance use disorder HUB's have opened across NH. Granite Pathways, a Network4Health partner, was selected as the HUB (now referred to as the Doorway) in our region. We have taken concrete steps to assure coordination and collaboration across the SOR and waiver initiatives.

The funding uncertainty, related to continuing negotiations DHHS and NH counties, was ultimately resolved for 2018. However, continuing unresolved issues for 2019 and 2020 raises concerns among our network partners. Network4Health is committed to continuing current

program implementation but understands that any funding decreases will necessitate reevaluation of all project priorities and may require modifications to project plans.

In addition, this reporting period marks the first in which 100% of funding is based on the Delivery System Reform Incentive Payment (DSRIP) program outcome measures. Network4Health works closely with leadership of NH DHHS as outcome measures have been and continue to be implemented.

## **Administration**

During the reporting period, there have been no changes in the executive leadership of Network4Health. Project Directors are responsible for the operation of the six projects operationalized in late 2017.

## **Soliciting Community Input**

Community engagement sessions- South Central and Greater Manchester Community Outreach Coordinators facilitated “focus group” sessions with stakeholders and consumers. During the reporting period, Network4Health conducted a total of **six** community engagement sessions in the following locations with 37 total participants:

- a. New Horizons Homeless Shelter (3 participants, 2 female, 1 male); Manchester, NH
- b. Hillsborough County Drug Court (6 men currently enrolled in the program); Manchester, NH
- c. Families in Transition (7 participants, 1 male, 6 female); Manchester, NH
- d. Center for Life Management (7 participants, 2 female, 5 male); Derry, NH
- e. Parkland Partial Hospitalization Program (10 participants, 6 female, 4 male); Derry, NH
- f. On the Road to Wellness (4 participants, 1 female, 3 male); Derry, NH

### Focus Group summary:

Standard questions asked:

1. Have you or someone you know had trouble obtaining or accessing health care and what were some of the reasons?
2. Tell us a little bit more about accessing behavioral health care including mental health services and substance misuse services.
3. In the last year or two, what are the places you think that our system of care is either falling behind or improving?

Feedback from the focus groups is consistent with much of what has been documented in the previous reports. What is of great value for us is the opportunity for improvement in the way service and care is being delivered.

## Key Findings/Themes:

### What are barriers to accessing care?

- Reported barriers were focused around systems issues regarding the complexity of the enrollment process, the costs of co-pays and deductibles, long wait periods resulting delays in coverage and care, and increased utilization of the emergency departments for non-emergent care
- Stigma, especially in emergency department settings.
- Continuity of care is lacking and in some cases non-existent.
- Absence of dental and vision coverage under Medicaid.

### What is being done well?

- Safe Stations and Granite Pathways (Doorway)
- Drug Court
- Reunification Program
- Hope for NH (Peer Support) is welcoming, also a Narcan distribution site
- Healthcare for the Homeless (HCH) new Suboxone clinic

### Suggestions/Opportunities for improvements:

- Increase capacity – medical detox, residential care, sober housing, intensive outpatient treatment and 12 step programs.
- Increased case management services to support persons maneuvering through the systems of care and service.
- Transportation that is reliable, affordable, flexible and safe.
- Training and education:
  - Stigma reduction/client sensitivity for medical professionals.
  - Teachers /staff on mental health and how to support students.
  - Adverse Childhood Experiences - how to identify children who have suffered trauma.
  - Gender training/education.
- Outreach workers in the field and Peer Coach services.
- Syringe/Needle exchange program.
- Lack of communication between doctor's and mental health providers.
- Prevention education and peer support services in the schools and youth serving organizations.

South Central and Greater Manchester Community Outreach Coordinators represent Network4Health in a variety of community meetings, task forces and activities related to SUD. A list of activities and meetings that they were involved with during this reporting period follows.

### Greater Manchester Happenings:

1. 'Hear It Here' Community Learning Series – for the Greater Manchester Chamber of Commerce.
2. Manchester Safe Station - coordinates community meetings for the Safe Station partners.
3. Calculating Adequate Systems Tools (CAST). Represented N4H on the team that completed the tool for the Manchester community.
4. Linking Actions for Unmet Needs in Children's Health (LAUNCH) Manchester - targets the needs and opportunities of children aged 0 – 8 years.
5. Participating in the Mayor's Homelessness Task Force meetings forum to address homeless issues in Manchester.
6. Participate in the Compassionate Community Forum. Collaboration of faith based organizations and human service providers.
7. Involved with the planning of the CDC's Opioid Rapid Response Team (ORRT) visits to Manchester.
8. Working with Southern NH Planning Commission on a substance use story mapping project.
9. Participate in the Manchester Perinatal SUD Alliance.
10. Participate in Creating Neighborhoods of Opportunity - community discussion around strategies to address Manchester's most pressing Public Health concerns.
11. Facilitator of the Greater Manchester SUD Collaborative. Collaboration to identify gaps, needs and barriers for their clients, themselves and their organizations and investigates creative solutions.
12. Participate in the Youth Collaborative - Youth focused SUD collaborative of prevention, intervention, treatment, recovery, and healthcare organizations.
13. Participate in the Overdose Prevention and Response pilot project with Centers for Disease Control (CDC), National Association for County and City Health Officials (NACCHO) and National Resource Center for Academic Detailing (NaRCAD) to develop a plan and ongoing work with Academic Detailers.
14. Participate in the NH Providers Association; Network4Health's Greater Manchester Community Outreach Coordinator serves as a board member.
15. Network4Health's Greater Manchester Outreach Coordinator also is a Graduate of the Class of 2019, Leadership Greater Manchester.

### South Central Happenings:

1. Participate in the South Central Leadership group – A collaboration with the South Central Substance Misuse Prevention Coordinator.
2. Participate in the Derry Mental Health Taskforce –a community group formed to advocate for improved mental health services.
3. Participate in Hub Accessing Meetings- to educate stakeholders on the role of the Hubs or Doorways in the south central area.

4. Participate in the Southern NH Human Services Council- a collaboration to discuss and share information.
5. Participated in the *We Are One* event- resource tables, conversation, music, and a panel of teens and young adults who shared their stories about thriving despite having mental illness -100+ participants
6. Participate in the SoRock Coalition, which engaged Senator [REDACTED] and Senator [REDACTED] to discuss HB 481 and needs of the community.
7. Participated in Choose Love- Collaborated to host [REDACTED] to talk about her social emotional learning curriculum. Most schools in Derry have decided to adopt the Choose Love curriculum.
8. Participated in the Londonderry Community Forum-Assisted the Londonderry Police Department with a “Living with an Addiction or Substance Use Disorder- Problems and Possibilities”.
9. Participate on Mental Health Matters- appeared Mental Health Matters portion of the Derry Public Access TV
10. Participating in Project First- assisted the Salem Fire Department by sharing information and connections as well as assisting in the interviews to choose the team members.

## **Network Development**

During this reporting period, there have been no changes in Network4Health’s partner membership. Our 43 partners include organizations that provide or address primary care, mental health care, and behavioral health care as well social health care. The Network4Health Steering Committee reviews the need for new network partners on an ongoing basis.

As planned, Network4Health held its quarterly “All Network Partners” meetings in March and June 2019. Our March meeting included an update by Granite Pathways on the status of the Greater Manchester/Derry/Salem HUB established by the State Opioid Response grant. In addition, Amerihealth Caritas, NH’s newest Medicaid Managed Care Organization, provided an overview of their organization with a focus on experience with alternative payment models.

At the June meeting, a representative of the Granite Pathways Youth Treatment Center provided a program update. Also, the Director of NH 211 attended to update our partners on enhancements that are being made with funding from the State Opioid Response grant. Network4Health Executive Director reported on sustainability planning being conducted by the Steering Committee and provided a comprehensive overview of NH initiatives potentially impacting plans for the future. Network4Health IT and Population Health Director provided an update on data collection and analytics.

## Governance

The Network4Health Steering Committee met monthly throughout the reporting period and continues to provide oversight of project plan development, implementation and budgeting. The Steering Committee has authorized the following change in membership: Dr. [REDACTED] replaced Dr. [REDACTED] representing Dartmouth Hitchcock Manchester.

During the reporting period, the Steering Committee has continued to monitor closely the evolving funding challenges that have occurred related to county participation. In addition, sustainability of Network4Health and its projects following the termination of the NH Transformation Waiver is an ongoing priority. Regular updates on NH initiatives that could offer potential N4H involvement going forward are provided by the Executive Director at each Steering Committee meeting. The ad hoc Strategic Planning Committee is available for in depth examination. Initiatives currently being monitored include: InCK and MOM grants submitted during the reporting period; Medicaid Managed Care Organization contracting and the newly proposed "Local Care Management Entity"; the NH Mental Health 10 Year; and, planning surrounding the future of NH Long Term Services and Supports (LTSS).

## Budget

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

Network4Health adopted a fiscally conservative approach to utilization of Project Design and Capacity building funds received in the first year of operation. There have been no significant changes in the planned utilization of these funds during the reporting period.

The following budget table reports expenses (actual and projected) for Project Design and Capacity Building Funds (PPI) as well as for all six projects implemented by Network4Health.

Project	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan-June 2019 Actuals	Jul-Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected
PPI	\$67,559	\$523,029	\$732,500	\$343,062	\$1,273,367	\$1,640,741	\$636,632
A1	\$0.00	\$37,216	\$290,590	\$319,011	\$2,302,467	\$1,891,028	\$360,512
A2	\$0.00	\$36,268	\$713,415	\$516,111	\$1,927,026	\$1,649,279	\$355,675
B1	\$0.00	\$2,800	\$627,580	\$1,052,152	\$3,986,903	\$4,067,703	\$2,146,802
C	\$0.00	\$11,121	\$250,251	\$134,046	\$548,904	\$674,649	\$238,067
D	\$0.00	\$0.00	\$0.00	\$704,004	\$446,056	\$468,542	\$238,530
E	\$0.00	\$8,329	\$66,295	\$141,636	\$632,442	\$768,419	\$239,360

The budget below provides a detailed description of how Network4Health has utilized and intends to utilize its Project Design and Capacity Building Funds over the course of the

demonstration. Our total Project Design and Capacity Building (PDCB) expense for this reporting period was \$343,062. Total invoiced and paid expenses for PDCB since inception is \$1,666,150.

<b>PROJECT DESIGN AND CAPACITY BUILDING</b>	<b>ACTUAL CY 2016 (Yr1)</b>	<b>ACTUAL CY 2017 (Yr2)</b>	<b>ACTUAL CY 2018 (Yr 3)</b>	<b>ACTUAL CY 2019 (Yr4) Jan to June</b>	<b>PROJECTED CY 2019 (Yr4) July to December</b>	<b>PROJECTED CY 2020 (Yr5)</b>	<b>PROJECTED CY 2021 (Yr6)</b>
Total Revenue (received in two payments)	\$ 5,216,890						
Rollover		\$ 5,149,331	\$ 4,626,302	\$ 3,893,802	\$ 3,550,740	\$ 2,277,373	\$ 636,632
<b>Total Revenue</b>	<b>\$ 5,216,890</b>	<b>\$ 5,149,331</b>	<b>\$ 4,626,302</b>	<b>\$ 3,893,802</b>	<b>\$ 3,550,740</b>	<b>\$ 2,277,373</b>	<b>\$ 636,632</b>
<b>Salary &amp; Benefits-Executive Director (1.0 FTE); Project Management (1.4 FTE); Finance Coordinator (1.0 FTE); Community Project Directors (3.0 fte); Community Engagement Coordinators (1.0 fte); Associate Executive Director (.4 FTE)</b>		\$ 473,355	\$ 639,365	\$ 330,133	\$ 480,296	\$ 834,741	\$ 429,892
<b>Consulting</b>							
Bailit Health	\$ 67,559	\$ 40,834	\$ 26,907	\$ 11,065	\$ 33,935	\$ 45,000	\$ 15,000
UNH Law Health Practice & Policy Institute Privacy Consult		\$ 5,500					
Privacy Legal Consult			\$ 2,200				
<b>Total Consulting</b>	<b>\$ 67,559</b>	<b>\$ 46,334</b>	<b>\$ 29,107</b>	<b>\$ 11,065</b>	<b>\$ 33,935</b>	<b>\$ 45,000</b>	<b>\$ 15,000</b>
Steering Committee Project Team Support and other N4H administrative support.		\$ 1,826	\$ 58,268	\$ 562	\$ 749,468	\$ 750,000	\$ 186,240
Quarterly Partner Meetings- refreshments		\$ 1,226	\$ 1,973	\$ 557	\$ 5,443	\$ 6,000	\$ 3,000
Miscellaneous Office Supplies		\$ 289	\$ 3,787	\$ 745	\$ 4,225	\$ 5,000	\$ 2,500
<b>Total Other</b>		<b>\$ 3,340</b>	<b>\$ 64,028</b>	<b>\$ 1,864</b>	<b>\$ 759,136</b>	<b>\$ 761,000</b>	<b>\$ 191,740</b>
<b>Total Expenses</b>	<b>\$ 67,559</b>	<b>\$ 523,029</b>	<b>\$ 732,500</b>	<b>\$ 343,062</b>	<b>\$ 1,273,367</b>	<b>\$ 1,640,741</b>	<b>\$ 636,632</b>
<b>Variation to Budget (Transfer Funds to Subsequent Year)</b>	<b>\$ 5,149,331</b>	<b>\$ 4,626,302</b>	<b>\$ 3,893,802</b>	<b>\$ 3,550,740</b>	<b>\$ 2,277,373</b>	<b>\$ 636,632</b>	<b>\$ 0</b>

# Project A1: Behavioral Health Workforce Capacity Development

## Narrative

*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 to reflect progress made toward recruitment, retention, hiring and training during this reporting period.*

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In this section we provide an overview of the significant work and progress that has occurred relative to our workforce development efforts during this reporting period.

## Education

### **Update on Behavioral Health Scholars Program: Manchester Community College**

The Network4Health Behavioral Health Scholarship Program was initiated in August, 2018 at MCC. It aims to increase participation and matriculation in behavioral health-oriented degree programs at Manchester Community College in order to increase the behavioral health workforce, and increase awareness of careers in human services and behavioral health. The scholarship supports students currently enrolled in these programs at MCC are working towards:

- Associate's Degree in Behavioral Science
- Associate's Degree in Human Services
- Direct Support Services Certificate
- Substance Misuse Prevention Certificate
- Recovery Support Worker Certificate
- Mental Health Support Certificate

Students can be FT or PT, in on-line or traditional programs with a GPA of 2.5 or higher. In addition, we asked that students live or work in a Region 4 town. Students were asked to submit an application, attach a 250 – 350 word essay on why they are choosing a career in behavioral health, and what they plan to do with their education.

\$50,000 was allocated to this program for the 2018-2019 academic year, and N4H was prepared to make awards of up to \$5,000.00. However, most awards were granted in smaller denominations since many students are receiving other types of financial aid.

*Results to date:* Since inception in August 2018, 20 Network4Health Behavioral Health Scholarships totaling \$34,000 have been awarded.

### **Behavioral Health Scholars Program: Granite State College**

Network4Health pursued a similar agreement with Granite State College to offer a scholarship program to increase participation and matriculation in behavioral health-oriented degree programs, increase the behavioral health workforce, and increase awareness of careers in human services and behavioral health.

Network4Health committed \$100,000 to this effort for the 2019 school year. Students will be awarded up to \$5,000 per year for full time enrollment, \$2,500 for part time enrollment. We will be looking to support students currently enrolled in these following programs:

- BS in Human Services
- BS in Psychology
- BS in Applied Studies – Human Services and Early Childhood Development
- AS in Behavioral Sciences

Students can be FT or PT, in on-line or traditional programs with a GPA of 2.5 or higher although preference will be given to full time students. Students must live or work in one of the Region 4 towns. Awards are spread over GSC’s 4 terms. Students must complete a FAFSA (Free Application for Federal Student Aid) and have exhausted grant and scholarship aid first. Pell eligible students are able to apply as well. Students will submit an application; attach a 250 – 350 word essay on why they are choosing a career in behavioral health, and what they plan to do with their education.

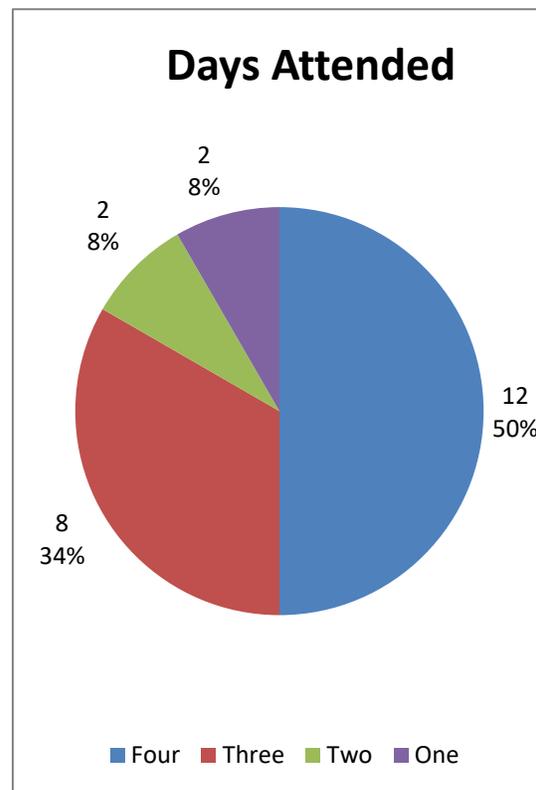
*Results to date:* Since inception in September of 2018, 28 Network4Health Behavioral Health Scholarships totaling \$27,500 have been awarded.

**Fundamentals of Leadership Program with Granite State College:**

Summary of Results:  
Attendee Data

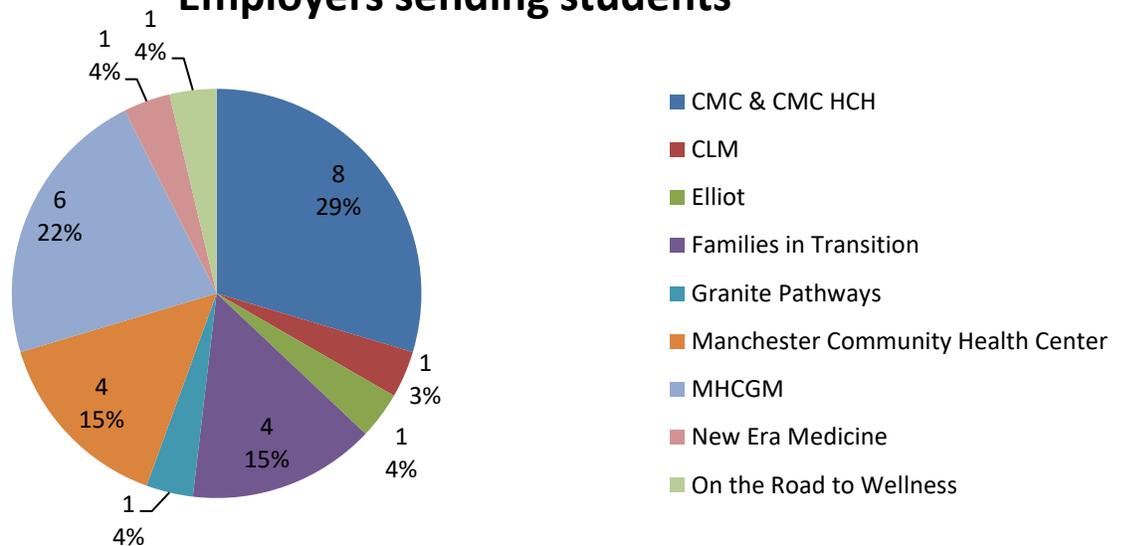
- 30 applicants
- 0 remained on waitlist
- 30 completed
- 100% completion rate

Network4Health recognizes that there is a clear difference between management and leadership. While managers are often implementers and are focused on the day to day, leaders need to be change-agents, visionaries, have long-term views of things, be multi-taskers and work on building relationships. One cannot overstate the importance of strong and capable leadership as a driver of retention, recruitment, and engagement of employees across an organization. During this period, Network4Health partnered once again with Granite State College to offer a Fundamentals of Leadership program at no cost to partner employees.



This program began in March 2019 and ran for 2 months until April 2019. Participant employees were in class for 4 sessions over 2 months, and had approximately 2 hours of online work to do per week between sessions.

## Employers sending students



This course introduced students to the fundamentals of leadership development. Students gained awareness of their personal leadership style and examined leadership concepts, models and practices that lead to effective team and organizational performance. Topics included: Leadership Essentials and Strategies, Team Building, and Coaching and Mentoring. A variety of interactive teaching methods were employed during the course, to include: case studies, current business articles, in-class simulation exercises, interaction and small group projects.

Pre- and post-evaluation data shows substantive gains in skills, confidence, and feelings of connectedness among practitioners in their fields. Of particular note, participants remarked that they increased their skills in the following:

- The differences between management and leadership
- Coaching vs. mentoring
- Insights into personal leadership style and maximizing personal strengths
- Learned how to lead and motivate staff more effectively
- Improved communication skills

Participants stated that they will carry skills learned in the class into their roles by:

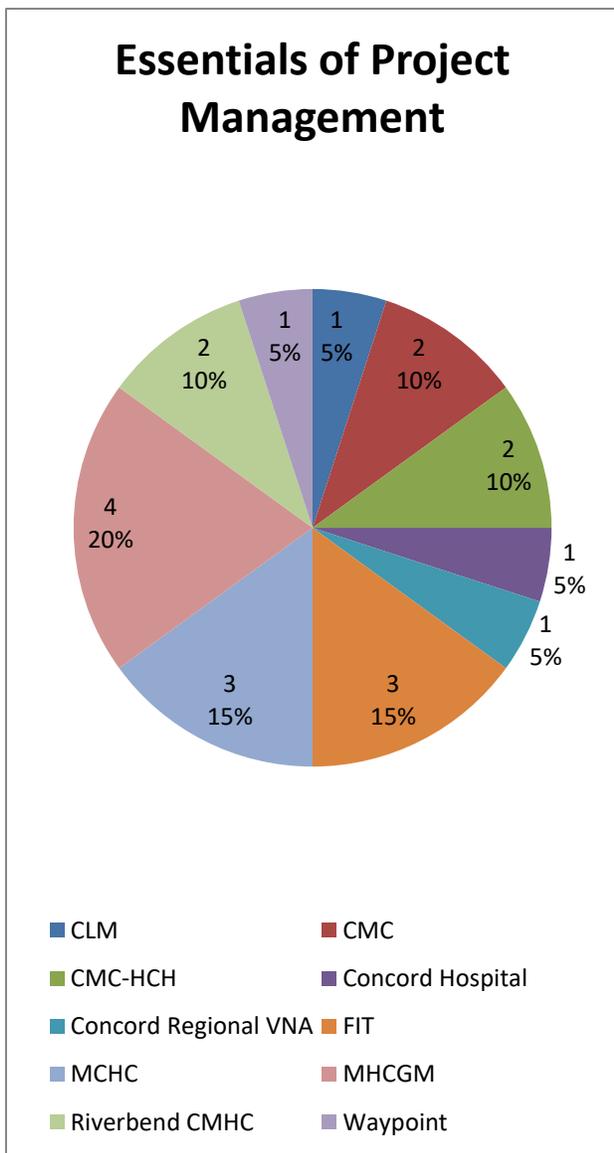
- Sharing learnings with supervisors and colleagues and look for ways to implement best practices across the team
- Increase coaching and mentoring with direct reports
- Pay attention to personality types and realize different approaches for each

A comprehensive final report on the satisfaction and outcomes of this course is available upon request.

