

**New Hampshire
Department of Health and Human Services**

***Building Capacity for Transformation Waiver
Integrated Delivery Network
Semi-Annual Report
(July – December 2019)***

***Network4Health (IDN 4)
April 1, 2020***



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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 sixth Semi Annual Report outlining achievements during the July 1, 2019 through December 31, 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:

- As part of our network wide focus on trauma informed care, our Director of Integrated Treatment of Co-Occurring Disorders Project (E4) trained at the Substance Abuse Mental Health Services Administration (SAMSHA) Gains Center for Behavioral Health and Justice Transformation to teach “Trauma Training for Justice Professionals”. Thus far, this four