### **Essentials of Project Management Program with Granite State College:**

Rolling out new programs and new initiatives are commonplace for many of our network partners. Whether it's through funding from a new grant, a merger, a new strategic direction, or changing mission, our partners are constantly faced with the challenge of putting new efforts together and implementing them in a short period of time. So how do other companies pull it all together and do so successfully? The answer is often project management. Most professionals have a general understanding of how to manage a project – oftentimes gained from trial and error - but few have taken

a closer look at the science and methodology of project management. Network4Health partnered with Granite State College to offer The Project Management Academy to help bridge this knowledge gap.



This course introduced students to the essentials and best practices associated with high quality project management. This course was not meant to prepare attendees to be project managers or to take industry recognized credentials such as the PMP™. Participants learned to apply various project management processes and tools to:

- Effectively deliver on time and within budget, and to communicate effectively with project stakeholders;
- Determine and manage risk for strategic and ethical decision-making;
- Respond positively to changing project management environments including human resources, cost, timelines, and workflow

A variety of interactive teaching methods were employed during the course, including: Case studies, current business articles, in-class simulation exercises, interaction and small group projects. In addition, students were asked to have a project they were in the process of managing or rolling out and utilize concepts learned in class to improve that process.

Classes were held for 3 days over the month of June 2019 for a total of 18 hours. Recruitment wasn't as strong as predicted, so Network4Health was also happy to partner with IDN 2 to offer slots to that region as well. 4 people participated from IDN 2

*Results to date: 20 starts, 20 completers.*

A comprehensive final report on the satisfaction and outcomes of this course is available upon request.

### **Behavioral Health Education Roundtable:**

Network4Health's Workforce Development Director partnered with Southern New Hampshire Area Health Education Center and hosted two Behavioral Health Educational Round Tables on February 8, 2019 and on April 22, 2019.

#### February 8, 2019

14 attendees from colleges, representatives from IDN 4 and IDN 6 staff and partner organizations, community organizations, and professional organizations. Agenda included:

- Welcome, Introductions, and Recap

- 10 Year Mental Health Plan - Guest speaker: [REDACTED], DHHS
- Cherokee Health Systems: Describing Integrated Care Models in Education - Guest speaker: [REDACTED], CHS
- Curriculum Enhancement Discussion: Rivier University, changes to psychology programming
- SB-308 discussion

April 22, 2019

7 attendees from colleges, IDN 4, and community organizations were present. Agenda included:

- Welcome, Introductions, and Recap
- Curriculum Enhancement – UNH Institute On Disability: “The NH Children’s Behavioral Health Workforce Development Network - Core Competencies and their Relationship to Creating Effective Systems of Care.” Guest speaker: [REDACTED], UNH IOD
- Group discussion
  - K-12 Pipeline - [REDACTED]
  - Articulation Agreements - [REDACTED]
- Economic Development in NH – Guest speaker, [REDACTED], Director - NH Division of Economic Development - Business and Economic Affairs

The Round Tables have been successful and participants are interested in continuing them. Our next Round Table is scheduled for October 25, 2019.

#### **Additional items related to education efforts:**

- Director helped coordinate and participated in an online webinar on behavioral health careers with Granite State College. 10 participants.
- Network4Health provided sponsorship at a human services/BH career education event at Manchester Community College called “What? Why? Human Services.”
- Pursuing a scholarship program with UNH for master level students in social work, and a variety of behavioral health oriented programs – online and on campus.

## ***Training***

#### **N4H Sponsored Trainings:**

For this reporting cycle, Network4Health has advertised 211 trainings, and used A1 dollars to support seats at 163 across all projects, funding 616 individuals. With most trainings, continuing education unit (CEU) credits were able to be offered.

IDN 4 once again collaborated with Cherokee Health Systems to bring their expertise to the region.

- In February, March, and April IDN 4 partnered with IDNs 1 & 6 to organize three ‘consultation calls’ for IDN members to discuss
  - The Integrated Care Model and Discussion
  - The Integrated Care Team Method and Discussion
  - Money: Long-term Financial Sustainability of Integrated Care and Discussion
- Each IDN then scheduled Cherokee for a one-day in person session to deliver a topic unique to the needs for that region. IDN 4 had Cherokee present on 6/14/19. Our structure was:

- A morning breakfast for integrated care champions on “Sustaining an Integrated Care Culture.”
- A day-long workshop delivered by Cherokee staff on “Integrated Care Operations and Clinical Workflow”
- Overall, 70 attendees were present for both

IDN 4 also brought Dr. [REDACTED] to the region to begin a series of workshops on trauma. Dr. [REDACTED] has spent more than 25 years committed to understanding and effectively addressing the impact of traumatic exposure on children and families, and has demonstrated expertise in working with others to create trauma responsive systems. She brings together recent discoveries from developmental neuroscience and attachment to help audiences learn how reflective practice leads to better working environments and outcomes for professionals and those they serve.

The first one on trauma-informed care training filled up with 135 attendees. Her next training is scheduled for October 2019.

### **RFP for Off-Set Productivity**

Many partners throughout our region have staff that would benefit from further training. Unfortunately due to the pressures of service delivery, our partners find themselves having to make decisions about staff providing needed care and/or billable services versus increasing professional skills. The same goes for supervision of clinical staff. Being able to free up senior clinical staff members to provide much needed supervision hours to aspiring or established clinicians is an equally difficult choice our member organizations have to make.

In January of 2019 N4H issued this RFP, intending to give our partners resources they can put to use to offset the cost of sending staff to trainings or providing supervision time. This is known as a “productivity offset.” While not intended to cover the entire hourly cost of an FTE who attends a training or provides supervision, these funds are available to reduce funding issues experienced by having an employee out of the office at a training or dedicating time to supervision.

For January to December 2019, Network4Health is making up to \$100,000 available for this program. Awards will be given in amounts up to \$10,000 per agency. Agencies may apply once per year unless specific arrangements have been made with Network4Health.

- Criteria
  - Organizational eligibility
    - Any N4H partner that is not involved with a B1-funded IEP
  - Philosophy - Stronger proposals will include, but not be limited to, the following criteria:
    - Demonstration of careful stewardship of resources
    - Foster culture of continuous learning, improvement, innovation and collaboration
    - Show links between professional education and learning, and the transformation of care in the region
  - Allowable use of funds
    - Broadly, this program will cover offset productivity costs directly related, but not limited to:
      - Reimbursing employee time spent acquiring CEU’s to keep licensure active
      - Reimbursing employee time spent at trainings that increase professional knowledge about subjects related to healthcare or behavioral healthcare,

job performance or skills enhancement, clinical service delivery, etc. including online or distance learning modalities

- Costs related to supervision of CRSW's, LADC's, MLADC's, LICSW's, LCMHC's, LMFT's, LCS's, or Psych Nurse NPs, Behavioral Health PA's
- Allowable hourly rate of reimbursements:

	RATE PER HOUR
Provider (MD, DO)	\$200
Physician Assistants and Nurse Practitioners	\$100
Clinical Staff and Organization Leadership	\$55
Non-clinical Staff	\$30

- Application
  - Executive summary – no more than 2 pages
  - Budget and budget narrative – no more than 3 pages
  - Budget request utilizing only the sheet included

Deadline for submission	First 50% of funding awarded by	Mid-point report due	Second 50% of funding awarded by	Final report due
05/03/19	06/03/19	10/31/19	11/30/19	04/30/20
07/01/19	08/01/19	12/31/19	01/31/20	06/30/20
09/01/19	10/01/19	02/28/20	03/31/20	08/31/20

- Reporting
  - Recipient organizations will be expected to report on progress and outcomes at the times listed in the chart above. Awardees will be measured on the following data points:
    - Budget
      - Provide an accounting of expenditures
      - Compare the actual vs. planned utilization of funds.
    - Trainings and off-set costs
      - Which trainings were attended during the reporting period
      - What were the outcomes (CEUs? Certificate? Increased skill?)
    - Supervision offset
      - How many hours of supervision were utilized; Which positions were supervised; How many hours
      - Outcomes? (Applied for licensure? Obtained licensure? N/A?)
  - After the first reporting period is over, the second installments of funds will be released to awardees based on their performance in the first half of the implementation period

*Successes to date:*

The Upper Room in Derry was awarded \$10,000 from this grant in June 2019. They were the only IDN 4 partner to apply in this reporting period. Among other things, these funds will go towards supervision hours for staff becoming a Certified Prevention Specialist and allow staff to be trained in reflective practice techniques.

### **Mental Health First Aid:**

Network4Health will be funding staff from the Mental Health Center of Greater Manchester to deliver Mental Health First Aid training at:

- LNA apprenticeship training being run by CMC – late August 2019
- Front-line and direct care staff at Hillsborough County Nursing Home (costs may be split with IDN 3)

### **Certified Recovery Support Worker:**

N4H once again offered scholarship dollars to applicants of the CRSW training program being run by the Mental Health Center of Greater Manchester. The training was run in June 2019

Total students: 20

Network4Health Scholarships (12 Scholarships @ \$170/per person)	\$ 2040.00
CRSW manuals (11 at \$44.00/per person)	<u>\$ 484.00</u>
Total N4H commitment	\$2524.00

### **Additional items related to training efforts:**

- IDN4 and IDN 5 worked together to explore how to develop a skill building program for peer workers. These workers may have been out of the workforce for some time and would benefit from a refresher on 'keep your job' skills. Our Workforce Development Director connected with NH WorkReady (at the CCSNH) and set up a demo of that project for IDNs 4 & 5. This grant funded program is open to any job seeker re-entering the workforce or looking for confidence building. This would be ideal for the peer workforce.
- Director facilitated conversations with Cherokee Health Systems and East Boston Neighborhood Health Center to bring CHS' addiction training to NH in October 2019. Also connected Amerihealth Caritas to CHS which resulted in a significant sponsorship investment which will lower the cost of attending by >50%.
- Network4Health coordinated with the Center for Life Management in Derry to respond to a request from Amoskeag Health for brief trainings on 'mental health awareness' for its frontline staff. CLM provided 5 trainings between April and June 2019 with the possibility of 2 more.

## ***Retention***

Much of the work we are doing in our region has an overlapping effect with retention efforts. These include, but are not limited to the following:

- Providing career advancement opportunities through the scholarship programs
- Improving management and leadership skills through the programs with Granite State College
- Providing professional development opportunities through funding trainings and CEUs
- Providing funds to offer retention bonuses through the PRRI and CRRI programs
- Providing scholarships for CRSW training and creating a career ladder for employees

## ***Recruitment***

**Prescriber Recruitment and Retention Initiative (PRRI):**

In early 2018 Network4Health introduced a Prescriber Recruitment and Retention Initiative. Through this initiative, Network4Health will reimburse 50% of allowable recruitment/retention costs up to \$10,000 to any of our partners who hire or retain a MAT prescriber (MD, DO or APRN). Interest in this program has waned in this reporting period despite new marketing efforts. No new applications have been received.

**Clinician Recruitment and Retention Initiative (CRRI):**

During this reporting period, Network4Health launched the CRRI. Similar in concept to the PRRI, this program reimburses for 50% of costs up to \$7500 related to hiring or retaining a behavioral health service provider, defined as:

- i. MLADCs: Masters Level Licensed Alcohol and Drug Counselor
- ii. HCPs: Psychologist (PhD or equivalent)
- iii. LICSWs: Licensed Clinical Social Workers (MSW or PhD)
- iv. PNSs: Psychiatric Nurse Specialists (RN or non-prescribing MSN level only)
- v. LPCs: Licensed Professional Counselors including Licensed Pastoral Counselors (MA or PhD)
- vi. LMHCs: Mental Health Counselors (MA or PhD)
- vii. MFTs: Marriage and Family Therapists (MA or PhD)
- viii. LADCs: Licensed Alcohol and Drug Counselor (Associate or Bachelor level)

As of this writing, no partner has taken advantage of this program yet.

**Staffing All Projects**

*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 include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects.*

Provider Type	Project(s)	MASTER IDN Workforce (FTEs)				
		Projected Total Need	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Master Licensed Alcohol and Drug Counselors	B1	1	1	1		
	C1	0	0	0		
	D3 PHP	1	1	1		
	E4	1	1	1		
Licensed Mental Health Professionals	B1	6	4	5		
	C1	1	1	1		
	D3 PHP	1	1	1		
	E4	0	0	0		
Peer Recovery Coaches	B1	3	2	3		
	C1	0	0	0		
	D3 PHP	1	1	1		
	E4	0	0	0		

Provider Type	Project(s)	MASTER IDN Workforce (FTEs)				
		Projected Total Need	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Other Front Line Providers	B1	26	20	26		
	C1	6	6	6		
	D3 PHP	3	3	3		
	E4	0	0	0		
Totals	B1	36	27	35		
	C1	7	7	7		
	D3 PHP	6	6	6		
	E4	1	1	1		

## Other Progress and Accomplishments

Network4Health continues to be active in other workforce development-related initiatives within their region and across the state:

- “Workforce Wednesday” was published 13 times during this period. We have grown our list to 292 recipients.



**WORKFORCE WEDNESDAYS**  
January 2<sup>nd</sup>, 2019

**NETWORK 4 HEALTH**

**HAPPY NEW YEAR 2019 FROM THE STAFF AT NETWORK4HEALTH!**

**HRSA Releases New Behavioral Health Labor Market Information for New Hampshire**

The 21st Century Cures Act mandated that HRSA conduct analyses on the adult and pediatric mental health and substance abuse disorder workforce. The nation's workforce of mental health and substance use disorder providers is critical to providing Americans with access to essential healthcare services. As the opioid crisis continues, HRSA is analyzing the size and distribution of this workforce, both today and in future years. This is because the need for a robust behavioral health workforce is clear.

- A 2017 report by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that nearly one in five adults in the United States—44.7 million people—suffered from a mental illness in the past year.
- In 2016, 28.6 million people aged 12 or older used an illicit drug in the past 30 days, corresponding to about 1 in 10 Americans overall and 1 in 4 among young adults aged 18 to 25. Illicit drug use is driven primarily by marijuana use and the misuse of prescription pain relievers.
- An estimated 11.8 million people misused opioids in the past year, including 11.5 million pain reliever misusers and 948,000 heroin users. About 116 people each day die from opioid-related drug overdoses in the United States.

Beyond the direct toll on individuals and families, mental illness and substance use disorders are well-established drivers of disability, mortality, and healthcare costs. (From: <https://www.hrsa.gov/healthworkforce/news/press-releases/behavioralhealth-workforce-projections>) In the last quarter of 2018, the Health Resources and Services Administration (HRSA) released some new data for the behavioral health workforce both nationally and at state level. They generated national-level health workforce estimates for the health workforce for the following behavioral health occupations between 2016 and 2030:

- Addiction counselors
- Marriage and family therapists
- Mental health and school counselors
- Psychiatric technicians and psychiatric aides
- Psychiatric nurse practitioners and psychiatric physician assistants
- Psychiatrists
- Psychologists
- Social workers

**Topics in This Issue:**

- WHEN SURVIVAL IS A FULL-TIME JOB PAGE 2
- FOUNDATIONS OF LEADERSHIP – NOW ACCEPTING APPLICATIONS PAGE 3
- MATCH TRAINING PAGE 4
- GRANT AND FUNDING OPPORTUNITIES PAGE 4
- SCHOLARSHIP AND FELLOWSHIP OPPORTUNITIES PAGE 5
- CNIC MEDICAL ASSISTANT APPRENTICESHIP PROGRAM PAGE 5
- ATTENTION RN'S: YOUR OWNOR MATTERS PAGE 5
- KNOW YOUR CAREER PATH: LDAC'S – BACHELOR LEVEL PAGE 6
- CIRCLE OF SECURITY PARENTING (COSPP) TRAINING OPPORTUNITY PAGE 7
- SPONSORED AND FREE TRAINING LIST PAGE 8
- MANAGEMENT CORNER: BRIDGING BOARD MEMBERS BETWEEN MEETINGS PAGE 9



**WORKFORCE WEDNESDAYS**  
March 13<sup>th</sup>, 2019

**NETWORK 4 HEALTH**

**DEPLOYING COMMUNITY PARAMEDICS TO ADDRESS MEDICATION COMPLEXITY AT HOME**

As many of you know, Network4Health has been investigating a number of “emerging careers” in healthcare and behavioral health and about 6 months ago, we worked with Myers & Stauffer to publish a paper on Community Paramedicine (CP) and its potential in New Hampshire. CP is continuing to grow around the country and below is another promising effort for their use in lowering hospitalizations and ER usage.

*Excerpt from “Deploying Community Paramedics to Address Medication Complexity at Home” by Caitlin Thomas-Henkel & Sandi Grogan, MSW | JANUARY 30, 2019*  
<https://www.healthaffairs.com/doi/10.1371/journal.pone.0205007.g001>

Complicated drug regimens are often a challenge for people with complex health and social needs, including individuals with physical and behavioral health comorbidities, seniors, and those dually eligible for Medicare and Medicaid. It is not uncommon for people with complex needs to take 20 or more medications daily, typically prescribed by multiple providers, and often with complicated dosing schedules and confusing instructions.

Outside of clinic walls, people are left to interpret and develop their own medication schedules with little to no ongoing support, which is where things get tricky, if not downright dangerous. The more complicated the medication regimen, the higher the probability of a patient not following it correctly, increasing the likelihood for largely preventable adverse drug events to occur. Additionally, each medication added to a drug regimen is linked to a 10 percent increase for adverse drug events, which can lead to increased hospitalizations, exacerbations of disease, and even premature death—not to mention the impact on patients’ quality of life and adverse drug event expenses.

The difficulties of managing complicated medication regimens are compounded among people with low incomes and multiple chronic conditions who face social challenges, such as low health literacy and lack of transportation and access to nutritious food. Managing medication complexity requires that patients have a firm grasp of the purpose of their medications and how to use them. It also requires that they are able to follow a daily and consistent schedule over time, which includes the ability to adapt to changes within the schedule as necessary. This is no small task for someone already burdened with multiple chronic conditions and challenging social issues. Addressing medication complexity

**Topics in This Issue:**

- DEPLOYING COMMUNITY PARAMEDICS TO ADDRESS MEDICATION COMPLEXITY PAGE 1
- NEW! ESSENTIALS OF PROJECT MANAGEMENT COURSE PAGE 4
- MIHCM 15<sup>th</sup> ANNUAL SYMPOSIUM PAGE 5
- SESSIONS NOW AVAILABLE FROM RH SUMMIT PAGE 5
- PROJECT ECHO PAGE 6
- GRANT OPPORTUNITIES PAGE 7
- GREAT UPCOMING TRAININGS PAGE 7
- KNOW YOUR CAREER PATH: LICSW PAGE 8
- SPONSORED AND FREE TRAINING LIST PAGE 9
- MANAGEMENT CORNER: STRUCTURED INTERVIEWS, PART 2 PAGE 13

# WORKFORCE WEDNESDAYS

April 10<sup>th</sup>, 2019



## HOW 'UPSKILLING' CAN MAXIMIZE HOME CARE WORKERS' CONTRIBUTIONS AND IMPROVE SERIOUS ILLNESS CARE

3/4/19 Angelie Drake, Contributor – [Health@ffirs.org](mailto:Health@ffirs.org)  
<https://www.healthaffairs.org/doi/10.1377/hlthaff.20180277.420585/fufl>



The work of caring for Americans who wish to continue living in their homes as they age and manage illnesses has become increasingly complex. Populations receiving long-term supports and services are growing at unprecedented rates, living longer, and presenting a greater prevalence of serious, chronic, and comorbid conditions.

Maximizing home care workers' effectiveness through upskilling typically entails enhanced training in a set of core competencies and workflow innovation that allows these workers to contribute observations from the home to other practitioners on a care team.

**Upskilling Models in Practice**  
 A number of long-term care providers have recognized the opportunities presented by home care workers to support the delivery of high-quality care in home and community settings at lower costs. Upskilling training and care team integration of more than 6,000 home care workers in California's in-home supportive services program contributed to a 43 percent decline in the rate of repeat emergency department (ED) visits and a 43 percent decline in the rate of re-hospitalization, yielding savings up to \$12,000 per patient. Even short-term intensive skill building, such as a program targeting symptom identification, condition management, and promotion of health behaviors and medication adherence among home health aides at Veterans' homes in New York, is associated with statistically significant improvements in self-care and quality of life among high-risk patients.

In 2015, I was part of a team that developed a new model to support upskilling among home health aides and improve care transitions for Medicaid-eligible, long-term care patients in New York City. We provided more than 200 hours of training in chronic disease knowledge, communication skills, and enhanced observe/record/report skills to home health aides who were elevated to the new role of Care Connections Senior Aides. These aides then made home visits to support the on-the-job upskilling of hundreds of entry-level home care workers to help improve patient transitions from the hospital and solve caregiving challenges. The senior aides also served as links to interdisciplinary teams, bringing information from the home to inform decisions about care.

Outcomes from this pilot included an 8 percent reduction in the rate of ED visits among 3,430 patients, reduced strain among patient family members, and improved job satisfaction among home care workers. Participants offered scores of anecdotes in which

TOPICS IN THIS ISSUE	
MAXIMIZING HOMECARE WORKERS THROUGH UPSKILLING	PAGE 1
ESSENTIALS OF PROJECT MANAGEMENT COURSE	PAGE 4
INHECM 15 <sup>TH</sup> ANNUAL SYMPOSIUM	PAGE 5
BH CAREER AND EDUCATION INFO	PAGE 5
NEW HRSA GRANT OPPORTUNITIES	PAGE 6
LUNCH & LEARN	PAGE 7
THE AMERICAN SOLDIER	PAGE 8
BEHAVIORAL HEALTH EDUCATION SCHOLARSHIPS	PAGE 8
SPONSORED AND FREE TRAININGS LIST	PAGE 9
MANAGEMENT CORNER: THE 6 BEST INTERVIEW QUESTIONS FOR EMPLOYERS	PAGE 14

# WORKFORCE WEDNESDAYS

May 22<sup>nd</sup>, 2019



## IS AMERICA MISSING 2.5 MILLION WOMEN WORKERS?

Is America Missing 2.5 Million Women Workers?  
 APRIL 17, 2019 • MALREEN CONWAY & MARK G. POPOVICH  
<https://www.speininstitute.org/files/posts/is-america-missing-2.5-million-women-workers/>

Today's headlines trumpet a red-hot labor market. There are myriad stories of employees unable to fill vacant posts and an epidemic of talk about purported skills shortages. A closer look at key labor statistics, however, shows a troubling pattern of lower engagement in the workforce. Declines in labor force participation rates have been a major contributor to today's ultra-low unemployment rates. Economists, journalists, politicians, and others have attended to this trend, but attention has mainly focused on men's declining labor force participation. It is time to give equal attention to the implications of declining labor force participation among women.



**Why is lower labor force participation (LFP) for women important?** First, the opportunity to be in the paid workforce is certainly as important to women as men. Both genders deserve equal opportunity in the labor market, and it should go without saying that women's talents and abilities are vital to our economy; a labor market unwelcoming to women leaves our economy deprived of talent and our society diminished. In addition, poverty and near-poverty in America is female – with 56% of women living in poverty, that's 40% higher than for men. In today's labor market, marked by the consequences of decades of stagnant wages, connecting women to work does not on its own provide an escape from poverty, but it does create access to means-tested social supports, such as the Supplemental Nutrition Assistance Program and the Earned Income Tax Credit, most of which are now contingent on working. Making progress toward pay equity and higher labor force participation rates for women are important steps to address poverty, make progress toward the ideal of equal opportunity, and build a flourishing and vibrant economy. While this blog attends to women overall, we also note that both LFP and median earnings are lower for women in all race and ethnic groups than the corresponding men. With the exception of Asian women, LFP is higher and median earnings are lower for latinas and other women of color compared to white women.

**Fact 1:**  
 Millions of women are "missing" from the labor force compared to pre-recession levels. We calculate that 2.5 million or more women are not in the labor force as of 2018, compared to the decade preceding the Great Recession. Before the mid-1990s, a much lower share of women than men were in the formal labor force. The gender gap in labor force participation narrowed markedly from 1965 to 1999, when the rate of women's labor force participation peaked. But the sharp change during the Great Recession and

TOPICS IN THIS ISSUE	
IS AMERICA MISSING 2.5M WOMEN WORKERS?	PAGE 1
ESSENTIALS OF PROJECT MANAGEMENT COURSE	PAGE 4
ONE BIG QUESTION	PAGE 4
GROWING YOUR BH CAREER AND EDUCATION	PAGE 5
FREE TRAINING FOR CHWs	PAGE 5
FREE TRAINING FROM NH HEALTHY FAMILIES	PAGE 6
THE AMERICAN SOLDIER	PAGE 7
BEHAVIORAL HEALTH EDUCATION SCHOLARSHIPS	PAGE 8
SPONSORED AND FREE TRAININGS LIST	PAGE 8
MANAGEMENT CORNER: SITUATIONAL INTERVIEW QUESTIONS	PAGE 12

- Director attended 2<sup>nd</sup> NH Race and Equity statewide meeting and was part of an Economic Committee Workgroup
- Director was invited to be part of a healthcare advisory meeting with Granite State College and Manchester Community College
- Director was invited to address a class of psychology students at New England College to discuss the DSRIP waiver, social determinants of health (SDOHs), and workforce development
- Director was invited to present to the CHI Leadership Group on the state of the healthcare and BH workforce in NH
- Network4Health has contributed considerable work to the NH AHEC Healthcare Careers Guide including writing and editing several sections containing a number of jobs – particularly those related to behavioral health
- Director was invited to be part of The New Hampshire Alliance for Healthy Aging's Strategic Group on Healthcare Workforce - Direct Care Workforce Stakeholder Roundtable
- Director was invited to be an advisor for the UNH Primary Care Behavioral Health Training Program within the UNH College of Health and Human Services
- Network4Health continues to be part of the NH Sector Partnership Initiative; the Legislative Commission on the Primary Care Workforce, and the UNH IOD Children's BH Workforce Roundtable

## 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.

The Workforce Development budget is presented below. Modifications have been made based on the following factors.

**Revenue:** Project budgets have been adjusted to reflect the actual receipt of funding. The anticipated, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced due to ongoing negotiations with NH counties or as a result of unmet DSRIP project performance metrics, Network4Health will revise budgets and project plan deliverables subject to Steering Committee and NH DHHS approval.

**Expenses:** Actual expenses (paid and invoices received) for the period of January to June 2019 are presented. Anticipated expenses (including those for the current reporting period) are projected in subsequent reporting periods. Given that final incentive funding is not expected until mid-2021, we have projected expenses in that period as we conclude the waiver projects.

	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4) Jan to June	PROJECTED CY 2019(Yr4) July to December	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
<b>TRANSFORMATON FUNDS</b>						
A1: BH Workforce (New)	\$ 862,544	\$ 655,534	\$ 1,177,360	\$ 1,272,267	\$ 875,323	\$ 357,796
A1: BH Workforce (Rollover)		\$ 825,328	\$ 1,190,272	\$ 2,048,621	\$ 1,018,421	\$ 2,716
<b>Total Revenue</b>	<b>\$ 862,544</b>	<b>\$ 1,480,862</b>	<b>\$ 2,367,632</b>	<b>\$ 3,320,888</b>	<b>\$ 1,893,744</b>	<b>\$ 360,512</b>
<b>Recruitment</b>		\$ 5,000	\$ 7,500	\$ 942,500	\$ 610,000	\$ 120,000
<b>Training/Development</b>	\$ 20,527	\$ 128,474	\$ 196,811	\$ 1,241,541	\$ 1,050,000	\$ 125,000
<b>Salaries and benefits- Workforce Director (1.0 fte) and Workforce Coordinator (1.0 fte)</b>	\$ 14,768	\$ 148,165	\$ 111,495	\$ 110,448	\$ 219,845	\$ 109,922
<b>Occupancy</b>		\$ 6,325	\$ 2,875	\$ 4,025	\$ 6,900	\$ 3,450
<b>Technology (Computer, phone, software)</b>	\$ 1,921	\$ 2,626	\$ 330	\$ 3,953	\$ 4,283	\$ 2,140
<b>Total Expenses</b>	<b>\$ 37,216</b>	<b>\$ 290,590</b>	<b>\$ 319,011</b>	<b>\$ 2,302,467</b>	<b>\$ 1,891,028</b>	<b>\$ 360,512</b>
<b>Variation to Budget (Transfer Funds to Subsequent Year)</b>	\$ 825,328	\$ 1,190,272	\$ 2,048,621	\$ 1,018,421	\$ 2,716	\$ -

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

### **Narrative**

*Provide a detailed narrative which lists every participating provider at the practice level and the progress made during the reporting period.*

Network4Health continues to support all partners to advance technology within our community focusing on:

- Electronic Health Record (EHR) adoption
- Electronic communication of protected information
- Sharing of data between organizations/Shared Care Planning
- Integrated referral systems
- Event notification tools

### **Electronic Health Record Adoption:**

Network4Health's support of EHR enhancement within our community of partners has been the foundation of our IT success. N4H has supported the development of EHRs to support requirements to compliment an integrated care model. Whether the development, build and implementation of a new system for Families in Transitions/New Horizons or enhancements with CMC to support integrated workflow, funding and resources provided through the waiver has brought us to a new level.

At the onset of the waiver 18 of our 42 partners were actively using electronic health records and through our support the number has increased to 24. This, along with the addition of multiple partners sharing EHR access for common patients has changed our information landscape.

In the 3<sup>rd</sup> quarter of 2019, Network4Health released an RFP for an affiliate model; cloud based electronic medical record that could be used by five community organizations (Pastoral Counseling Services, Upper Room, Community Crossroads, Moore Center, Public Health school advocacy program) in our network. These organizations would see substantial benefit from this implementation with both clinical and revenue cycle improvements.

### **Electronic communication of protected information:**

All HIPAA regulated organizations that have partnered with N4H are now using secure direct messaging technologies in daily practice. We continue to work to eliminate manual processes relating to patient information from referrals, transitions of care and/or billing and incorporate them into electronic workflows. N4H has supported training to increase staff awareness and use of these technologies. In our current environment secure direct messaging is being used consistently for claims submission and reconciliation, referrals, transitions of care, shared care planning, and provider communication.

Our next phase will allow us to provide this functionality for patient communication through the use of “MY LINKS”. This patient facing tool will allow patients to use secure direct messaging to communicate with providers safely. Initial testing of this product is currently underway at our two largest hospital organizations.

### **Sharing of data between organizations/Shared Care Planning:**

Network4Health continues to encourage innovation, and creativity amongst our partners to support data sharing and subsequently shared care planning. While multiple partners are using our traditional Collective Medical (CM) platform for shared care planning, others have been challenged by regulatory restrictions and have required alternate solutions.

This challenge brought partners to the table with excellent results. In organizations where data sharing restrictions made CM an incomplete solution, systems were developed to incorporate event alerts and direct messaging to provide immediate access to clinical data during clinical events including emergency interventions. This effort and along with the sharing of EHR access amongst more than 60 percent of our partners has allowed shared care planning to flourish.

### **Integrated closed loop referral systems:**

Referrals represent a unique inflection point where the next step in care is driven not only by clinical goals, but also by plan design and the resources available within the provider’s own community. To support our partners and patients, Network4Health continues to champion for a state-wide closed loop referral system. In our analysis we determined that a centralized system could be more cost effective and provide better patient support. Currently Network4Health is leading discussions with multiple stakeholders and other IDNs to determine a collaborative solution to closed loop referral. Until these discussions are complete, Network4Health has worked with all partners to develop an interim workflow to insure closed loop referral functionality through the use of secure direct messaging

### **Collective Medical - Event Notification and Shared Care Planning**

As of June 30, 2019, 90 percent of our HIPAA regulated organizations are live with Collective Medical event notification. From a functional level the system is sending our partners more than twelve hundred notifications daily.

The implementation of this software has had a significant impact on care in our community:

- The development of ED utilization task forces that provide multidisciplinary case management reviews to support decrease in ED usage through proactive care planning.
- The inclusion of case management within the “real time care” environment. Providing EDs with contact information to access medical records, patient history, and care guidelines has made significant impact on our level of care. ED providers are reporting “seamless interactions that provide patient data in a way we never had it before”.
- Event notification has prompted the inclusion of outreach workers from behavioral health organizations to provide real time intervention in EDs across our region. These interventions have decreased behavioral health ED holds and IEA (involuntary emergency admissions).
- The use of Collective Medical has brought realization to the ED community that overutilization is not limited to their four walls, and collaboration with primary care providers and other emergency departments is imperative to improvement in patient care and cost reduction.

We continue to work on ways to improve processes and have submitted multiple enhancement requests to Collective Medical to provide more comprehensive workflows and interoperability.

The following represents an outline of Technology improvements for B1 participants seen during the reporting period:

	List of providers	6/30/2019 Reporting Period Technology Progress Summary
1	<b>Catholic Medical Center</b> (CMC)- Amoskeag Family Practice	<ul style="list-style-type: none"> <li>• CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</li> <li>• CMC has integrated Patient Link as a data collection tool across all practices. This provides consistent data collection that is efficient for patient and provider.</li> <li>• CMC continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• CMC has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> <li>• CMC at the request of the IDN has provided “view Only” access to multiple partner organizations who share patients with the organization</li> </ul>
2	<b>Catholic Medical Center</b> – Behavioral Health Practice	<ul style="list-style-type: none"> <li>• CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</li> <li>• CMC has integrated Patient Link as a data collection tool across all practices. This provides consistent data collection that is efficient for patient and provider.</li> <li>• CMC continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• With support of the waiver CMC has redesigned behavioral health documentation based on evidence-based models and will implement with new EHR scheduled for September go-live</li> <li>• CMC has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> <li>• CMC at the request of the IDN has provided “view Only” access to multiple partner organizations who share patients with the organization</li> </ul>
3	<b>Catholic Medical Center</b> – Bedford Center Internal Medicine and Pediatrics (formerly Family Health & Wellness Center at Bedford)	<ul style="list-style-type: none"> <li>• CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</li> <li>• CMC has integrated Patient Link as a data collection tool across all practices. This provides consistent data collection that is efficient for patient and provider.</li> <li>• CMC continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• CMC has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> <li>• CMC at the request of the IDN has provided “view Only” access to multiple partner organizations who share patients with the organization</li> </ul>

4	<b>Catholic Medical Center - Willowbend Family Practice</b>	<ul style="list-style-type: none"> <li>• CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</li> <li>• CMC has integrated Patient Link as a data collection tool across all practices. This provides consistent data collection that is efficient for patient and provider.</li> <li>• CMC continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• CMC has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> <li>• CMC at the request of the IDN has provided “view Only” access to multiple partner organizations who share patients with the organization</li> </ul>
5	<b>Catholic Medical Center – Healthcare for the Homeless (HCH)</b>	<ul style="list-style-type: none"> <li>• HCH completed report requirements for Provider Level Depression Management reporting in conjunction with Amoskeag Health to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>• Practice team met with EHR technical support team and team from Amoskeag Health (formerly Manchester Community Health Center) to discuss incorporation of a Risk Stratification tool into the EHR. Current risk stratification model requires multiple report runs and the use of an Access Database.</li> <li>• Enhanced integration through use of the Collective Medical event notification portal has significantly increased the HCH outreach team’s ability to identify patients with emergency department visits or hospital inpatient admissions.</li> <li>• A workflow was implemented for HCH staff to check the the Collective Medical portal each morning for real time data, which allows them to schedule same-day visits with patients. This has been particularly beneficial for patients who present at Elliot Hospital. Since implementation, HCH’s Outreach Team has increased visits to Elliot to better coordinate care.</li> <li>• HCH continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• HCH has begun to incorporate the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> </ul>
6	<b>Center for Life Management – Behavioral Health</b>	<ul style="list-style-type: none"> <li>• CLM IT team completed extensive work to develop a seamless integration with Patientlink to automate the CCSA into their EMR for identification of high-risk patients, transitioning from a manual process. Patientlink has developed the Adult, Preadult and Children templates that will be used for acquiring data directly from the patients. The team has targeted 12/2019 for completion and rollout to staff.</li> <li>• CLM in conjunction with MHCGM IT has proposed for consideration by the IDN and Collective Medical having a button present in Collective Medical portal and in the shared care planning section of the CLM EMR that will trigger an event notification. That event notification would be a coordinated care request to be sent by an interested care provider seeking to coordinate care with any entities currently providing mental health and/or substance use disorder services to the patient. On receipt</li> </ul>

		<p>of the request the mental health/ substance use disorder care provider would be able to reach out to the patient and have a conversation about: 1) developing a shared care plan and coordinating services with that requesting provider; 2) acquire and manage an appropriate release, and 3) have a clear and existing methodology for the patient to promptly change access rights associated with individual providers involved in their care</p> <ul style="list-style-type: none"> <li>• CLM consistently participates in N4H Risk Stratification Workgroup to define cross-organizational strategies for identifying moderate to high risk patients.</li> <li>• CLM completed a NIST certification</li> <li>• CLM continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• CLM has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> <li>• CLM has received access to medical records from the Elliot and Parkland Hospital systems to support the needs of shared patients</li> </ul>
7	<p><b>Dartmouth-Hitchcock (DH) - Adult Primary Care</b></p>	<ul style="list-style-type: none"> <li>• Manual CCSA's for Medicaid patients were transitioned to an electronic system using myDH patient portal or in-office iPad for automated transition of documentation and identification of patient risks</li> <li>• The system-wide DH ACO Department is utilizing Collective Medical event notification on behalf of the entire system</li> <li>• The DH Manchester BH and care coordination team was trained in the use of Collective Medical event notification portal, but does not yet have access</li> <li>• The Mental Health Center of Greater Manchester was provided DH Connect access for 5 of their staff. They have been able to look at medication lists as well as appointment times which, in turn has improved continuity of care.</li> <li>• DH continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• DH has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> </ul>
8	<p><b>Dartmouth-Hitchcock - Pediatric Primary Care</b></p>	<ul style="list-style-type: none"> <li>• Manual CCSA's for Medicaid patients were transitioned to an electronic system using myDH patient portal or in-office iPad for automated transition of documentation and identification of patient risks</li> <li>• The system-wide DH ACO Department is utilizing Collective Medical event notification on behalf of the entire system</li> <li>• The DH Manchester BH and care coordination team was trained in the use of Collective Medical event notification portal, but does not yet have access</li> <li>• The Mental Health Center of Greater Manchester was provided DH Connect access for 5 of their staff. They have been able to look at medication lists as well as appointment times which, in turn has improved continuity of care.</li> <li>• DH continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• DH has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> </ul>

9	<b>Easterseals NH – Farnum Center</b>	<ul style="list-style-type: none"> <li>Completed EHR modifications required to allow documentation sharing between Farnum staff and Easterseals NH care coordinators</li> <li>Farnum/Easterseals NH team participated in a review and demonstration of the Collective Medical event notification tool and portal for implementation later in 2019</li> <li>Farnum continues to collect CCSA data and is reporting on all required measures to the state</li> <li>Farnum has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> </ul>
10	<b>Elliot Health System - Doctors Park Pediatrics</b>	<ul style="list-style-type: none"> <li>The Elliot IT team completed implementation of Collective Medical event notification for all Elliot primary care offices, and available in the Collective Medical portal. Training and workflow development are in ongoing to incorporate use of the Collective Medical event notification portal into the primary care setting in the second half of 2019.</li> <li>The practice transitioned to utilizing the CRAFTT substance use screening and the PHQ-9, rather than the PHQ-2 and then the PHQ-9, for depression screenings. They also implemented an integrated care tracking report, currently being piloted in Excel, to support the tracking and outcomes of the screenings.</li> <li>All patient referrals are entered in the Epic EHR and, furthermore, the Elliot health system maintains an algorithm for referrals of high-risk patients to the Mental Health Center of Greater Manchester.</li> <li>Elliot continues to collect CCSA data and is reporting on all required measures to the state</li> <li>Elliot has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> </ul>
11	<b>Elliot Health System – Partial Hospitalization Program (PHP)</b>	<ul style="list-style-type: none"> <li>The PHP program completed implementation of Collective Medical event notification. They defined and implemented a workflow to manage the incoming notification for the participant panel.</li> <li>In the past 6 months, the PHP program has been incredibly busy developing the BH module in EPIC. All Elliot SUD programs in conjunction with the IDN have collaborated to develop the forms, design the workflows and are currently involved in testing. Completion of the BH module is tentatively scheduled for November 2019.</li> <li>As part of collaborative efforts with Southern NH Medical Center in Nashua, the Elliot PHP program has been reviewing and revising all forms. This includes the selection of evidenced-based screening tools, development of treatment plans, discharge workflows, etc.</li> <li>PHP continues to collect CCSA data and is reporting on all required measures to the state</li> <li>PHP has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows</li> </ul>
12	<b>Families in Transition- New Horizons - Family Willows Treatment Center</b>	<ul style="list-style-type: none"> <li>IEP project team is maturing and continues to meet regularly with the Network4Health B1 team as well as with the Network4Health HIT team, who is closely supporting their organization-wide EMR implementation</li> <li>With the support of the IDN FIT has developed a fully integrated EHR supporting all of their programs. This EHR supports DSM, Referral tracking, Census management, Capacity planning and will change the landscape of this growing organization.</li> <li>FIT continues to collect CCSA data and is reporting on all required measures to the state</li> <li>FIT has incorporated the use of Secure direct Messaging revenue cycle</li> </ul>

		workflows
13	<b>Fusion Health Services</b>	<ul style="list-style-type: none"> <li>• Further work was completed with an IT consultant to create a dashboard identifying patient needs based on completion of the CCSA. Integration of data flow between Patientlink,</li> <li>• Fusion is incorporating the use of Collective Medical into daily workflows</li> <li>• FIT continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• FIT has incorporated the use of Secure direct Messaging into revenue cycle workflows</li> </ul>
14	<b>Amoskeag Health, formerly known as Manchester Community Health Center - Hollis Street</b>	<ul style="list-style-type: none"> <li>• Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</li> <li>• Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>• Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports.</li> <li>• Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions in a common EHR.</li> <li>• Additional training on the use of Collective Medical and working with providers is being provided on June 27, 2019 to CHW's and Case Manager's. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</li> <li>• Amoskeag continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• Amoskeag has incorporated the use of Secure direct Messaging into revenue cycle workflows</li> <li>• The IDN is working with Amoskeag to support new patient facing data collection tools to support improved patient satisfaction</li> </ul>
15	<b>Amoskeag Health, formerly known as Manchester Community Health Center - Tarrytown</b>	<ul style="list-style-type: none"> <li>• Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</li> <li>• Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>• Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports.</li> <li>• Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions in a common EHR.</li> <li>• Additional training on the use of Collective Medical and working with</li> </ul>

		<p>providers is being provided on June 27, 2019 to CHW's and Case Manager's. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</p> <ul style="list-style-type: none"> <li>• Amoskeag continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• Amoskeag has incorporated the use of Secure direct Messaging into revenue cycle workflows</li> <li>• The IDN is working with Amoskeag to support new patient facing data collection tools to support improved patient satisfaction</li> </ul>
16	<p><b>Amoskeag Health, formerly known as Manchester Community Health Center -Westside Neighborhood Health Center</b></p>	<ul style="list-style-type: none"> <li>• Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</li> <li>• Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>• Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports.</li> <li>• Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions in a common EHR.</li> <li>• Additional training on the use of Collective Medical and working with providers is being provided on June 27, 2019 to CHW's and Case Manager's. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</li> <li>• Amoskeag continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• Amoskeag has incorporated the use of Secure direct Messaging into revenue cycle workflows</li> <li>• The IDN is working with Amoskeag to support new patient facing data collection tools to support improved patient satisfaction</li> </ul>
17	<p><b>Amoskeag Health, formerly known as Manchester Community Health Center - Child Health Services</b></p>	<ul style="list-style-type: none"> <li>• Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</li> <li>• Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>• Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports.</li> <li>• Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions in a common EHR.</li> <li>• Additional training on the use of Collective Medical and working with</li> </ul>

		<p>providers is being provided on June 27, 2019 to CHW's and Case Manager's. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</p> <ul style="list-style-type: none"> <li>• Amoskeag continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• Amoskeag has incorporated the use of Secure direct Messaging into revenue cycle workflows</li> <li>• The IDN is working with Amoskeag to support new patient facing data collection tools to support improved patient satisfaction.</li> </ul>
18	<p><b>Mental Health Center of Greater Manchester (MHCGM) – Behavioral Health</b></p>	<ul style="list-style-type: none"> <li>• MHCGM continued work to create a risk console that will show the social determinants of health from the CCSA</li> <li>• MHCGM began utilizing DHConnect to access records of mutual MHCGM/Dartmouth-Hitchcock patients</li> <li>• MHCGM has participated in several demos of “Open Beds” and “Unite Us” closed loop referral systems. The team had some discussions about how MHCGM would manage these systems internally. This would necessitate designating staff to manage the referrals and update the system.</li> <li>• MHCGM currently has designated staff members who monitor Collective Medical (CM) event notification alerts daily through the CM portal and a shared email address/inbox. Those staff members are responsible for scanning the alerts into the EMR and notifying the attending practitioners. Additionally, the Intensive Transition Team (ITT) and Crisis Assessment and Treatment Team (CATT) supervisors monitor the alerts for high utilizers, assigning transition case managers to specific cases, as needed.</li> <li>• MHCGM currently working with Netsmart and Collective Medical to integrate the CM event notifications automatically into our EMR, bypassing the need for emails, scanning, etc.</li> <li>• MHCGM continues to collect CCSA data and is reporting on all required measures to the state</li> <li>• MHCGM has incorporated the use of Secure direct Messaging into revenue cycle workflows</li> </ul>

## 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	# of B1 Participating Practices	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	18	9	17	
Shared Care Plan	18	0	18	
Closed Loop Referral workflow	18	10	18	
Closed Loop Referral system	18	0	2	
Data Reporting	18	13	18	
Data Sharing	18	4	15	
Care Coordination	2	0	2	
Direct Secure Messaging	18	18	18	
Performance Measure Name	# of non B1 Participating Practices			
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	32	5	24	
Shared Care Plan	16	0	4	
Closed Loop Referral system	24	0	0	
Data Sharing	16	1	3	
Direct Secure Messaging	32	6	25	

## 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.*

The HIT to Support Integration is presented below. Modifications have been made based on the following factors.

Revenue: Project budgets have been adjusted to reflect the actual receipt of funding. The anticipated, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced due to ongoing negotiations with NH counties or as a result of unmet DSRIP project performance metrics, Network4Health will revise budgets and project plan deliverables subject to Steering Committee and NH DHHS approval.

Expenses: Actual expenses (paid and invoices received) for the period of January to June 2019 are presented. Anticipated expenses (including those for the current reporting period) are projected in subsequent reporting periods. Given that final incentive funding is not expected until mid-2021, we have projected expenses in that period as we conclude the waiver projects.

	CY 2017 (Yr2)	CY 2018 (Yr 3)	CY 2019 (Yr4) Jan to	CY 2019 (Yr4)	CY 2020	CY 2021 (Yr6)
Transformation Funds	Actuals	Actual	June Actual	July to December Projected	(Yr5) Projected	Projected
A2 HIT Revenue (New)	\$862,544	\$655,534	\$1,177,360	\$1,272,267	\$875,323	\$357,796
A2 HIT Revenue (Rollover)		\$ 826,276	\$ 768,395	\$ 1,429,644	\$ 774,885	\$ 929
Total Revenue	\$ 862,544	\$ 1,481,810	\$ 1,945,755	\$ 2,701,911	\$ 1,650,208	\$ 358,725
<b>Event Notification System and Shared Care Plan</b>						
Premanage ED - annual Subscription for CMC, Elliot, Parkland		\$ 36,598	\$ 32,453	\$ 50,728	\$ 85,677	\$ 43,000
Premanage Primary/Community (\$0.12 per Medicaid member per month) - Software License		\$ 85,605	\$ 34,242	\$ 55,758	\$ 90,000	\$ 45,000
Premanage PMDP (\$50 / provider/yr, ~200 providers) - Software License		\$ -	\$ -	\$ 10,609	\$ 10,927	\$ 10,000
<b>B1 Integration Enhancement Plan Support Funds</b>						
Integrated Care IEP Implementation Support (care planning tool licensing, other HIT tool licensing, implementation fees, HIT Training, HIT consulting, existing tool development or customization costs, etc.		\$ 62,616	\$ 169,830	\$ 1,205,170	\$ 975,000	
<b>Secure Messaging</b>						
Direct secure messaging (\$750*30) - Software License			\$ -	\$ 25,000	\$ 25,000	\$ 25,000
<b>Data Aggregator</b>						
Data aggregator implementation		\$ 157,415	\$ 36,000			
Data aggregator Annual Service Fees		\$ 62,675	\$ 62,675	\$ 31,338	\$ 62,675	\$ 62,675
Data Aggregator Customizations, Consulting, Custom Reporting		\$ -	\$ -	\$ 100,000	\$ -	
Secure Data Storage						
<b>Referrals</b>						
Closed Loop Referral System			\$ -	\$ 100,000	\$ 75,000	
<b>CCSA Implementation</b>						
Patient Link Implementation and Licensing Costs		\$ 109,310	\$ -	\$ 100,000	\$ 75,000	\$ 50,000
EMR Integration (Technical Assistance Fund)			\$ -	\$ 45,000	\$ 25,000	
<b>Other</b>						
Contingency Fund	\$ 2,170	\$ 11,877	\$ -	\$ 50,000	\$ 25,000	
Internet Connectivity		\$ 148	\$ 3,577	\$ 8,423	\$ -	
HIT Salary	\$ 34,098	\$ 187,171	\$ 177,334	\$ 145,000	\$ 200,000	\$ 120,000
<b>Total Expenses</b>	\$ 36,268	\$ 713,415	\$ 516,111	\$ 1,927,026	\$ 1,649,279	\$ 355,675
<b>Variation to Budget (Transfer Funds to Subsequent Year)</b>	\$ 826,276	\$ 768,395	\$ 1,429,644	\$ 774,885	\$ 929	\$ 3,050

# Project B1: Integrated Healthcare

## Narrative

Include a detailed narrative which lists every participating provider at the practice level and the progress made during the reporting period toward the Integrated Care Practice Designation

*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*

## Network4Health B1 Project Progress Update

During this reporting period, Network4Health’s B1 Integrated Healthcare project participants continued to make progress towards integrated care. The Network4Health team is pleased to share results from the April 2019 Site Self-Assessment (SSA) survey tool that is being used by each B1 partner across all Integrated Delivery Networks (IDN) statewide in Attachment\_B1.1 (SSA results shared with Network4Health partners in July 2019). The SSA, somewhat subjective by design, helps N4H B1 project participants to collectively review where they are on the integration continuum, and gain a better understanding of the components of integration, fostering internal discussion, and informing strategic planning. We are pleased to see the significant improvement in practice integration scores, with three organizations ranking themselves as highly integrated practices that would align with Level V on the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) [Six Levels of Collaboration/Integration](#). Please note when reviewing our report that some practice id’s represent all practices within an organization that are participating in the Network4Health B1 project, for example Amoskeag Health (formerly Manchester Community Health Center) has 4 practice sites, but has one SSA number. In addition, practice id’s 4-104, 4-106 and 4-116 completed an initial baseline survey, but dropped out of the Network4Health B1 project as reported in past reports.

Overall, the Network4Health B1 participants have made extraordinary progress to strengthen collaboration and integration in their practices within a short quality improvement window. The most recent SSA helped us identify the following areas of opportunity for collaborative learning and development between B1 partners for the remainder of the waiver time period:

- Standardization and Sharing of Patient Centered Treatment/Care Plans
- Patient Communication Practices regarding Integrated Care
- Patient and Family Input/Communication with the Treatment/Care Plan

### *B1 Partner Integrated Care Progress*

The table below summarizes the progress of all Network4Health B1 practices during the January to June 2019 reporting period.

Progress Toward Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	6/30/2019 Reporting Period Practice Progress Summary
1	Catholic Medical Center (CMC)- Amoskeag Family Practice	<p><b>Medication-assisted treatment (MAT):</b> CMC completed development of MAT workflows/policies for use in their primary care practices.</p> <p><b>Enhanced use of technology:</b> CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary</p>

		<p>team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</p> <p><b>Joint Workflows:</b>          -Continued workflow refinement and collaboration between CMC primary care and the Mental Health Center of Greater Manchester for closed loop referral and data sharing (with patient consent).          -CMC Primary Care leadership has increased collaboration with hospital based social work team and one cross-practice ambulatory care social worker to clarify roles, workflows and increase cross-team communication with acute team.</p>
2	Catholic Medical Center – Behavioral Health Practice	<p><b>Enhanced use of technology:</b> CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</p>
3	Catholic Medical Center – Bedford Center Internal Medicine and Pediatrics (formerly Family Health & Wellness Center at Bedford)	<p><b>Medication-assisted treatment (MAT):</b>          CMC completed development of MAT workflows/policies for use in their primary care practices. An MAT pilot was started at 3 practices, including one provider at Bedford Center Internal Medicine and Pediatrics: Jill MacGregor APRN.</p> <p><b>Enhanced use of technology:</b> CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</p> <p><b>Joint Workflows:</b>          -Continued workflow refinement and collaboration between CMC primary care and the Mental Health Center of Greater Manchester for closed loop referral and data sharing (with patient consent).          -CMC Primary Care leadership has increased collaboration with hospital based social work team and one cross-practice ambulatory care social worker to clarify roles, workflows and increase cross-team communication with acute team.</p>
4	Catholic Medical Center - Willowbend Family Practice	<p><b>Medication-assisted treatment (MAT):</b> CMC completed development of MAT workflows/policies for use in their primary care practices. An MAT pilot was started at 3 practices, including 2 providers at Willowbend Family Practice: Julie Morrison, MD and Marcy Boucher, MD.</p> <p><b>Enhanced use of technology:</b> CMC is utilizing Collective Medical’s EDIE event notification portal to identify high ED utilizers. A centralized cross-disciplinary team including ED providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice.</p> <p><b>Joint Workflows:</b>          -Continued workflow refinement and collaboration between CMC primary care and the Mental Health Center of Greater Manchester for closed loop referral and data sharing (with patient consent).          -CMC Primary Care leadership has increased collaboration with hospital based social work team and one cross-practice ambulatory care social worker to clarify roles, workflows and increase cross-team communication with acute team.</p>

5	<p><b>Catholic Medical Center</b> – Healthcare for the Homeless (HCH)</p>	<p><b>First in NH Diabetes Recognition for BH Team Member</b> HCH’s Licensed Clinical Mental Health Counselor completed certification process and was the first in NH to be listed on ADA’s website for Diabetes Recognition for Behavioral Health Providers</p> <p><b>Medication-assisted treatment (MAT):</b> -New buprenorphine X-Waivered APRN started 06/03/2019 -Ongoing continuous improvement and refining of workflows for MAT clinic services -Completed participation and case study presentation in Project ECHO Medications for Addiction Treatment: Building Competency and Capacity for Primary Care Teams in Northern New England (08/18 through 04/19; presented Case Study on 03/21/2019). -Two Behavioral Health team members started supervision toward obtaining their MLADC licenses under the Behavioral Health Coordinator</p> <p><b>Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model) :</b> Ongoing continuous improvement and refining of workflows for 2018 implementation of Institute for Clinical Systems Improvement (ICSI) evidence based model for mild to moderate depression for primary care.</p> <p><b>Enhanced use of technology:</b> -HCH completed report requirements for Provider Level Depression Management reporting in conjunction with Amoskeag Health to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer. -Practice team met with EHR technical support team and team from Amoskeag Health (formerly Manchester Community Health Center) to discuss incorporation of a Risk Stratification tool into the EHR. Current risk stratification model requires multiple report runs and the use of an Access Database. - Enhanced integration through use of the Collective Medical event notification portal has significantly increased the HCH outreach team’s ability to identify patients with emergency department visits or hospital inpatient admissions. A workflow was implemented for HCH staff to check the the Collective Medical portal each morning for real time data, which allows them to schedule same-day visits with patients. This has been particularly beneficial for patients who present at Elliot Hospital. Since implementation, HCH’s Outreach Team has increased visits to Elliot to better coordinate care.</p> <p><b>Joint Workflows:</b> Workflow session held between HCH and Families in Transition to ensure awareness of programs, key contacts and existing workflows between the two organizations. This collaborative work is ongoing.</p>
6	<p><b>Center for Life Management</b> – Behavioral Health</p>	<p><b>Enhanced use of technology:</b> -CLM IT team completed extensive work to develop a seamless integration with Patientlink to automate the CCSA into their EMR for identification of high risk patients, transitioning from a manual process. Patientlink has developed the Adult, Preadult and Children templates that will be used for acquiring data directly from the patients. The team has targeted 12/2019 for completion and rollout to staff. -CLM IT has proposed for consideration by the IDN and Collective Medical having a button present in Collective Medical portal and in the shared care planning section of the CLM EMR that will trigger an event notification. That event notification would be a coordinated care request to be sent by an interested care provider seeking to coordinate care with any entities currently</p>

		<p>providing mental health and/or substance use disorder services to the patient. On receipt of the request the mental health/ substance use disorder care provider would be able to reach out to the patient and have a conversation about: 1) developing a shared care plan and coordinating services with that requesting provider; 2) acquire and manage an appropriate release, and 3) have a clear and existing methodology for the patient to promptly change access rights associated with individual providers involved in their care. N4H HIT Director is coordinating conversations amongst the different groups regarding the feasibility and scalability of the proposed approach.</p> <p>-CLM consistently participates in N4H Risk Stratification Workgroup to define cross-organizational strategies for identifying moderate to high risk patients.</p> <p><b>Joint Workflows:</b></p> <p>-CLM continues to expand collaboration and case conferences for shared patients with primary care providers at Derry Medical and Southern NH Internal Medicine</p> <p>-CLM began an internal Care Management Workgroup that meets weekly to strengthen organizational structure and workflows. The workgroup includes team members from children and adult case management, nursing, and quality improvement</p>
7	<p><b>Dartmouth-Hitchcock (DH) - Adult Primary Care</b></p>	<p><b>Medication-assisted treatment (MAT)</b></p> <p>-DH continues to work developing a MAT program, which includes working with Fusion Health for intake and induction. DH is also increasing the number of buprenorphine waived providers. DH is evaluating when DH will begin MAT inductions. The team is currently working on proactive calling patients to begin the MAT intake process.</p> <p>-Providers, Behavioral Health Consultant, Management, Quality and Family Support Specialist (social work) participate in monthly MAT meetings to refine MAT processes and workflows</p> <p><b>Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)</b></p> <p>DH Behavioral Health Consultants are working within the IMPACT model for treatment of mild-to-moderate depression</p> <p><b>Enhanced use of technology</b></p> <p>-Manual CCSA's for Medicaid patients were transitioned to an electronic system using myDH patient portal or in-office iPad for automated transition of documentation and identification of patient risks</p> <p>-The system-wide DH ACO Department is utilizing Collective Medical event notification on behalf of the entire system</p> <p>-The DH Manchester BH and care coordination team was trained in the use of Collective Medical event notification portal, but does not yet have access</p> <p>-The Mental Health Center of Greater Manchester was provided DH Connect access for 5 of their staff. They have been able to look at medication lists as well as appointment times which, in turn has improved continuity of care.</p> <p><b>Joint Workflows</b></p> <p><i>Adult Primary Care:</i></p> <p>-Developed shared workflows for adult population who present to Primary Care office with severe symptoms of depression and anxiety as well as diagnosis of bipolar disorder, OCD and schizophrenia with the Mental Health Center of Greater Manchester. Specific workflows for referrals to MHCGM's ITT Team, Open Access Intake times and PHQ9 protocol.</p> <p>-DH Manchester implemented use of signed Releases of Information (ROI) for outside agency communication. DH has patients sign a ROI for the Mental</p>

		<p>Health Center of Greater Manchester (MHCGM) when referring patient to MHCGM services. This has allowed for improved communication and patient care.</p> <p>-D-H met with the YMCA to discuss referral process for multiple support services and health education programs they offer. Conferred with D-H nursing staff, Diabetes Educator, Pharmacist and Nutritionist on the process to refer to YMCA programs.</p>
8	<b>Dartmouth-Hitchcock</b> - Pediatric Primary Care	<p><b>Joint Workflows</b> <i>Pediatric Department:</i></p> <ul style="list-style-type: none"> <li>-Developed a joint workflow with the Mental Health Center of Greater Manchester to help patients connect to services in a timelier manner.</li> <li>-Working with Riverbend Community Mental Health Center and Center for Life Management to also develop joint workflows to address high risk behavioral health patients connecting to treatment at the mental health centers.</li> <li>-Pediatrics has met with New Hampshire Hospital and Hampstead Hospital identifying a point person at each hospital for the BH pediatric team to call with any hospital admissions or discharges.</li> <li>-Pediatrics is partnering with Waypoint to develop coordinated care in order to refer patients to their services in a timelier manner.</li> <li>-DH collaborates with other referral agencies include Fast Forward and Strafford Action Partnership of Strafford County.</li> </ul>
9	<b>Easterseals NH – Farnum Center</b>	<p><b>Medication-assisted treatment (MAT)</b></p> <ul style="list-style-type: none"> <li>-Farnum offers medically supervised outpatient services for people with opiate use disorder. Clinic participants are required to meet regularly with a medical doctor or nurse practitioner who specializes in addiction medicine and specifically trained in the use of Suboxone and other MATs such as Naltrexone and Vivitrol.</li> </ul> <p><b>Enhanced use of technology</b></p> <ul style="list-style-type: none"> <li>-Completed EHR modifications required to allow documentation sharing between Farnum staff and Easterseals NH care coordinators</li> <li>-Farnum/Easterseals NH team participated in a review and demonstration of the Collective Medical event notification tool and portal for potential implementation later in 2019</li> </ul>
10	<b>Elliot Health System</b> - Doctors Park Pediatrics	<p><b>Medication-assisted treatment (MAT)</b></p> <ul style="list-style-type: none"> <li>-Dr. [REDACTED], a pediatric primary care physician, is waived.</li> <li>-Three pediatric providers and five triage nurses received MAT training.</li> <li>-The Elliot team indicated that MAT referrals are tracked through their EPIC referral system.</li> </ul> <p><b>Enhanced use of technology</b></p> <ul style="list-style-type: none"> <li>-The Elliot IT team completed implementation of Collective Medical event notification and has made the Doctors Park Pediatrics patient panel, as well as all other Elliot primary care offices, available in the Collective Medical portal. Training and workflow development are in the planning phase to incorporate use of the Collective Medical event notification portal into the primary care setting in the second half of 2019.</li> <li>-The practice transitioned to utilizing the CRAFTT substance use screening and the PHQ-9, rather than the PHQ-2 and then the PHQ-9, for depression screenings. They also implemented an integrated care tracking report, currently being piloted in Excel, to support the tracking and outcomes of the screenings.</li> <li>- All patient referrals are entered in the Epic EHR and, furthermore, the Elliot</li> </ul>

		health system maintains an algorithm for referrals of high-risk patients to the Mental Health Center of Greater Manchester.
11	<b>Elliot Health System</b> – Partial Hospitalization Program(PHP)	<p><b>Medication-assisted treatment (MAT)</b> The PHP program interacts with MAT providers in two ways:</p> <ol style="list-style-type: none"> <li>1. A MAT provider is on staff for the program and is fully integrated into the team. The MAT provider attends the treatment review team discussions.</li> <li>2. If the program participant prefers, the team refers them to their primary care provider for MAT. 70% of Elliot PHP participants are Elliot patients, so the referral is very easy to do within the system. The PHP team also refers to primary care in whatever system they are in, mostly Elliot, CMC or Amoskeag Health (formerly Manchester Community Manchester Health Center).</li> </ol> <p><b>Enhanced use of technology</b> -The PHP program completed implementation of Collective Medical event notification. They defined and implemented a workflow to manage the incoming notification for the participant panel. -In the past 6 months, the PHP program has been incredibly busy developing the BH module in EPIC. All Elliot SUD programs have collaborated to develop the forms, design the workflows and are currently involved in testing. Completion of the BH module is tentatively scheduled for November 2019. -As part of collaborative efforts with Southern NH Medical Center in Nashua, the Elliot PHP program has been reviewing and revising all forms. This includes the selection of evidenced-based screening tools, development of treatment plans, discharge workflows, etc. -The PHP program team continues to focus on improving workflows for MAT referrals, prescribing practices and referrals for ongoing care.</p>
12	<b>Families in Transition- New Horizons</b> - Family Willows Treatment Center	<p><b>Medication-assisted treatment (MAT):</b> -Working collaboratively with MAT providers, but does not include prescribers/providers at this time.</p> <p><b>Enhanced use of technology:</b> -IEP project team is maturing and continues to meet regularly with the Network4Health B1 team as well as with the Network4Health HIT team, who is closely supporting their organization-wide EMR implementation</p>
13	<b>Fusion Health Services</b>	<p><b>Medication-assisted treatment (MAT):</b> -Fusion’s seven waived APRN’s provides MAT services to patients and accepts MAT referrals from Network4Health providers -Fusion’s Medical Director provides training to IDN 4 partners to support expanding MAT capabilities -Expanded Fusion MAT services with partnership at the Mental Health Center of Greater Manchester (MHCGM). Additional time was added to make services available in Emergency Services from 4 to 8 hours, and case management needs are coordinated between Fusion staff and MHCGM’s Intensive Transition Team (ITT). Joint planning is underway to expand MAT services to Bedford Counseling Associates.</p> <p><b>Enhanced use of technology:</b> -Further work was completed with an IT consultant to create a dashboard identifying patient needs based on completion of the CCSA. Integration of data flow between Patientlink, EMR and dashboard is currently underway.</p>

		<p><b>Joint Workflows</b></p> <p>-Joint workflow planning meetings were held with the Mental Health Center of Greater Manchester and Dartmouth-Hitchcock Manchester to further define MAT workflow between agencies and Fusion.</p> <p>-Joint workflow has been established with Granite Pathways Doorways Program as the Manchester Hub for SOR. The program is followed weekly through phone calls transitioned to case managers at both organizations. Due to departure of Fusion Case Manager, Fusion’s Medical Director is currently managing care coordination activities to support Doorways Program referrals.</p>
14	<p><b>Amoskeag Health, formerly known as Manchester Community Health Center - Hollis Street</b></p>	<p><b>Medication-assisted treatment (MAT):</b> MAT services were in practice prior to 1115 waiver. Using continuous quality improvement to revise workflows as needed. Collaborating closely with other IDN 4 partners implementing MAT to share best practices and lessons learned, as well as ongoing mentoring.</p> <p><b>Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)</b></p> <p>After much research and analysis, Amoskeag Health decided to design its own model for depression care, based heavily on primary care depression models from the Institute for Clinical Systems Improvement (ICSI) and Advancing Integrated Mental Health Center (AIMS). Amoskeag Health had [REDACTED] of Dartmouth provide training on Problem Solving Therapy followed by weekly consultative phone calls. He will present Behavioral Activation training in August, again followed by consultation phone calls.</p> <p><b>Enhanced use of technology:</b></p> <p>-Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</p> <p>-Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</p> <p>-Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer’s reports.</p> <p>-Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions.</p> <p>-Additional training on the use of Collective Medical and working with providers is being provided on June 27, 2019 to CHW’s and Case Manager’s. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</p> <p><b>Joint Workflows:</b></p> <p>-ProHealth is a program of the Mental Health Center of Greater Manchester (MHCGM). This program will be embedding Amoskeag Health primary care provider(s) into the behavioral health setting at MHCGM. Workflows and protocols are in development with an anticipated August opening.</p>

15	<p><b>Amoskeag Health, formerly known as Manchester Community Health Center - Tarrytown</b></p>	<p><b>Medication-assisted treatment (MAT):</b> MAT services were in practice prior to 1115 waiver. Using continuous quality improvement to revise workflows as needed. Collaborating closely with other IDN 4 partners implementing MAT to share best practices and lessons learned, as well as ongoing mentoring.</p> <p><b>Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)</b>  After much research and analysis, Amoskeag Health decided to design its own model for depression care, based heavily on primary care depression models from the Institute for Clinical Systems Improvement (ICSI) and Advancing Integrated Mental Health Center (AIMS). Amoskeag Health had [REDACTED] of Dartmouth provide training on Problem Solving Therapy followed by weekly consultative phone calls. He will present Behavioral Activation training in August, again followed by consultation phone calls.</p> <p><b>Enhanced use of technology:</b>  - Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology  - Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.  - Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports.  - Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions.  - Additional training on the use of Collective Medical and working with providers is being provided on June 27, 2019 to CHW's and Case Manager's. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</p> <p><b>Joint Workflows:</b>  -ProHealth is a program of the Mental Health Center of Greater Manchester (MHCGM). This program will be embedding Amoskeag Health primary care provider(s) into the behavioral health setting at MHCGM. Workflows and protocols are in development with an anticipated August opening.</p>
16	<p><b>Amoskeag Health, formerly known as Manchester Community Health Center -Westside Neighborhood Health Center</b></p>	<p><b>Medication-assisted treatment (MAT):</b> MAT services were in practice prior to 1115 waiver. Using continuous quality improvement to revise workflows as needed. Collaborating closely with other IDN 4 partners implementing MAT to share best practices and lessons learned, as well as ongoing mentoring.</p> <p><b>Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)</b>  After much research and analysis, Amoskeag Health decided to design its own model for depression care, based heavily on primary care depression models from the Institute for Clinical Systems Improvement (ICSI) and Advancing Integrated Mental Health Center (AIMS). Amoskeag Health had [REDACTED] of Dartmouth provide training on Problem Solving Therapy followed by weekly consultative phone calls. He will present Behavioral Activation training in</p>

		<p>August, again followed by consultation phone calls.</p> <p><b>Enhanced use of technology:</b></p> <ul style="list-style-type: none"> <li>-Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</li> <li>-Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>-Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports.</li> <li>-Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions.</li> <li>-Additional training on the use of Collective Medical and working with providers is being provided on June 27, 2019 to CHW's and Case Manager's. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression.</li> </ul> <p><b>Joint Workflows:</b></p> <ul style="list-style-type: none"> <li>-ProHealth is a program of the Mental Health Center of Greater Manchester (MHCGM). This program will be embedding Amoskeag Health primary care provider(s) into the behavioral health setting at MHCGM. Workflows and protocols are in development with an anticipated August opening.</li> </ul>
17	<p><b>Amoskeag Health, formerly known as Manchester Community Health Center - Child Health Services</b></p>	<p><b>Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)</b></p> <p>Child Health Services team completed implementation of the MATCH implementation.</p> <p><b>Enhanced use of technology:</b></p> <ul style="list-style-type: none"> <li>-Significant work to review existing methodologies for high risk patient identification and actively working with EHR technical support to identify ways to more effectively and efficiently use technology</li> <li>-Practice completed report requirements for Provider Level Depression Management reporting in conjunction with Healthcare for the Homeless team to streamline tracking of progress with depression model. Report is currently in-development with EHR report writer.</li> <li>-Amoskeag Health went live with Collective Medical event notification workflow in March 2019. The team began data analysis of frequent utilizer's reports. Information gathering meetings with Health First Family Center in Franklin and Healthcare for the Homeless were held to determine best practices in workflow design and interventions. Amoskeag Health plans to utilize Community Health Workers and Case Managers to trial interventions with families of pediatric patients, representing close to 70% of the high utilizer population. Patient-centered goals will be created through this process and through the implementation of the evidence-based care plans for adult patients with depression. Additional training on the use of Collective Medical and working with providers is being provided on June 27, 2019 to CHW's and Case Manager's.</li> </ul>

18	<b>Mental Health Center of Greater Manchester (MHCGM) – Behavioral Health</b>	<p><b>Medication-assisted treatment (MAT):</b>  MHCGM expanded existing Vivitrol MAT services to include the availability of Suboxone with Fusion Health partnership at MHCGM’s Cypress Center. Additional time was added to make services available in MHCGM’s Emergency Services from 4 to 8 hours, and case management needs are coordinated between Fusion staff and MHCGM’s Intensive Transition Team (ITT). Joint planning is underway to expand MAT services to Bedford Counseling Associates.</p> <p><b>Enhanced use of technology:</b>  -MHCGM continued work to create a risk console that will show the social determinants of health from the CCSA  -MHCGM began utilizing DHConnect to access records of mutual MHCGM/Dartmouth-Hitchcock patients  -MHCGM has participated in several demos of “Open Beds” and “Unite Us” closed loop referral systems. The team had some discussions about how MHCGM would manage these systems internally. This would necessitate designating staff to manage the referrals and update the system.  -MHCGM currently has designated staff members who monitor Collective Medical (CM) event notification alerts daily through the CM portal and a shared email address/inbox. Those staff members are responsible for scanning the alerts into the EMR and notifying the attending practitioners. Additionally, the Intensive Transition Team (ITT) and Crisis Assessment and Treatment Team (CATT) supervisors monitor the alerts for high utilizers, assigning transition case managers to specific cases, as needed.  -MHCGM currently working with Netsmart and Collective Medical to integrate the CM event notifications automatically into our EMR, bypassing the need for emails, scanning, etc.</p> <p><b>Joint Workflows</b>  -MHCGM continued to meet with Catholic Medical Center Primary Care and Dartmouth Hitchcock Manchester primary care staff to refine collaborative workflows during the reporting period.  -MHCGM met with Executive Director of Building Community in NH to discuss possible collaboration efforts</p>
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## 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.*

The Integrated Healthcare budget is presented below. Modifications have been made based on the following factors.

Revenue- Project budgets have been adjusted to reflect the actual receipt of funding. The anticipated, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced due to ongoing negotiations with NH counties or as a result of unmet DSRIP project performance metrics, Network4Health will revise budgets and project plan deliverables subject to Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) for the period of January to June 2019 are presented. Anticipated expenses (including those for the current reporting period) are projected in

subsequent reporting periods. Given that final incentive funding is not expected until mid-2021, we have projected expenses in that period as we conclude the waiver projects.

<b>TRANSFORMATON FUNDS</b>	<b>ACTUAL CY 2017 (Yr2)</b>	<b>ACTUAL CY 2018 (Yr3)</b>	<b>ACTUAL CY 2019 (Yr4) Jan to June</b>	<b>PROJECTED CY 2019 (Yr4) July to December</b>	<b>PROJECTED CY 2020 (Yr5)</b>	<b>PROJECTED CY 2021 (Yr6)</b>
B1: Integrated Healthcare Revenue (New)	\$1,035,053	\$ 786,640	\$ 1,412,832	\$ 2,630,775	\$3,871,864	\$ 2,146,776
B1: Integrated Healthcare Revenue (Rollover)		\$1,032,253	\$ 1,191,313	\$ 1,551,993	\$ 195,865	\$ 26
<b>Total Revenue</b>	<b>\$1,035,053</b>	<b>\$1,818,893</b>	<b>\$ 2,604,145</b>	<b>\$ 4,182,768</b>	<b>\$4,067,729</b>	<b>\$ 2,146,802</b>
<b>Salaries and benefits- Integrated Healthcare Clinical Director (1.0 fte)</b>		\$ 109,820	\$ 89,020	\$ 81,818	\$ 167,869	\$ 86,452
<b>Technology (Laptops, phones, software)</b>		\$ 848	\$ 330	\$ 3,670	\$ 4,000	\$ 2,000
<b>UNH Institute on Health Policy and Practice/Citizen's Health Initiative Baseline and Follow-up Assessments.</b>	\$ 2,800	\$ 4,780	\$ -	\$ 3,744	\$ 5,606	
<b>UNH IHPP/CHI Integration Enhancement Project plan development.</b>		\$ 30,772				
<b>UNH Law IHPP/CHI Integration coaching.</b>		\$ 182,350	\$ 178,965	\$ 79,858	\$ 131,118	
<b>Practice level Integrated Healthcare Enhancement Project plan funding.</b>		\$ 293,260	\$ 780,962	\$ 3,810,913	\$ 3,752,210	\$ 2,054,900
<b>Occupancy</b>		\$ 5,750	\$ 2,875	\$ 6,900	\$ 6,900	\$ 3,450
<b>Total Expenses</b>	<b>\$ 2,800</b>	<b>\$ 627,580</b>	<b>\$ 1,052,152</b>	<b>\$ 3,986,903</b>	<b>\$4,067,703</b>	<b>\$ 2,146,802</b>
<b>Variation to Budget (Transfer Funds to Subsequent Year)</b>	<b>\$1,032,253</b>	<b>\$1,191,313</b>	<b>\$ 1,551,993</b>	<b>\$ 195,865</b>	<b>\$ 26</b>	<b>\$ -</b>

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

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

Achieved	Total Goal Number Designated	Baseline Designated 12/31/18	Number Designated 6/30/19	Number Designated 12/31/19	Number Designated 6/30/20
Coordinated Care Practice	Up to 18	18	18		
Integrated Care Practice	Up to 5	5	5		

# Network4Health Behavioral Health Site Self Assessment Survey Results

July 12<sup>th</sup>, 2019





# Agenda

- Assessment Best Practices
- Integrated Delivery Network 4 Results
- Things to Consider Moving Forward

# What works best?

## **BE TIMELY WITH YOUR ASSESSMENTS**

**Improves ability to trend and guides resource allocation**

## **COMMUNICATION WITH PRACTICES**

**Conveying the importance of self-assessments**

## **HIGHLIGHT AREAS OF SUCCESS**

**Call out what is already working!  
Don't focus only on the areas of improvement**

## **FOLLOW-UP**

**How are you circling back to practices post assessment and following up on regional results?**

# Lessons from the Field

- Reminding practices of the “How To” to take an SSA
- Fostering a culture of trust to move toward data transparency
- Highlighting specific SSA Domains in any trainings/educational offerings to IDN Practices
- Connecting action steps to specific questions/domains on the SSA
- Facilitating the assessment, collecting discussion/qualitative data

# SSA Collection Process Overview

## Baseline

- 15 Practices
- Survey Opened: 9/15/17
- Last SSA Submitted on: 10/16/2017
- Report out: 11/29/2017

## 6 Month Follow-Up

- 13 practices, 2 new baselines
- Open Date: 05/14/2018
- Last SSA Submitted on: 08/07/2018
- Report out: 10/09/2018

## 12 Month Follow-Up

- 15 Practices, including 1 new baseline
- Survey Opened: 03/15/2019
- Last SSA Submitted on: 04/30/2019
- Report out: 07/12/2019

# SAMHSA/SSA Crosswalk - Guideline

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

Adapted from the foundational work of Maine Health Access Foundation, funded by the Robert Wood Johnson Foundation Diabetes Initiative.

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Heath B, Wise Romero P, Reynolds K. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. A review and proposed standard framework for levels of integrated healthcare. Published March 2013.

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# Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 4 And IDN Practice Number: 4-117

## Average Scores: Domain One

### Intergrated Services and Patient and Family Centeredness

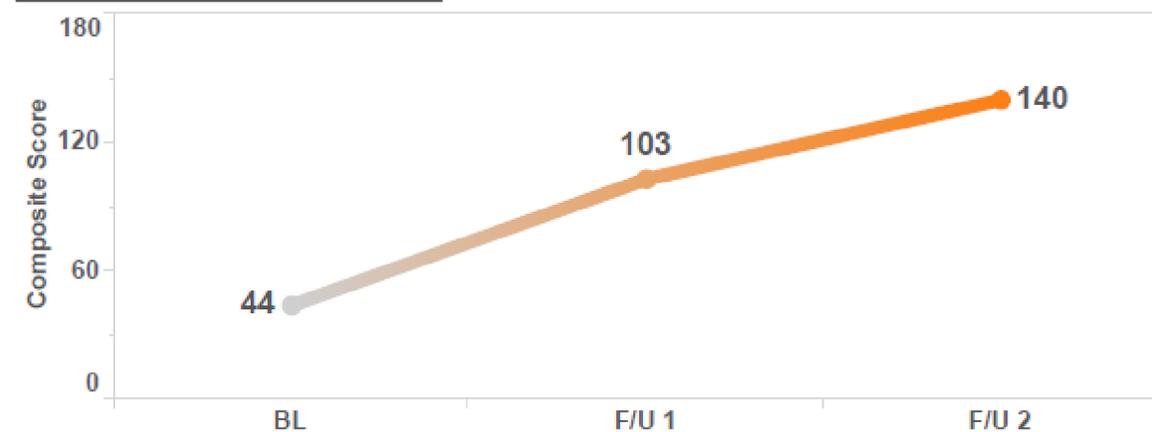
	BL	F/U 1	F/U 2
1. Level of integration: primary care and mental/behavioral health care	3	6	8
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	9	8	8
3. Treatment plan(s) for primary care and behavioral/mental health care	2	6	8
4. Patient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

## Average Scores: Domain Two

### Practice/Organization

	BL	F/U 1	F/U 2
1. Organizational leadership for integrated care	2	9	8
2. Patient care team for implementing integrated care	1	7	7
3. Providers' engagement with integrated care ("buy-in")	1	5	8
4. Continuity of care between primary care and behavioral/mental health	2	5	8
5. Coordination of referrals and specialists	2	7	8
6. Data systems/patient records	2	4	8
7. Patient/family input to integration management	2	6	5
8. Physician, team and staff education and training for integrated care	2	5	8
9. Funding sources/resources	1	5	7

## Composite Score Progression



Note:

BL - Baseline Assessment

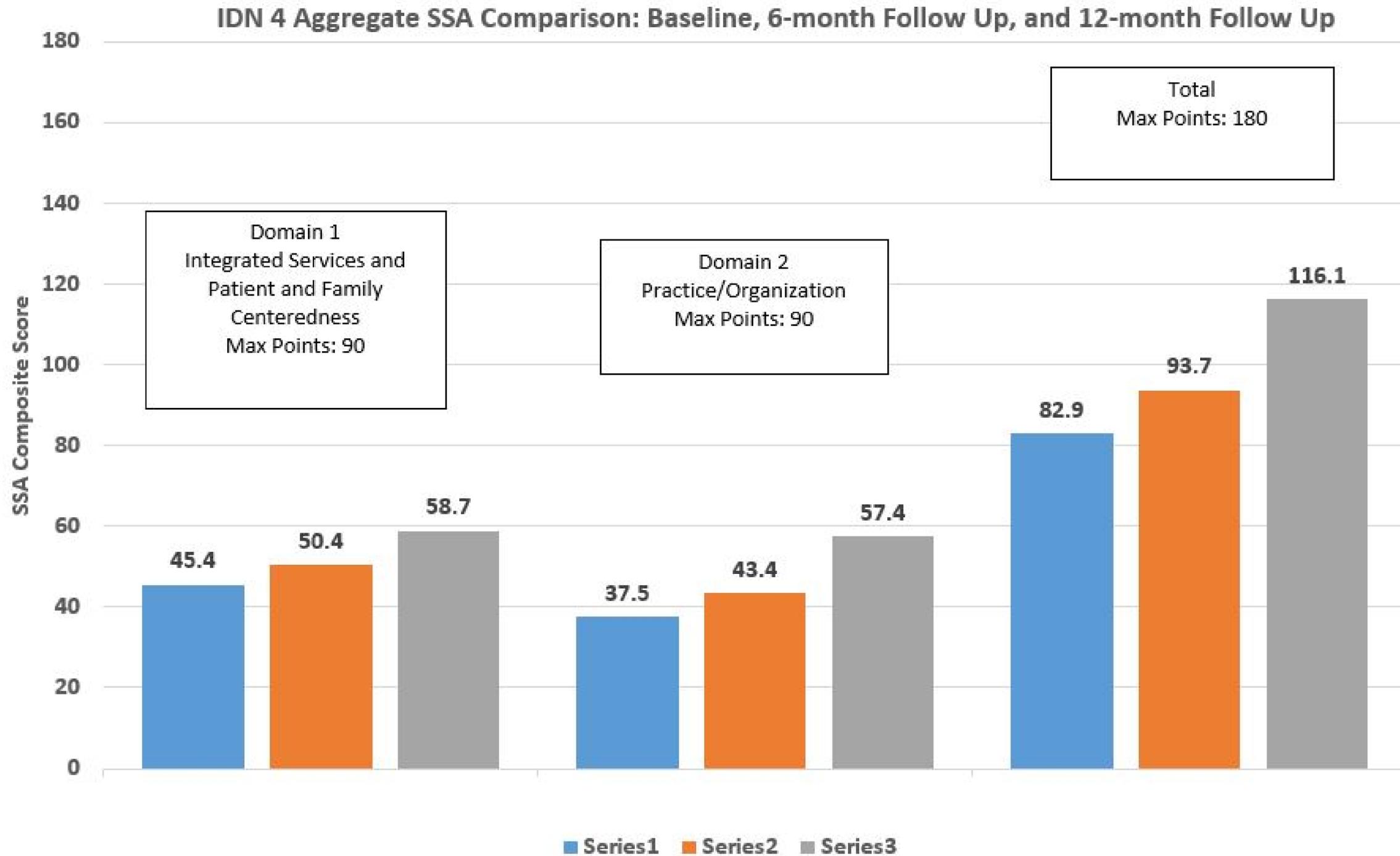
F/U 1 - First Follow-Up Assessment

F/U 2 - Second Follow-Up Assessment

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5/23/2019

# IDN 4 Overview





IDN Region:  
4

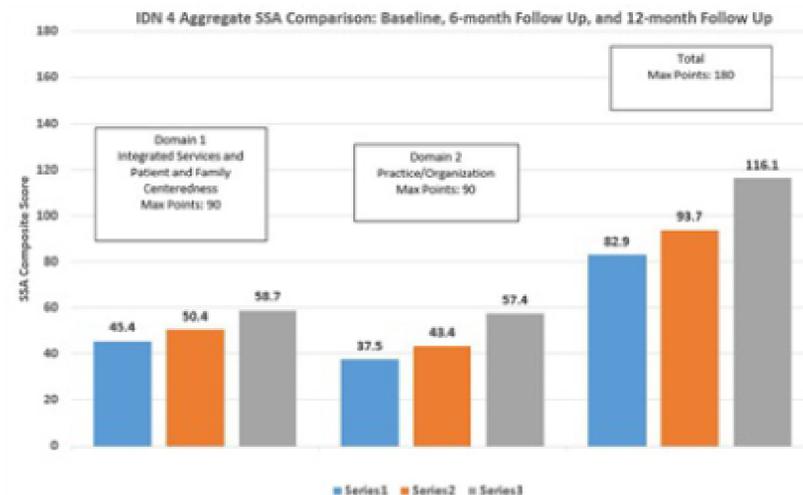
# Site Self-Assessment (SSA) Roll-Up Report

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

	BL	F/U 1	F/U 2
1. Level of integration: primary care and mental/behavioral health care	3.7	4.9	5.4
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	6.4	7.0	7.7
3. Treatment plan(s) for primary care and behavioral/mental health care	3.7	4.4	5.7
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	4.8	5.3	6.0
5. Patient/family involvement in care plan	5.1	5.4	6.8
6. Communication with patients about integrated care	4.8	5.1	6.0
7. Follow-Up of assessments, tests, treatment, referrals and other services	5.6	6.3	6.8
8. Social support (for patients to implement recommended treatment)	5.7	6.1	7.2
9. Linking to community resources	5.7	6.0	7.1

## Average Scores: Domain Two Practice/Organization

	BL	F/U 1	F/U 2
1. Organizational leadership for integrated care	4.8	5.9	6.7
2. Patient care team for implementing integrated care	3.6	4.7	6.0
3. Providers' engagement with integrated care ("buy-in")	4.7	5.0	6.8
4. Continuity of care between primary care and behavioral/mental health	4.6	5.1	6.7
5. Coordination of referrals and specialists	4.7	5.1	6.5
6. Data systems/patient records	4.2	4.9	6.8
7. Patient/family input to integration management	3.7	3.9	5.0
8. Physician, team and staff education and training for integrated care	3.8	4.8	6.6
9. Funding sources/resources	3.4	4.1	6.1



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

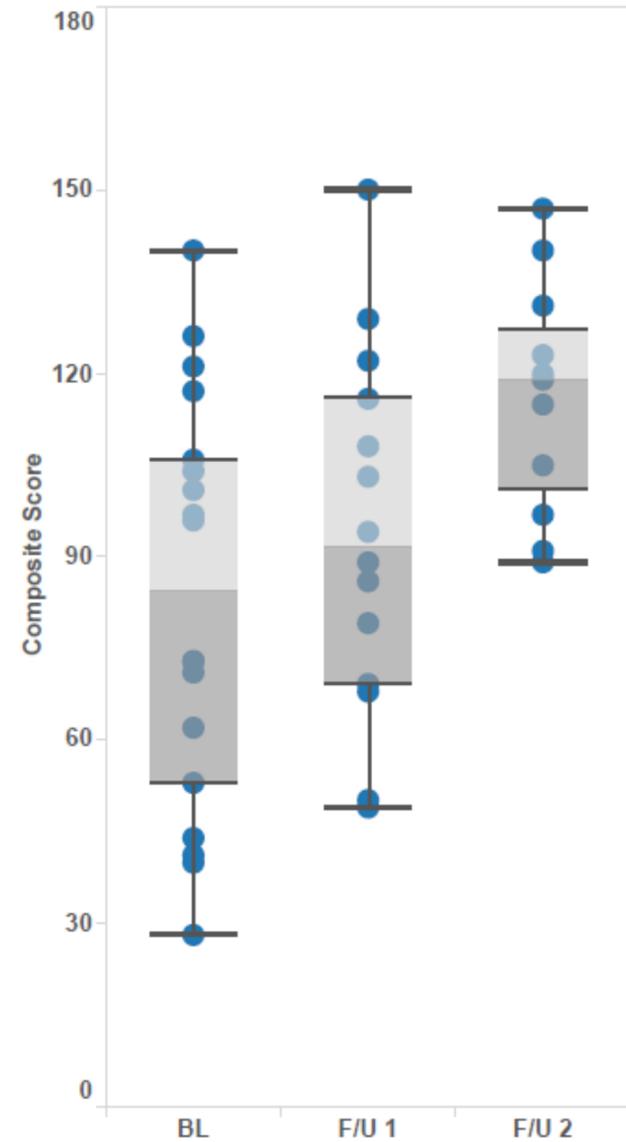
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Maine Health Access Foundation. Site Self-Assessment. Updated 2016

# Site Self-Assessment (SSA) Trend Report

*For IDN Leadership Use Only*

**Composite Score Distribution**



**Baseline:**  
 Upper Whisker: 140  
 Upper Hinge: 106  
 Median: 84.5  
 Lower Hinge: 53  
 Lower Whisker: 28

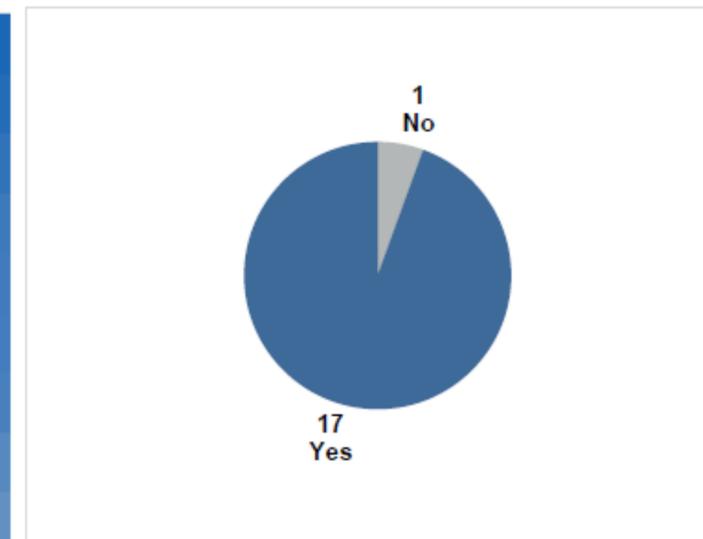
**Follow-Up 1:**  
 Upper Whisker: 150  
 Upper Hinge: 116  
 Median: 91.5  
 Lower Hinge: 69  
 Lower Whisker: 49

**Follow-Up 2:**  
 Upper Whisker: 147  
 Upper Hinge: 127  
 Median: 119  
 Lower Hinge: 101  
 Lower Whisker: 89

**Composite Scores by Practice**

Practice	SSA No.		
	BL	F/U 1	F/U 2
4-115	126	129	147
4-117	44	103	140
4-110	121	122	131
4-113	41	69	123
4-106	73	86	120
4-109	106	50	119
4-102	62	79	115
4-114	40	49	105
4-112	96	116	97
4-101	104	89	91
4-105	71	68	89
4-103	97	94	
4-104	101		
4-107	73		
4-116	28		
4-118	53	108	
4-119	140	150	
4-120	117		

**"Did you discuss these ratings with other members of your team?"**  
 (Most Recent SSA Taken by Practices)

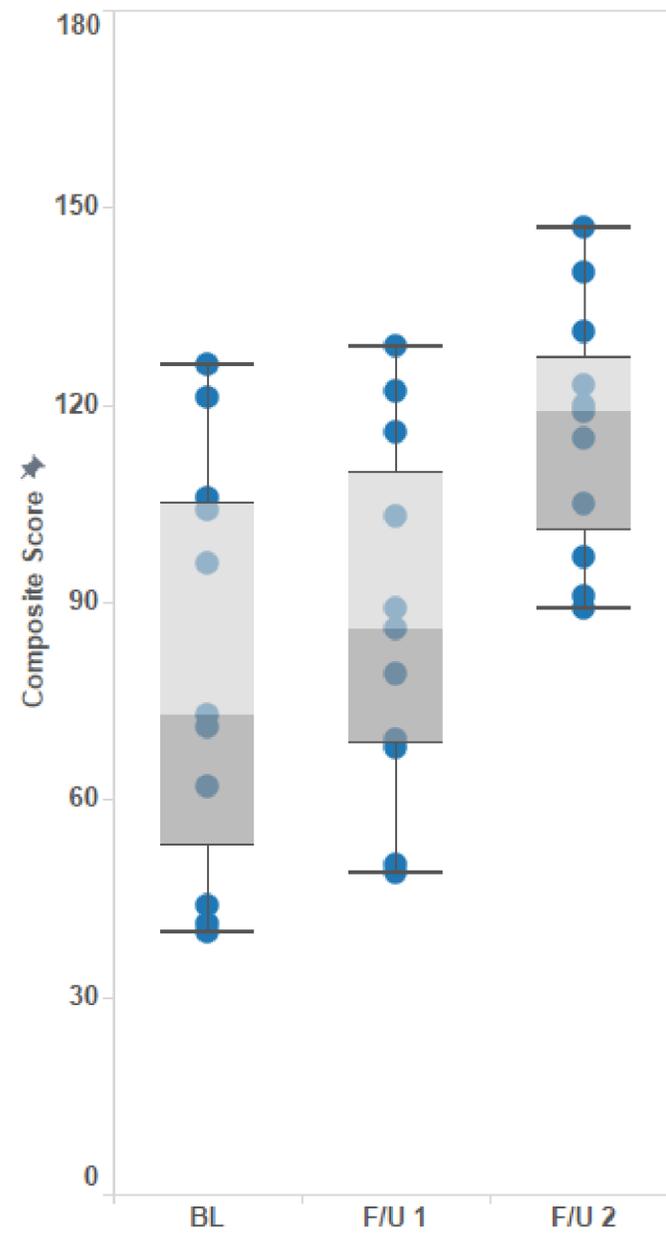


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# Site Self-Assessment (SSA) Trend Report

For IDN Leadership Use Only

Composite Score Distribution



**Baseline:**

Upper Whisker: 126  
 Upper Hinge: 105  
 Median: 73  
 Lower Hinge: 53  
 Lower Whisker: 40

**Follow-Up 1:**

Upper Whisker: 129  
 Upper Hinge: 109.5  
 Median: 86  
 Lower Hinge: 68.5  
 Lower Whisker: 49

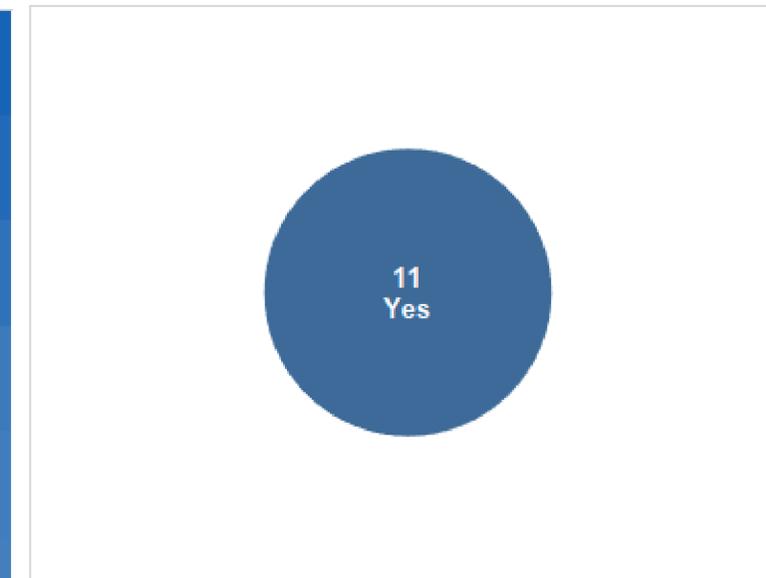
**Follow-Up 2:**

Upper Whisker: 147  
 Upper Hinge: 127  
 Median: 119  
 Lower Hinge: 101  
 Lower Whisker: 89

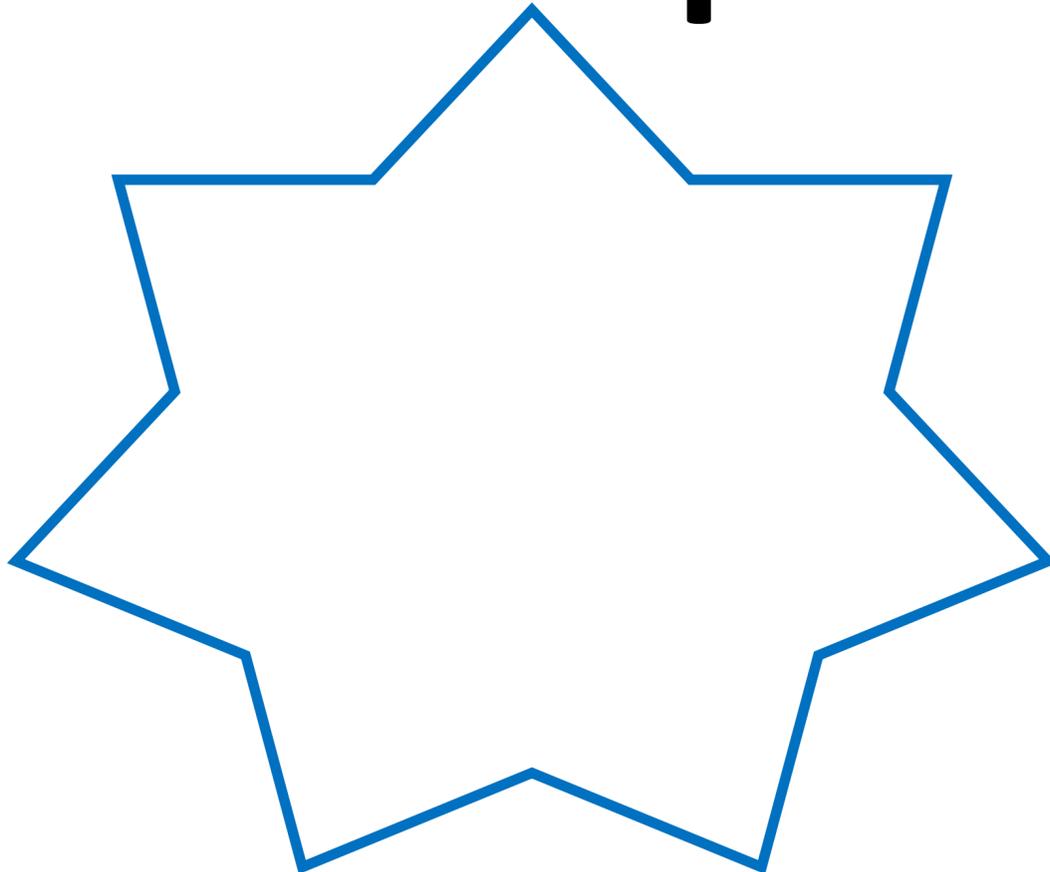
Composite Scores by Practice

Practice	BL	SSA No. F/U 1	F/U 2
4-115	126	129	147
4-117	44	103	140
4-110	121	122	131
4-113	41	69	123
4-106	73	86	120
4-109	106	50	119
4-102	62	79	115
4-114	40	49	105
4-112	96	116	97
4-101	104	89	91
4-105	71	68	89

"Did you discuss these ratings with other members of your team?"  
 (Most Recent SSA Taken by Practices)



# Responses from Practices



**“...We've gained a better understanding of what integration means for our own agency, and we've taken many steps toward achieving our integration goals. This year we have a better understanding of the concepts of integration which has resulted in a more critical assessment. We also have a broader array of programs represented in the self assessment.”**

**“We are working to improve our approach of connecting all the providers weekly to discuss patient care.”**

# Things to consider

- Reinforcing organized approaches
- Preparing for sustainability
- What does “true” integration look like for the practice?
- Where do practices go from here?

# References

Blount A. Integrated primary care: organizing the evidence. *Families, Systems, & Health*. 2003; 21 (2):121-133. doi: 10.1037/1091-7527.21.2.121.

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Collins C, Hewson DL., Munger R. Wade T. Milbank Memorial Fund. Evolving models of behavioral health Integration in primary care. Published 2010

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# Resources

- **SSA Instructions Tutorial.** A narrated PowerPoint presentation with instructions for practices on completing the SSA and receiving results.
- [https://media.unh.edu/media/IDN+SSA+Tutorial+/1\\_s09aum68](https://media.unh.edu/media/IDN+SSA+Tutorial+/1_s09aum68)

## Projects C: Care Transitions-Focused

### Narrative

*Provide a detailed narrative which describes the progress made during this reporting period.*

Network4Health's Critical Time Intervention (CTI) program is fully implemented. As of June 30, 2019, we are currently serving 62 clients out of 294 referrals (87 total served since inception). Since our last reporting period we have had 30 participants graduate from the program to date. Participants are still moving through the phases of CTI in accordance with fidelity standards of the Critical Time Intervention model. All participants have phase plans in place and Transition Coaches continue to complete phase plan reviews at the 90, 180, and 270 day marking period. All participants enrolled in CTI continue complete the Illness Management & Recovery scale (IMR) upon admission. All of CTI's graduates have also completed the IMR scale upon exiting the program.

Through CTI, Network4Health continues to provide barrier reduction funds to support participants in obtaining proofs such as: photo ID, birth certificate, social security cards etc. These have been instrumental in ongoing cases with assisting clients applying for benefits, obtaining stable housing and securing employment, as part of their transition plan.

Network4Health and its partners have held several trainings for the CTI project during this reporting period. The Care Transitions Clinical Director, Administrative Assistant and the 5 CTI Coaches all attended trainings, including:

- In January of 2019:
  - 1/15/19: 2 Coaches attended Cyber Security
  - 1/17/19: 4 coaches and Director attended the In Person Community of Practice (COP) with the other IDN's while CTI Intern and 1 other coach completed Motivational Interviewing I
  - 1/22/19: all 5 coaches attended a meeting/training with the New Hampshire Department of Corrections.
  - Throughout January each CTI coach met with the Hillsborough County DOC for an overview before meeting clients within the correctional facilities.
- In February of 2019:
  - 2/7/19: 2 coaches attended Motivational Interviewing II
  - 2/20/19: The Mental Health Center of Greater Manchester held a safety plan meeting which the CTI administrative assistant attended
  - 2/20/19: The Mental Health Center of Greater Manchester held a Zero Suicide training that 3 coaches attended
  - 2/25/19: CTI Director and 2 coaches completed the "Understanding Adverse Childhood Experiences and working with Complex Trauma
  - 2/26/19: CTI Director attended "Compassion Fatigue & Various Trauma training.
- In March of 2019:
  - 3/1/19: 2 coaches completed the Non-violent Crisis Intervention (CPI) training,
  - 1 coach completed a 4 day Dialectical Behavior Therapy training that started 3/8/19
  - 3/14/19: 1 coach completed her CALM (Counseling on Access to Lethal Means) training and 1 coach completed CBT overview
  - 3/15-3/19: 1 coach completed the Wellness Recovery Action Plan facilitator training
  - 3/21/19: 3 coaches participated in the Columbine Suicide training and another attended on 3/27
  - 3/22/19: 1 coach and CTI Director attended the Supervisors & Supervisees Learning Together conference in Plymouth NH.
  - 3/28/19: CTI Director attended the Opioid Addiction & Treatment seminar

- 3/29/19: Administrative Assistant and CTI Director attended Understanding the Trauma Responsive Framework.
- In April of 2019:
  - 4/5/19: 1 coach attended the Families & Recovery training
  - 4/11/19: CTI Director and 1 coach met with Catholic Medical Center and Intensive Treatment Team for a collaborative meeting.
  - 4/12/19: 2 coaches attended the Functional Support Services billing training
  - 4/24/19: all 5 coaches and CTI Director attended an in Person COP meeting
  - 4/25/19: CTI director completed the “Issues for Substance use, Mental Health and other Healthcare Providers” training.
  - Also on 4/25 1 coach attended Medication-Assisted Treatment training and the other 4 attended on 4/30/19.
- In May of 2019:
  - 5/10/19: Intersection Between Substance use Prevention & Recovery- 1 coach attended
  - 5/22/19: SAMHSA community Re-entry Webinar training- 5 coaches attended
  - 5/23-5/24/19: CTI Director attended a 2 day NASW Annual Conference
- In June of 2019:
  - 6/13/19: 1 coach completed her 2 day Dialectical Behavior Therapy training
  - 6/18/19: 1 coach attended the Personality d/o with Co-occurring Disorders training
  - 6/26/19: CTI Director attended the Cognitive Behavioral Therapy for Suicidal Prevention.

## 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.*

Network4Health has continued to include additional performance measures for the number of clients served at any time in the program, referrals received to reflect community engagement, and number of individuals completed to reflect cumulative numbers to date, not just this reporting period. Referrals are reviewed as a team and are assessed by a coach to determine eligibility. During assessment, clients are provided materials detailing CTI program specifics and phases and are given the opportunity to consent or decline. Some clients require multiple visits prior to making a decision about their willingness to participate in the CTI program.

The focus for this reporting period was to finalize reports on targeted performance measures. We have continued to work with the MCHGM’s EMR team to finalize reports. At this time, we can accurately report on Performance Measure “average number of days from transition to first outpatient behavioral health visit”. We can report on Performance Measure “average number of MH and SUD visits” per phase. Finally, we can also report on Performance Measure “number of community resources” individuals are connected to during each Phase throughout their participation in CTI.

With regards to Performance Measure “Average number of MH and SUD appointments”:

- This data is preliminary and only reflective of individuals who have completed that phase. We are unable to reflect data on all individuals currently being served in the program as individuals

are at different points within each phase. You will note that each performance measure has been updated to reflect the sum total of individuals this data is reflective of (n=x).

We anticipated that CTI participants would have increased average visits as they moved from Phase 2 to Phase 3. However, during this reporting period, despite our best efforts to outreach all participants, it was found that the average number of mental health and substance use visits have decreased. We hypothesize that the decreased visits are due to factors such as:

- Social determinants causing disengagement from CTI and MH/SUD services; homelessness, transportation, and/or relapse.
- Improvement in symptom management, resulting in a decrease need in frequent services

**Note:** These numbers are reflective of all clients served during this reporting period. This includes clients that have consented and disengaged from CTI services, the number of clients served at any time in the program, and number of individuals completed. This is to reflect the cumulative numbers since inception, not just this reporting period. CTI fidelity requires that any participant consented shall remain open and eligible to the CTI program for the full 9 months, despite level of participation. Due to this, we hypothesize that the number of disengaged clients may be distorting these numbers and does not accurately reflect the number of services by engaged participants in the CTI program

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Number of individuals served anytime in program (cumulative)	Up to 333	60	87	
Number of individuals referred to program (cumulative)	Up to 333	163	294	
Number of individuals completed program (cumulative)	Up to 333	12	30	
# of days from transition to first BH outpatient visit (n=87)	Up to 20 days	12.08	11.74	
Average # of Mental health & substance abuse visits at end of Phase 1 (n= 67)	Up to 4	6.41	5.74	
Average # of Mental health & substance abuse visits at end of Phase 2 (n=49)	Up to 6	6.25	6.2	
Average # of Mental health & substance abuse visits at end of Phase 3 (n=38)	Up to 8	4.75	5.55	
Increase average # of community resource contacts from program enrollment to program completion (based on number of graduates) (n=30)	Up to 5	NA	6	

## 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.*

The Care Transitions budget is presented below. Modifications have been made based on the following factors.

Revenue- Project budgets have been adjusted to reflect the actual receipt of funding. The anticipated, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced due to ongoing negotiations with NH counties or as a result of unmet DSRIP project performance metrics, Network4Health will revise budgets and project plan deliverables subject to Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) for the period of January to June 2019 are presented. Anticipated expenses (including those for the current reporting period) are projected in subsequent reporting periods. Given that final incentive funding is not expected until mid-2021, we have projected expenses in that period as we conclude the waiver projects.

<b>TRANSFORMATON FUNDS</b>	<b>ACTUAL CY 2017 (Yr2)</b>	<b>ACTUAL CY 2018 (Yr3)</b>	<b>ACTUAL CY 2019 (Yr4) Jan to June</b>	<b>PROJECTED CY 2019 (Yr4) July to December</b>	<b>PROJECTED CY 2020 (Yr5)</b>	<b>PROJECTED CY 2021 (Yr6)</b>
C1: Care Transitions Revenue (New)	\$ 230,012	\$ 174,809	\$ 313,963	\$ 431,276	\$ 468,542	\$ 238,530
C1: Care Transitions Revenue (Rollover)		\$ 218,891	\$ 143,449	\$ 323,366	\$ 205,738	\$ (369)
<b>Total Revenue</b>	<b>\$ 230,012</b>	<b>\$ 393,700</b>	<b>\$ 457,412</b>	<b>\$ 754,642</b>	<b>\$ 674,280</b>	<b>\$ 238,161</b>
<b>Salary and benefits- Transitions Coaches (6.0 fte) and Administrative Assistant (1.0 fte)</b>		\$ 219,564	\$ 120,472	\$ 478,528	\$ 590,000	\$ 200,000
<b>Technology (Laptops, phones, software)</b>	\$ 8,955	\$ 16,640	\$ 6,691	\$ 21,824	\$ 28,515	\$ 10,000
<b>Barrier Reduction Funds (Client Emergency funds and Interpretation Services)</b>		\$ 887	\$ 803	\$ 39,197	\$ 40,000	\$ 20,000
<b>Occupancy</b>	\$ 2,166	\$ 13,160	\$ 6,080	\$ 9,355	\$ 16,134	\$ 8,067
<b>Total Expenses</b>	<b>\$ 11,121</b>	<b>\$ 250,251</b>	<b>\$ 134,046</b>	<b>\$ 548,904</b>	<b>\$ 674,649</b>	<b>\$ 238,067</b>
<b>Variation to Budget (Transfer Funds to Subsequent Year)</b>	\$ 218,891	\$ 143,449	\$ 323,366	\$ 205,738	\$ (369)	\$ 94

## **Projects D: Capacity Building Focused**

### **Narrative**

*Provide a detailed narrative which describes the progress made during this reporting period.*

The Elliot Hospital Partial Hospitalization Program developed by the hospital and Network4Health to serve the Greater Manchester community successfully opened on October 2018. During the period of January – June 2019, we expanded our referral base to other agencies of the community, signed a memorandum of understanding (MOU) and provided education to the region's Doorway, decreased stigma and began to change the culture of the Elliot system and ensured the continued quality of our program through consistent record reviews.

### **STIGMA**

Over the last six months, the Director of Substance Use Disorder Services has presented training on Addiction as a chronic brain disease, Stigma and HIPAA/42CFR Part 2 to all members of the Elliot Hospital Emergency Department, primary care practices and medical providers of Solution Health. Our efforts to transform the culture of stigma and discrimination impacting those with a substance use disorder within the Elliot Hospital Community and larger Manchester community have been largely successful, as evidenced by increased referrals from the Elliot Emergency Department, Behavioral Health and medical practices (28% of our referrals) and Drug Court referrals (30%). Additionally, because of the intensive training provided to the hospital systems and larger community, PHP staff are more frequently utilized as subject matter experts for consultations on inpatient units and community agencies.

### **REFERRALS/ADMISSIONS**

To date, 185 individuals have been referred to the PHP. 109 individuals have been evaluated and admitted to the program. Of those clients evaluated and admitted, 50% have successfully completed the program and of the remaining number, 27% did not appear for the start of the program and 23% were referred to different levels of care per ASAM criteria. As a result, we will continue our efforts to educate the community referring agencies as to appropriate PHP referrals. It is noteworthy that in the first several months of the program, many referral agencies and self-referred clients believed that the PHP was actually an inpatient hospitalization program. In order to address this confusion, PHP staff have attended many community collaboration meetings and have met with the director of the Concord Doorway. We will meet in early July with the Director of the Manchester Doorway.

### **RECORD REVIEWS**

It is usual and customary in the Elliot system to conduct monthly reviews of billing and compliance. Therefore, 100% of the charts have been reviewed and audited for accuracy and appropriateness. Additionally, we conduct concurrent peer reviews and psychiatric reviews on all records prior to discharge.

### **REFERRALS TO AFTERCARE**

One of the most critical aspects of the PHP or any substance use program is collaboration with referral agencies. Within 72 hours of evaluation, individuals or agencies who referred clients to the PHP are contacted and treatment plans are discussed. This continues throughout the program, in which the average length of stay is three weeks. Person-centered Treatment Plans are completed within 48 hours

of the evaluation with potential discharge plans identified. Upon program completion, 100% of the clients have been successfully referred to aftercare programs.

Staff continue to contact patients at 3 months, 6 months and 12 months intervals after program completion. This has assisted the program in continual collaboration with other community members, by facilitating further referrals if needed. Most importantly, this process has allowed program staff to identify patients who may be struggling with their recovery and immediately assist those patients with a resumption of treatment and services.

## NEW VENTURES

Over the last several months the PHP has become increasingly involved with the Network4Health B1 Integrated Healthcare Project and will, in July, finalize contracting to formalize our integration efforts. Additionally, in June, we met with the project team of the Network4Health E4 Integrated Treatment of Co-Occurring Disorders Project and were evaluated for our integration of co-occurring disorders. We eagerly anticipate the results.

In the next six months, staff will continue to focus our efforts in increasing our referrals and admissions by continuing our close collaboration with other agencies and assisting them in improving the appropriateness of the referrals.

## Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include

- 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		
		12/31/18	6/30/19	12/31/19
# of admissions	Up to 19 by 12/31/18	31	109	
# of Program Completions	Up to 80% by 12/31/18	19%	50%	
# of chart reviews per quarter	Up to 50% by 12/31/18	50% documentation and 100% billing and coding	100% billing, coding and documentation	
# of patients successfully referred to aftercare programs in the community	Up to 80% by 12/31/18	74%	100%	

## **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.*

The Expansion of Substance Use Disorder Treatment Options (Partial Hospital Program) budget is presented below. Modifications have been made based on the following factors.

Revenue- Project budgets have been adjusted to reflect the actual receipt of funding. The anticipated, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced due to ongoing negotiations with NH counties or as a result of unmet DSRIP project performance metrics, Network4Health will revise budgets and project plan deliverables subject to Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) for the period of January to June 2019 are presented. Anticipated expenses (including those for the current reporting period) are projected in subsequent reporting periods. Given that final incentive funding is not expected until mid-2021, we have projected expenses in that period as we conclude the waiver projects.

Despite opening in October 2018, delays in contracting and invoicing resulted in no expenses being paid until the current reporting period. Salary and start-up expenses are reflected in the budget below. Following a discussion with NH DHHS staff, this budget has been revised to reflect DSRIP funding and its utilization only. Earned revenue will be used to support unfunded costs.

<b>TRANSFORMATON FUNDS</b>	<b>ACTUAL CY 2017 (Yr2)</b>	<b>ACTUAL CY 2018 (Yr3)</b>	<b>ACTUAL (Yr4) JAN TO JUNE</b>	<b>PROJECTED CY 2019 (Yr4) JULY TO DEC</b>	<b>PROJECTED CY 2020 (Yr5)</b>	<b>PROJECTED CY 2021 (Yr6)</b>
Expected Patient Volume with Ramp Up		19	68	69	137	69
D3 SUD EXP. Revenue (New)	\$ 230,012	\$ 174,809	\$ 313,963	\$ 431,276	\$ 468,542	\$ 238,530
D3 Revenue (Rollover)		\$ 230,012	\$ 404,821	\$ 14,780	\$ -	\$ -
<b>Total Revenue</b>	<b>\$ 230,012</b>	<b>\$ 404,821</b>	<b>\$ 718,784</b>	<b>\$ 446,056</b>	<b>\$ 468,542</b>	<b>\$ 238,530</b>
<b>Salaries and Benefits</b>			\$ 344,979	\$ 446,056	\$ 468,542	\$ 238,530
<b>Rent, Utilities &amp; Housekeeping</b>	\$ -		\$ -			
<b>Cell Phones</b>			\$ -			
<b>Lab</b>	\$ -		\$ -			
<b>Food/Snacks</b>	\$ -		\$ -			
<b>Travel/Training</b>	\$ -		\$ -			
<b>Marketing</b>	\$ -		\$ -			
<b>Miscellaneous Supplies</b>	\$ -		\$ 1,931			
<b>Start Up Costs</b>						
<b>EMR build and implementation</b>	\$ -		\$ 323,189			
<b>FF&amp;E</b>	\$ -		\$ -			
<b>Security</b>	\$ -		\$ 4,938			
<b>IT Hardware/Infrastructure</b>	\$ -		\$ 21,657			
<b>Facility/Construction</b>	\$ -		\$ -			
<b>Signage (internal and external)</b>	\$ -		\$ -			
<b>Miscellaneous/Contingency</b>	\$ -		\$ -			
<b>On-boarding</b>	\$ -		\$ 7,310			
<b>Total Expenses</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 704,004</b>	<b>\$ 446,056</b>	<b>\$ 468,542</b>	<b>\$ 238,530</b>
<b>Variation to Budget (Transfer Fu</b>	<b>\$ 230,012</b>	<b>\$ 404,821</b>	<b>\$ 14,780</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Projects E: Integration Focused

### Narrative

*Provide a detailed narrative which describes the progress made during this reporting period.*

#### Network4Health E4 Project Progress Update

Through our integration focused project (E4) Network4Health aims to support the increase of dual diagnosis identification and evidence-based integrated treatment competencies for patients with both a severe mental illness and substance use disorder at participating Network4Health organizations. The Integrated Treatment of Co-occurring Disorders (ITCOD) project team continues to follow its implementation plan to use two parallel approaches to enhance the identification and treatment of patients with co-occurring disorders:

- Dual Diagnosis Capability (DDC) program assessments and organizational quality improvement plans (QIP) to support the availability of integrated treatment within Network4Health partner agencies mental health and SUD programs
- Integrated treatment of co-occurring disorders training and support activities for primary care and community-based social service organizations

During the *January 2019 – June 2019* project period, the ITCOD team and project participants made the following progress:

#### ***New Dual Diagnosis Capability Assessments and Quality Improvement Plans (QIPs)***

Two new Dual Diagnosis Capability assessments were completed in the reporting period for Network4Health partner organizations Elliot Health System (Elliot) and Families in Transition-New Horizons (FIT-NH) respectively. The status of each assessment follows.

- **FIT-NH: Open Doors Program**
  - DDC Assessment Date: April 15, 2019
  - DDC Final Report Delivery: May 6, 2019
  - QIP Timeline: May 2019-May 2020
  - QIP Goals:
    - Clarify intake workflow and client release of information; and increase coordination of care efforts with community based providers.
    - Increase staff knowledge and skills regarding co-occurring disorder identification, assessment and diagnosing, and treatment interventions
    - Increase tools used and content utilized in family based interventions and programming.
    - Increase available patient resources for SUD, MH and COD- both in patient waiting and common areas, as well as for clinicians to utilize in individual and family sessions.
- **Elliot: Partial Hospitalization Program**
  - DDC Assessment Date: June 10, 2019
  - DDC Final Report Delivery: July 8, 2019
  - The project team will be working with the PHP program to define and begin a quality improvement plan based on their DDC assessment results during the July to September 2019 timeframe.
- A QIP was started for the Parkland Medical Center team in Q4 2018. Due to resource availability and contracting delays, the Parkland team was unable to commit time to complete development

of the QIP recommendations. We do not currently have a timeframe with the Parkland team for completion of their QIP or finalization of contracting to provide QIP funding.

### ***Completed Quality Improvement Plans***

Partners who developed the original 3 Dual Diagnosis Capability Quality Improvement Plans (QIPs) completed their initial QIPs in May of 2019. Below summarizes the goals attained through their original QIP.

- **Center for Life Management (CLM): Adult Services Program**
  - QIP Timeline: June 2018 to May 2019
  - Goals attained:
    - Increased baseline knowledge for all clinical staff in SUD competencies by having up to 35% of clinical staff attend SUD/COD group supervision.
    - Increased baseline knowledge for all clinical staff in SUD competencies by sending 3 employees to attend NEIAS Best Practices or School of Addiction Studies.
    - Standardized Motivational Interviewing (MI) knowledge and skills for clinical staff by staff attendance at basic, intermediate and supervisory MI training for 90% of clinical staff.
    - Supervisors received basic training in MITI 4 tool for evaluating clinician's MI application, and were also introduced to the BECCI tool. A review/comparison of tools has begun with plans to pilot within next 3 months.
    - Standardized Stages of Change (SOC) knowledge and skills for clinical staff by providing in person basic Stages of Change training for 90% of the adult program department inclusive of clinicians, case managers, and community support service staff.
    - Developed COD collaboration group for clinicians to attend for consultation and case review.
    - Made SUD resource guide available to CLM in collaboration with NH South Central Continuum of Care Coordinator. Additional resource materials related to co-occurring disorders were updated and made available in waiting area.
    - Increased clinical application and documentation of SOC and MI skills with client through completion of the following activities:
      - Began development of standardized Supervision format and documentation log to use during all clinical supervisions. Development to continue.
      - IT enhancements related to SOC have been initiated.
      - DAST/AUDIT data analysis protocols in progress.
- **Families in Transition- New Horizons (FIT-NH): Willows Substance Use Treatment IOP Program**
  - QIP Timeline: June 2018 to May 2019
  - Goals attained:
    - Standardized educational materials clinicians utilize with clients and developed a list of local resources that are available to clinical staff.
    - Increased display of client education content with the purchase of a monitor for the lobby that now displays NAMI, ADHD and PTSD information. Resource information for the Mental Health Center of Greater Manchester, the local Mobile Crisis Response Team, Depression and brain science have also been displayed.
    - Supported licensure efforts of program staff with two employees having attended NEIAS Best Practices or School of Addiction Studies.

- Ensured routine Screening and Assessment for COD for all existing and new clients through the use of the PCL-5 for trauma, the PHQ 9 and the GAD7 as needed to screen all individuals entering into treatment. Therapists are using the DSM-5 to further diagnose as needed.
  - Incorporated COD screening tools into patient record in new EHR implementation (in-progress).
  - Trained staff in Stages of Change and Motivational Interviewing (beginner and intermediate).
  - Provided Supervisory training to clinical supervisors in the application of SOC and MI.
  - Increased staff knowledge, skills and application of Stages of Change and Stage- Wise treatment through the following activities:
    - o Started a Relapse Prevention group for people waiting to get into treatment
    - o Amending team meeting supervision notes to reflect stage of change for clients
    - o Utilizing a clinical supervision form that highlights stages of change with individual cases
  - Reviewed job descriptions and included more clinical and co-occurring language to support the hiring process.
  - 20-30 staff attended Stigma Reduction training.
  - Supported licensure efforts of program staff through:
    - o 5 new licenses
    - o 2 people working on CRSW certification
    - o 15 people having ongoing supervision to maintain licensure and certification
- o **The Mental Health Center of Greater Manchester (MHCGM): Emergency and Interim Services, Cypress Center and the Continuous Treatment Team**
- QIP Timeline: June 2018 to May 2019
  - Goals attained:
    - Standardized educational materials
      - o Resources were reviewed and have been made available on the shared network drive, as well as the Staff Portal.
      - o All staff were trained on availability and use of standardized materials
      - o Developed and displayed substance specific rack cards at all sites
      - o Created Stages of Change Posters to be displayed in each department
      - o Created Rack Cards as well as purchased/mounted racks in each department's waiting area
    - Provided 3 CRSW Academies, June 2018, October/November 2018, June 2019
    - Increased staff competencies:
      - o Provided training on IDDT, Stages of Change, Stigma and Intermediate MI for 60 staff members
      - o Expanded MLADC collaboration meeting
      - o Implemented monthly Motivational Interviewing Study Group for both Adults and Adolescent Clinicians
    - Increased initial licensure supervision for program staff

- 4 licensed staff members are providing supervision for 14 staff members working toward initial MLADC
- 3 staff members obtained MLADC licensure
- Covered the cost of re-certification for 1 existing CRSW and supported initial licensure cost for 2 MLADC
- Increased family education group availability and frequency:
  - Created Family 411 curriculum
  - First series of Family 411 held February 2019. Second 4-part series planned to begin in July 2019.
- Human Resources team in progress to implement recovery friendly workplace guidelines into the employee handbook
- Began MI for Supervisors training June 2019
- Began providing expanded MAT services to include Suboxone in February 2019 at Cypress Center and Emergency and Interim Care Services. Program will be expanded to outpatient BCA in July 2019.
- Made the following EMR changes to support the treatment of COD:
  - Built URICA stages of change screening tool in the EMR
  - Built Cypress Center Admission Evaluation and Treatment plan in EMR

### *In-progress Quality Improvement Plans*

There is one organization with an in-progress QIP that will be complete in July 2019. PCS continues to make progress towards completion of their initial QIP goals, as well as set new goals based on their re-assessment for 2019-2020.

- **Pastoral Counseling Services (PCS)**
  - QIP Timeline: August 2018 to July 2019
  - QIP Progress:
    - PCS continues a monthly MLADC Collaboration Group. This meeting is offered to all PCS clinical staff to discuss cases with on-staff MLADC.
    - Four therapists continue to receive weekly individual supervision as they work towards their MLADC. They are preparing for the test and to complete application.
    - Another successful 8-week co-occurring group has begun. This group supports PCS clients who are living with co-occurring disorders, and allows an MLADC candidate the opportunity to co-facilitate a group with the MLADC.
    - Stages of Change and Motivational Interviewing tools, such as the Readiness Ruler and Change Plan Worksheets will be discussed during staff meeting in July, 2019.
    - PCS staff attended trainings on Motivational Interviewing for Supervisors, CBT and Stages of Change.

### *DDC Re-assessment and Quality Improvement Plan Renewal*

The following Network4Health partners completed a half-day DDC re-assessment to look at the progress of their agency on identified areas of improvement from their original DDC assessment. Network4Health's DDC Assessment Team, as well as a consultant from Case Western Reserve University's Center for Evidence Based Practice (CEBP) went onsite to each organization to complete the re-assessments in late February 2019. Each organization received an updated DDC score and report,

and worked with the Network4Health Co-occurring Disorders Clinical Director to define new quality improvement goals for 2019-2020.

- **Center for Life Management (CLM): Adult Services Program**
  - DDC Re-assessment Date: February 27, 2019
  - QIP Renewal Timeline: May 2019- May 2020
  - QIP Renewal Goals:
    - Support ongoing clinical supervision (both individual and group) and supervisor capacity through consultation for supervising clinician's applications of COD interventions.
    - Increase capacity within EMR to implement, track, and report upon COD related interventions and documentation of such.
    - Begin process of developing Vivitrol Clinic. Including but not limited to: policy/procedure development, MAT related trainings for staff, intervention protocols and related materials, etc. (train up to 80 staff)
    - Increase staff's competency in understanding and treating COD through training efforts (including but not limited to DBT, CBT, TIC, SOC, MI, IMR, ASAM, SUD Core Competencies, DSM-V diagnosing of SUD, etc). Expect to train up to 80 staff.
  
- **Families in Transition- New Horizons (FIT-NH): Willows Substance Use Treatment IOP Program**
  - DDC Re-assessment Date: February 28, 2019
  - QIP Renewal Timeline: May 2019- May 2020
  - QIP Renewal Goals:
    - Support licensure efforts of staff (including initial and renewal fees, as well as one testing fee per initial licensure candidate). Includes: MLADC, LADC, LICSW, LCMHC, CRSW, IPS
    - Support ongoing clinical supervisions (group and individual)
    - Increase staff's competency in understanding and treating COD through increased training opportunities (both registration fees and staff offset) (including but not limited to DBT, CBT, TIC, SOC, MI, ASAM, MAT, Suicide pre and post-vention , DSM-V, etc.).
    - Provide additional resources to consumers regarding COD (including but not limited to: group education materials, brochures, posters, informational packets, rack cards, multi media, etc.).
  
- **The Mental Health Center of Greater Manchester (MHCGM)**
  - DDC Re-assessment Date: February 27, 2019
  - QIP Renewal Timeline: May 2019-May 2020
  - QIP Renewal Goals:
    - Support ongoing clinical supervision (both individual and group) and supervisor capacity through consultation for supervising clinician's applications of COD interventions.
    - Increase family education group availability and frequency.
    - Expand MAT services. Including but not limited to: policy/procedure development, MAT related trainings for staff (including ASAM (up to 30% of all staff) and ECHO Collaborative (up to 20 staff, intervention protocols and related materials, etc.
    - Standardize use of Stage Wise Assessment for both mental health and substance use disorders throughout the course of treatment

- Provide additional consumer resources regarding COD (including but not limited to: brochures, posters, informational packets, rack cards, multi media, etc.).
  - Support increase of individuals obtaining and maintaining credentials through the State of NH Board of Alcohol and Drug Use Professionals
- **Pastoral Counseling Services (PCS)**
    - DDC Re-assessment Date: February 28, 2019
    - QIP Renewal Timeline: August 2019- July 2020
    - QIP Renewal Goals:
      - Support ongoing clinical supervision (both individual and group) and supervisor capacity through consultation for supervising clinician's applications of COD interventions.
      - Support attendance at monthly MLADC-led group collaboration and consultation for all clinical staff.
      - Increase staff's competency in understanding and treating COD through training efforts (including but not limited to CBT, SOC, MI and SOC Intermediate, ASAM, SUD Core Competencies, Stigma Reduction, DSM-V diagnosing of SUD, COD interventions etc.) Expect to train up to 15 staff.
      - Increase group availability for clients with SUD and/or COD by offering up to three groups, facilitated by up to two staff.
      - Increase capacity within EMR to implement, track, and report upon COD related interventions and documentation of such.
      - Increase staff's knowledge of local peer recovery support agencies and groups, and referral processes.

### *ITCOD Training and Support for Primary Care and Community Based Organizations*

Through this project, Network4Health is committed to providing evidence-based training for relevant components of identification and treatment for patients with co-occurring severe mental health and substance use disorders to our primary care and community support partners. The following courses were delivered during the January – June 2019 reporting period. A listing of all attendees can be found in Attachment\_E4.1

- SUD and Mental Health Topics
  - Substance Use Disorders Overview and Sedative/Anxiolytic/Hypnotic Disorders by [REDACTED] of NH Healthy Families, Clinical Training Department was offered on 2/26/2019. There were fourteen attendees representing six partner agencies.
  - Integrated Treatment for Co-Occurring Disorders was presented by partner agency the Mental Health Center of Greater Manchester on 2/28/2019. There were a total of twenty five attendees, representing eight partner agencies.
  - Substance Use Disorders Overview Webinar by [REDACTED] of NH Healthy Families, Clinical Training Department was offered on 3/26/2019. There were five attendees representing three partner agencies.
  - Co-Occurring Disorders and SBIRT by [REDACTED] of NH Healthy Families, Clinical Training Department, was presented at Pastoral Counseling Services on 03/08 and 03/09/19. There were a total of eight attendees.
  - Substance Use Disorders Overview with a focus on Opiates and Marijuana by [REDACTED] of NH Healthy Families, Clinical Training Department was offered on 1/25/2019 to the staff of Pastoral Counseling Center. There were a total of ten attendees.

- Motivational Interviewing delivered by partner agency, Mental Health Center of Greater Manchester was offered on 1/17/2019. There were nineteen attendees representing five agencies.
- Enhanced IMR was provided on 4/24 and 4/25/2019 and presented by partner agency Mental Health Center of Greater Manchester. There were a total of twenty two attendees from five agencies.
- Drug Recognition was offered at the Mental Health Center of Greater Manchester, and presented by Officer Nate Linstad of the Manchester Police Department on 2/19, 2/22, and 4/18/19 respectively. There were a total of eighteen attendees.
- Motivational Interviewing was presented by the Mental Health Center of Greater Manchester on 5/3/2019. There were a total of twenty one attendees, representing seven agencies.
- Stages of Change was presented by partner agency Mental Health Center of Greater Manchester on 4/11/2019. There were twenty two attendees representing four agencies.
- Substance Related & Addictive Disorders: Inhalant Related Disorders by [REDACTED] of NH Healthy Families, Clinical Training Department offered on 3/26/2019. There was one attendee.
- Substance Related and Addictive D/O: Hallucinogen Related Disorders by [REDACTED] [REDACTED] of NH Healthy Families, Clinical Training Department was offered on 4/26/2019. There were six attendees from four partner agencies.
- Mental Health First Aid
  - Twenty Correctional Officers from the Hillsborough County House of Corrections attended an Adult Mental Health First Aid course on 3/6 and 3/7/19. The course was delivered by trainers from partner agency Mental Health Center of Greater Manchester.
  - Eight staff from two partner agencies (Elliot and Catholic Medical Center) attended Adult Mental Health First Aid, delivered by trainers from partner agency Mental Health Center of Greater Manchester on 7/1 and 7/2/2019.
- Network4Health’s Co-occurring Disorders Clinical Director continues to disseminate monthly electronic and hard copy materials to support primary care and community-based support organizations interactions with and treatment of patients with co-occurring disorders. Below were topics for January – June 2019:
  - January – Post Acute Withdrawal Syndrome
  - February- Recommended Protocols developed by ITCOD for Co-occurring Disorders and Medication Assisted Treatment and Benzodiazepine Use
  - March- HIV
  - April- Special Populations Mental Health (Men, Women, Adolescents, Children)
  - May- Hepatitis
  - June- 42-CFR Considerations for Practice
- Network4Health’s Co-occurring Disorders Clinical Director responded to a national solicitation to attend a Train the Trainer Event hosted by the SAMHSA GAINS Center: “How Being Trauma-Informed Improves Criminal Justice System Responses”. The one-day training is highly interactive and specifically tailored to community-based criminal justice professionals, including police officers, community corrections personnel, and court personnel. The goal of the training is to increase understanding and awareness of the impact of trauma, develop trauma-informed responses and provide strategies for developing and implementing trauma-informed policies. The ITCOD Director began outreach efforts to applicable partner agencies in Region 4 in June, and has received a positive response from multiple agencies looking to provide the training to their staff.

- In May 2019, Network4Health’s Co-occurring Disorders Clinical Director presented at the NH NASW Annual Conference in Whitefield, NH. The topic of the 90 minute presentation was “Strengthening Your Dual Diagnosis Assessment and Treatment Skills”. The presentation was well attended with over 25 attendees, representing multiple agencies from across the State. Comments from attendees included:
  - *“Excellent integration of MH & Substance Abuse treatment”*
  - *“Great speaker, this subject matter was very helpful and I appreciated the info about how to find resources in the public domain. Encouraged focus on key points and covered them well”*
  - *“Very engaging and upbeat speaker”*
  - *“Project is very interesting... the presenter has a ton of experience and knowledge”*
  - *“Very informative”*

In addition to the above mentioned educational materials, the bi-yearly Spring/Summer 2019 Integrated Treatment of Co-occurring Newsletter was disseminated in electronic copies to partner organizations in June 2019. Topics in this issue included: ITCOD project updates, upcoming trainings, and information regarding partner agency DDC activities and progress. A copy of the newsletter is available as Attachment\_E4.2.

### **Academic Detailing**

As reported previously, the Network4Health Co-occurring Disorders Clinical Director was trained in Academic Detailing, as a related activity through a recent CDC grant provided through partner agency Manchester City Health Department. Academic Detailing is an outreach education technique that combines the direct social marketing traditionally used by pharmaceutical representatives with unbiased content summarizing the best evidence for a given clinical issue. Academic Detailing is conducted with prescribers to encourage evidence-based practices in order to improve the quality of care and patient outcomes. In partnership with the Health Department, the Mental Health Center of Greater Manchester, Catholic Medical Center, Elliot Health System and Dartmouth-Hitchcock, the trained Detailing Team has met with over 50 prescribers at four provider organizations to discuss Opioid Use Disorders and treatment approaches and barriers. A special focus has been on Buprenorphine Waiver Training. The goal is to educate prescribers on best practices and available resources, in addition to encouraging prescribers to get waived to provide Medication Assisted Treatment (MAT) as an option for patients. The Academic Detailing Project is currently in Year Two of the Grant, allowing follow up visits with prescribers from Year One, in addition to new prescribers and continued education offerings.

### **Partner Outreach**

The Network4Health Co-Occurring Disorders Clinical Director and Network4Health Executive Director continue to outreach to Network4Health partner organizations to identify additional treatment programs to be assessed utilizing the Dual Diagnosis Capability assessments for 2019 and 2020. At this time, Catholic Medical Center’s Behavioral Health Services department has agreed to participate in a Dual Diagnosis Capability assessment in the fourth quarter of 2019.

### **Progress Assessment**

To support multiple requests across participating DDC assessment organizations, the Integrated Treatment of Co-occurring Disorders Community of Practice was held twice and focused on *Motivational Interviewing Resources for Clinical Supervisors* with [REDACTED], MSSA, LISW, LICDC, Director of Consulting and Training for Substance Abuse and Mental Illness (SAMI) initiatives at the Center for Evidence Based Practice at Case Western Reserve University. All Network4Health partner programs that have completed a Dual Diagnosis Capability assessment were invited to participate in a one hour

webinar in May and June 2019. Module 2, offering a continuation of Module 1 with expanded resources and suggested practices for will also be held twice at Community of Practice Meetings in July 2019. The Integrated Treatment of Co-occurring Disorders Advisory Board also met in June 2019 to review the accomplishments of the project, discuss themes and brainstorm additional focal areas the project might be able to accomplish during the waiver period.

## **Project Targets**

*Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include*

- *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		
		12/31/18	6/30/19	12/31/19
The number of staff trained in identifying individuals with co-occurring conditions and referring them for treatment.	<p>Targets will continue to be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization.</p> <p><b>The following targets have been identified in current Quality Improvement Plans:</b></p> <p><u>-Stages of Change and Motivational Interviewing Training:</u>            CLM: up to 41 staff            FIT-NH: up to 14 staff            MHCGM: up to 30 staff            PCS: up to 20 staff (Target for 2019)</p> <p><u>-Overcoming Stigma Training:</u>            FIT-NH- up to 10 staff            PCS: up to 20 staff (Target for 2019)</p> <p><u>-Substance Use Disorder Core Competencies:</u>            CLM- up to 41 staff            PCS: up to 20 staff (Target for 2019)</p>	<p><u>Motivational Interviewing I:</u>            PCS:5 staff            CLM:31 staff            FIT- NH: 29 staff            MHCGM: 8 staff</p> <p><u>Motivational Interviewing for Supervisors:</u>            CLM: 17 staff            FIT-NH: 7 staff</p> <p><u>Stages of Change:</u>            CLM: 68 staff            MHCGM: 38 staff</p> <p><u>Overcoming Stigma Training:</u>            FIT-NH: 22 staff</p> <p><u>Substance Use Disorder Core Competencies:</u>            CLM: 2 staff (multi-day training)            FIT-NH: 2 staff (multi-day training)</p>	<p><u>Motivational Interviewing I:</u>            CLM:31 staff            FIT- NH: 29 staff            MHCGM: 26 staff            PCS:8 staff</p> <p><u>Motivational Interviewing for Supervisors:</u>            CLM: 20 staff            FIT-NH: 8 staff            MHCGM: 8 staff</p> <p><u>Stages of Change:</u>            CLM: 68 staff            MHCGM: 50 staff            PCS: 8 staff</p> <p><u>Overcoming Stigma Training:</u>            FIT-NH: 22 staff</p> <p><u>Substance Use Disorder Core Competencies:</u>            CLM: 13 staff            FIT-NH: 4 staff            MHCGM: 36            PCS: 18 staff</p>	
The number of staff trained as Program Leaders for Integrated Treatment of Co-Occurring Disorders programs.	Up to 25 in 2018	19	19	

Performance Measure Name	Target	Progress Toward Target		
<p>The number of organizations assessed for fidelity to evidence based practice for the integrated treatment of co-occurring disorders. The measure will include a total count of organizations assessed by the DDCAT or DDCMHT index, as well as the count of organizations by dual diagnosis capability continuum designation:</p> <ul style="list-style-type: none"> <li>• Addiction-only services (AOS)</li> <li>• Mental Health-only services (MHOS)</li> <li>• Dual-diagnosis capable (DDC) <ul style="list-style-type: none"> <li>○ AOS/DDC</li> <li>○ MHOS/DDC</li> <li>○ DDC</li> </ul> </li> <li>• Dual-diagnosis enhanced (DDE) <ul style="list-style-type: none"> <li>○ DDC/DDE</li> <li>○ DDE</li> </ul> </li> </ul>	<p>December 2017: Up to 4  June 2018: Up to 5  December 2018: Up to 3</p>	<p>1 additional organizational program assessed (total 6)</p> <p>To date, all organizations have been assessed as Dual-diagnosis capable (DDC), however there is significant variation between organizations within the designation range.</p>	<p>2 additional organizational programs assessed (total 8)</p> <p>4 organizational programs re-assessed</p> <p>To date, all organizations have been assessed as Dual-diagnosis capable (DDC), however there is significant variation between organizations within the designation range.</p>	

Performance Measure Name	Target	Progress Toward Target	
<p>The number of patients served in evidence based integrated treatment of co-occurring disorders programs.</p>	<p>As part of their Quality Improvement Plan funding, E4 partners have agree to report the following client counts:</p> <ul style="list-style-type: none"> <li>Count of Medicaid patients with co-occurring disorders (COD) served by the Service Provider program(s) assessed using the Dual Diagnosis Capability Index in the last 12 months (last month of the reporting period looking 12 months back)</li> </ul> <p>Participating E4 partners will be expected to demonstrate incremental year over year increases in 2019 and 2020 to the volume of patients with co-occurring disorders served by their organization. The 2018 data will be used as a baseline for this assessment.</p>	<p>Total Medicaid clients with a co-occurring disorder in Integrated Treatment Programs:</p> <p><b><u>MHCGM:</u></b> 1/2018-12/2018: 696 clients</p> <p><b><u>FIT-NH:</u></b> 1/2018-12/2018: 322 clients</p> <p><b><u>CLM:</u></b> 1/2018-12/2018: 313 clients</p> <p><b><u>PCS:</u></b> 1/2018-12/2018: 49 clients</p> <p><b><u>Parkland:</u></b> Reporting to begin after completion of Quality Improvement Plan (QIP).</p>	<p>Total Medicaid clients with a co-occurring disorder in Integrated Treatment Programs:</p> <p><b><u>MHCGM:</u></b> 7/2018-6/2019: 761 clients</p> <p><b><u>FIT-NH:</u></b> 7/2018-6/2019: 435 clients</p> <p><b><u>CLM:</u></b> 7/2018-6/2019: 407 clients</p> <p><b><u>PCS:</u></b> 7/2018-6/2019: 33 clients</p> <p><b><u>Parkland:</u></b> Reporting to begin after completion of Quality Improvement Plan (QIP).</p>

## 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.*

The Integration of Co-Occurring Disorders Treatment budget is presented below. Modifications have been made based on the following factors:

Revenue- Project budgets have been adjusted to reflect the actual receipt of funding. The anticipated, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced due to ongoing negotiations with NH counties or as a result of unmet DSRIP project performance metrics, Network4Health will revise budgets and project plan deliverables subject to Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) for the period of January to June 2019 are presented. Anticipated expenses (including those for the current reporting period) are projected in subsequent reporting periods. Given that final incentive funding is not expected until mid-2021, we have projected expenses in that period as we conclude the waiver projects.

	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4) Jan to June	PROJECTED CY 2019 (Yr4) July to December	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
<b>TRANSFORMATON FUNDS</b>						
E4 INTEGRATED TX COD Revenue (New)	\$ 230,012	\$ 174,809	\$ 313,963	\$ 431,276	\$ 468,542	\$ 238,530
E4 INTEGRATED TX COD Revenue (Rollover)		\$ 221,683	\$ 330,197	\$ 502,524	\$ 301,358	\$ 1,481
<b>Total Revenue</b>	<b>\$ 230,012</b>	<b>\$ 396,492</b>	<b>\$ 644,160</b>	<b>\$ 933,800</b>	<b>\$ 769,900</b>	<b>\$ 240,011</b>
<b>Assessor Participation Offset (Training and Assessment Time)</b>	\$ 6,848	\$ 2,970	\$ 1,402	\$ 49,161	\$ 50,563	
<b>Program Leader Training (2018) Attendee Participation Offset</b>		\$ 6,160				
<b>Leader Training (2019) and Attendee Participation Offset</b>			\$ -	\$ 22,659		
<b>Quality Improvement Plan Funds</b>		\$ 39,891	\$ 137,496	\$ 521,504	\$ 676,000	\$ 216,000
<b>Assessor Training Course Development and Delivery</b>			\$ -	\$ 3,150	\$ 3,150	\$ 3,150
<b>Tools &amp; Training for Primary Care and Community Support Technology (Laptop, Phone, etc.)</b>	\$ 1,218	\$ 1,515	\$ 563	\$ 1,131	\$ 1,694	\$ 1,694
<b>Occupancy</b>	\$ 263	\$ 1,575	\$ 766	\$ 1,246	\$ 2,012	\$ 1,016
<b>Total Expenses</b>	<b>\$ 8,329</b>	<b>\$ 66,295</b>	<b>\$ 141,636</b>	<b>\$ 632,442</b>	<b>\$ 768,419</b>	<b>\$ 239,360</b>
<b>Variation to Budget (Transfer Funds to Subsequent Year)</b>	\$ 221,683	\$ 330,197	\$ 502,524	\$ 301,358	\$ 1,481	\$ 651

<b>Training Attendance Tracking</b>
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Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Director	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	NH Healthy Families	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Residential Counselor	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Consultant	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Residential Counselor	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Rockingham County	Case Manager	6
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	NH Healthy Families	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Spaulding Youth Center	Case Manager	5
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Residential Counselor	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Riverbend CMHC CMHC	Clinician	2
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Case Manager	4
Motivational Interviewing	1/17/2019	[REDACTED]	[REDACTED]	Mental Health Center of Greater Manchester	Case Manager	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Director	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4
Opiates and Marijuana- QIP Activity	1/25/2019	[REDACTED]	[REDACTED]	PCS	Clinician	4

<i>Opiates and Marijuana- QIP Activity</i>	1/25/2019	█	█	PCS	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	MCHC	SUD Supervisor	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Center for Life Management	Nurse Navigator	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Moore Center	Clinical Director	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Catholic Medical Center	Nurse Practitioner	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Center for Life Management	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Dartmouth Hitchcock	Psychologist	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Mental Health Center of Greater Manchester	Case Manager	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Catholic Medical Center BH	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Center for Life Management	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Center for Life Management	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders</i>	2/26/2019	█	█	Center for Life Management	Clinician	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Peer Support	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Case Manager	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Peer Support	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	█	█	Mental Health Center of Greater Manchester	Nurse	4

<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Case Manager</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Center for Life Management</i>	<i>Supervisor</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Elliot PHP</i>	<i>CRSW</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Center for Life Management</i>	<i>Clinician</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>New Era Medicine</i>	<i>Social Worker</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Parkland Medical</i>	<i>Clinician</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Parkland Medical</i>	<i>Clinician</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Granite Pathways</i>	<i>Staff Generalist</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Center for Life Management</i>	<i>Team Lead</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Hillsborough County Nursing Home</i>	<i>Director</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Center for Life Management</i>	<i>Case Manager</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Elliot PHP</i>	<i>RN</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Elliot PHP</i>	<i>Case Manager</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Elliot PHP</i>	<i>MAT Therapist</i>	4
<i>Integrated Treatment for Co-Occurring Disorders</i>	2/28/2019	████	████	<i>Parkland Medical</i>	<i>RN</i>	4
<i>Substance Use Disorders Overview Webinar</i>	3/26/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>VP</i>	4
<i>Substance Use Disorders Overview Webinar</i>	3/26/2019	████	████	<i>Fusion Health Services</i>	<i>Nurse Practitioner</i>	4
<i>Substance Use Disorders Overview Webinar</i>	3/26/2019	████	████	<i>FIT-NH</i>	<i>COO</i>	4
<i>Substance Use Disorders Overview Webinar</i>	3/26/2019	████	████	<i>Manchester Community Health Center</i>	<i>Coordinator</i>	4
<i>Substance Use Disorders Overview Webinar</i>	3/26/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Assistant Coordinator</i>	4
<i>Substance Related &amp; Addictive D/O: Inhalant Related Disorders</i>	3/26/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Director</i>	4
<i>Stages of Change</i>	4/11/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>CRSW</i>	4
<i>Stages of Change</i>	4/11/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	4
<i>Stages of Change</i>	4/11/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Residential Counselor</i>	4
<i>Stages of Change</i>	4/11/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>ProHealth Counselor</i>	4
<i>Stages of Change</i>	4/11/2019	████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	4

Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	Clinician	4
Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	Clinician	4
Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	Clinician	4
Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	Counselor	4
Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	Clinician	4
Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	CRSW	4
Stages of Change	4/11/2019			Mental Health Center of Greater Manchester	Supervisor	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			CREATE Counseling Center	Clinician	4
Stages of Change	4/11/2019			Riverbend CMHC CMHC	Clinician	2
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Stages of Change	4/11/2019			Pastoral Counseling Services	Clinician	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Coordinator	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Clinician	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Benefits Administrator	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Director	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Clinician	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Nurse	4
Drug Recognition	4/18/2019			Mental Health Center of Greater Manchester	Case Manager	4
Substance Related and Addictive D/O : Hallucinogens	4/26/2019			Mental Health Center of Greater Manchester	Director	4
Substance Related and Addictive D/O : Hallucinogens	4/26/2019			Mental Health Center of Greater Manchester	VPO	4

Substance Related and Addictive D/O : Hallucinogens	4/26/2019			Fusion Health Services	NP	4
Substance Related and Addictive D/O : Hallucinogens	4/26/2019			Manchester Community Health Center	Prenatal SUD Care Coordinator	4
Substance Related and Addictive D/O : Hallucinogens	4/26/2019			Elliot PHP	Director, Substance Use Services	4
Substance Related and Addictive D/O : Hallucinogens	4/26/2019			FIT-NH	VP	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	Patient Navigator	4
Motivational Interviewing	5/3/2019			Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Mental Health Center of Greater Manchester	Clinician	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Mental Health Center of Greater Manchester		4
Motivational Interviewing	5/3/2019			Pastoral Counseling Services	Clinician	4
Motivational Interviewing	5/3/2019			NFI North		
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	Patient Navigator	4
Motivational Interviewing	5/3/2019			Pastoral Counseling Services	Clinician	4
Motivational Interviewing	5/3/2019			City of Manchester NH Welfare Department	Case Manager	4
Motivational Interviewing	5/3/2019			Concord VNA	Nurse	2
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Catholic Medical Center	RN	4
Motivational Interviewing	5/3/2019			Pastoral Counseling Services	Clinician	4
Motivational Interviewing	5/3/2019			Mental Health Center of Greater Manchester	Clinician	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19			PCS	Clinician	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19			PCS	Director	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19			PCS	Clinician	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19			PCS	Clinician	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19			PCS	Clinician	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19			PCS	Clinician	4

Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19	█	█	PCS	Clinician	4
Co-Occurring Disorders and SBIRT: QIP Activity	03/08 and 03/09/19	█	█	PCS	Clinician	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	MA	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Accounting	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Benefits Administrator	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Benefits Administrator	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	CEO	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Benefits Administrator	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Benefits Administrator	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Benefits Administrator	4
Drug Recognition	2/19 and 2/22/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Supervisor	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Lieutenant	4

Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Lieutenant	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Correctional Officer	4
Mental Health First Aid	3/6/19 and 3/7/19	█	█	Hillsborough County Department of Corrections	Lieutenant	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Harbor Homes	Case Manager	
Enhanced IMR	4/24 and 4/25/2019	█	█	VAMC	Clinician	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Medication Services	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Riverbend CMHC CMHC	Clinician	2
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	CRSW	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Residential Counselor	4
Enhanced IMR	4/24 and 4/25/2019	█	█	VAMC	Clinician	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	ProHealth Counselor	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Harbor Homes	Case Manager	3
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Case Manager	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Residential Counselor	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Hreater Manchester	Case Manager	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Residential Counselor	4
Enhanced IMR	4/24 and 4/25/2019	█	█	Riverbend CMHC CMHC		2
Enhanced IMR	4/24 and 4/25/2019	█	█	Mental Health Center of Greater Manchester	Clinician	4

Attachment\_E4.1

<i>Enhanced IMR</i>	<i>4/24 and 4/25/2019</i>	████	██████	<i>Center for Life Management</i>	<i>Clinician</i>	<i>4</i>
<i>Enhanced IMR</i>	<i>4/24 and 4/25/2019</i>	██████	██████	<i>Center for Life Management</i>	<i>Clinician</i>	<i>4</i>
<i>Enhanced IMR</i>	<i>4/24 and 4/25/2019</i>	██████	████	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
<i>Enhanced IMR</i>	<i>4/24 and 4/25/2019</i>	████	██████	<i>Mental Health Center of Greater Manchester</i>	<i>Counselor</i>	<i>4</i>
<i>Enhanced IMR</i>	<i>4/24 and 4/25/2019</i>	████	████	<i>VAMC</i>	<i>Clinician</i>	<i>4</i>
<i>Enhanced IMR</i>	<i>4/24 and 4/25/2019</i>	████	██████	<i>VAMC</i>	<i>Clinician</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	██████	████	<i>Catholic Medical Center</i>	<i>Primary Care Navigator</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	████	██████	<i>Catholic Medical Center</i>	<i>Primary Care Navigator</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	████	██████	<i>Catholic Medical Center</i>	<i>Scheduling Coordinator</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	████	██████	<i>Catholic Medical Center</i>	<i>Care Coordinator/RN</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	██████	██████	<i>Catholic Medical Center</i>	<i>RN</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	████	██████	<i>Catholic Medical Center</i>	<i>Care Coordinator/RN</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	████	████	<i>Catholic Medical Center</i>	<i>Care Coordinator/RN</i>	<i>4</i>
<i>Adult Mental Health First Aid</i>	<i>7/1 and 7/2/2019</i>	████	██████	<i>Elliot Hospital/PHP</i>	<i>Case Manager</i>	<i>4</i>

# Integrated Treatment of Co-Occurring Disorders (ITCOD) Newsletter

Welcome to the fourth issue of the ITCOD newsletter! The purpose of the newsletter is to inform our Region 4 partner agencies of the current and upcoming happenings in relation to the Integrated Treatment of Co-Occurring Disorders Project

## INSIDE THIS ISSUE:

**DDC Updates**

1-2

**Trainings and Education**

3

**Self Care**

4

*ITCOD is issuing this newsletter as a part of our commitment to Performance Measures as set forth to the State of NH; you can expect more issues over the duration of the Waiver, on a bi-annual basis.*

Questions? Comments?

Please contact [REDACTED], LICSW, MLADC Director, Integrated Treatment for Co-Occurring Disorders at sawverka@mhcgm.org or 603-623-

## Dual Diagnosis Capability Assessment UPDATES!

**To date, we have completed program assessments at the following partner agencies:**



## DDC Assessment **UPDATES** continued...

- ❖ **The four programs that had DDC Assessments completed in 2018, have had one year follow up assessments, targeted at evaluating their original QIP objectives for increasing dual diagnosis capability** (see below for additional information)
  - *All four QIPs for Year 2 have been developed and approved, allowing for ongoing funding of initiatives!*
- ❖ **Three new programs have completed initial DDC assessments between Fall 2018 and Spring 2019**
  - *Year 1 QIPs for the three programs are in process of development and approval!*
  - *Agencies will be focused on increasing COD services through:*
    - *IT/EMR Changes and Additions*
    - *Training Opportunities*
    - *Supervision and Support for Staff*
    - *Increasing Use of COD Treatment Interventions*
- ❖ **An additional partner agency has committed to a DDC Assessment in Fall of 2019**

**After completing the four follow up DDC assessments we are excited to report that every program showed an increase in regards to the services they provide for co-occurring disorders! There was an average increase of .25% in 6 of the 7 performance domains!**

<b>Program Structure</b>	<b>Milieu</b>	<b>Assessment</b>	<b>Treatment</b>	<b>Staff</b>	<b>Training</b>
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***This is especially impressive given that organizational change often takes years!***

## HELPFUL ACRONYMS

SUD: Substance Use  
Disorder(s)

MH: Mental Health  
Disorder/Diagnosis

N4H: Network for Health

DDC: Dual Diagnosis  
Capability Assessment

COD: Co-Occurring  
Disorders

MAT: Medication Assisted  
Treatment (ie

Buprenorphine,  
Methadone, Naltrexone,  
etc).

QUD: Opioid Use Disorder

QIP: Quality Improvement  
Plan

## Academic Detailing continues for Year 2....

Manchester Health Department received grant from the CDC to explore, plan, and implement innovative Academic Detailing and collaborative approaches to support efforts to combat the opioid crisis within our community.

We are in Year 2 of grant funding and continue to meet with prescribers in the Manchester area offering support and resources related to OUD treatment options, MAT, Opioid prescribing practices, and updated, local statistics.

## TRAINING OFFERINGS SUPPORTED BY ITCOD IN 2019...

\*Indicates upcoming training

### NH Health Families Webinars (promoted by ITCOD)

SUD Overview and Sedative/Anxiolytic/Hypnotic Disorders    SUD Hallucinogens

\*SUD Inhalants    \*DSM 5 SUD Overview    \*Poverty Competence    \*Non-Suicidal Self Injury

\*Psychotropic Medications

### Mental Health First Aid (offered at least 1x/quarter)

\*YOUTH COURSE: June 24<sup>th</sup> and July 1<sup>st</sup> 12-4pm both days at 5 Blodget St, Manchester  
(contact MHCGM to register)

### Additional Trainings

Integrated Treatment for Co-Occurring Disorders (IDDT)

Enhanced IMR

Motivational Interviewing

Stages of Change

Strengthening Dual Diagnosis Capability (Presented by Director at NH NASW Annual Conference)

\*Trauma Informed Responses for Criminal Justice Systems  
(to be offered to any agency along the criminal justice continuum, as well as agencies that work with individuals involved within that system)

*Monthly resources continue to be sent both electronically and through USPS mail with good feedback from partners ... keep your eye out!*

# Now get out there and enjoy the weather!

## 9 Worthwhile Hiking Trails to New Hampshire Waterfalls

(adapted from: <https://newengland.com>)

### Basin-Cascades Trail | Lincoln

**Length:** Up to two miles round-trip

**Rating:** Easy



### Arethusa Falls | Hart's Location

**Length:** Three miles round-trip or five-mile loop

**Rating:** Moderate to difficult



### Rainbow Falls | Plymouth

**Length:** 1.5 miles

**Rating:** Easy



### Diana's Baths | Bartlett

**Length:** One mile round-trip or up to 10 miles

**Rating:** Easy to moderate



### Nancy Cascades | Livermore

**Length:** Five to 10 miles round-trip

**Rating:** Moderate to difficult



### Falling Waters Trail | Franconia

**Length:** Six miles round-trip or nine-mile loop

**Rating:** Moderate to difficult



### Ripley Falls | Hart's Location

**Length:** 1.2 miles round-trip

**Rating:** Easy to moderate



### Zealand Falls | Bethlehem

**Length:** Six to 10 miles round-trip

**Rating:** Moderate



### Bridal Veil Falls | Franconia

**Length:** Five miles round-trip

**Rating:** Moderate



## **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 Narrative**

*Provide a brief narrative which speaks to the following:*

- *Describe how the IDN is aligning performance metrics to the MCO APMs*
- *Identify partners who are currently participating in or in the planning process for MCO APMs*

Throughout the reporting period, Network4Health has assertively pursued efforts to explore, consider, and expand awareness of value based reimbursement for health related services among our network partners.

Educational opportunities related to Alternative Payment Models (APM) include:

- Regular meetings of the Network4Health B1 Integrated Care Work Group include information sharing related to alternative payment models.
- Our two community mental health center partners- Center for Life Management and The Mental Health Center of Greater- are participants in the Northern New England Practice Transformation Network which looks to achieve the quadruple aim: improved health outcomes, with a better patient care experience, at a lower cost, and with higher provider satisfaction. Alternative payment models are key to seeking these goals.
- Network4Health March 2019 "All Partners Quarterly Meeting" featured a presentation by Amerihealth Caritas, NH's newest Medicaid MCO, including an introduction of their company with a focus on experience with Alternative Payment Models (APM's) in other states.
- On June 14, 2019, Cherokee Health Systems provided a one day consultation to Network4Health B1 Integrated Healthcare partners including a focus on value based contracting.
- On June 26, 2019, Network4Health staff and partners attended a presentation by Jo Porter, Director of the UNH Institute for Health Policy and Practice, on "Value-Based Public & Private Payment Landscape in New Hampshire.

Network4Health staff have participated in multiple meetings with the three NH Medicaid MCOs. Meetings have included discussion of the APM requirements within MCO contracting.

Network4Health staff has conducted a thorough review of the requirements for Alternative Payment Models within the MCO Services Contract with the State. These contract terms are in alignment with the Alternative Payment requirements that exist within the Special Terms and Conditions for the New Hampshire Building Capacity for Transformation section 1115(a) Medicaid demonstration.

MCO contracts include the following:

- A requirement to expand the use of alternative payments so that 50% of all MCO medical payments are in Qualifying APM's.
- Qualifying APM's, selected by the MCO, shall meet the requirements for the HealthCare Payment and Learning & Action Network (HCP-LAN) APM Framework at a Category 2C (which requires Pay-for Performance programs that reward delineated quality performance metrics). In addition, MCO's are required to pursue increased levels of APMs along the Framework continuum of clinical and financial risk for provider organizations.
- Achievement priorities for APM include: decrease unnecessary service utilization; reduce preventable admissions and thirty (30) day hospital readmissions; improve timeliness of prenatal care and reduction of Neonatal Abstinence Syndrome; improve integration of physical and behavioral health; better manage pharmacy utilization; enhancement of access to and effectiveness of Substance Use Disorder treatment; and opportunities to address social determinants of health.

As part of implementation of the NH Transformation Waiver, Network4Health and its partners have been directly and indirectly making efforts to accomplish the requirements identified above. We look forward to collaboration with the NH Medicaid MCOs in achieving these important goals. We offer support and cooperation as the MCOs formulate APM implementation plans in accordance with the APM Strategy adopted by the NH DHHS.

It is important to note that Network 4Health provider partners are currently negotiating contracting with the MCO's. As a part of provider contracting, it is anticipated that requirements for APM implementation will be negotiated.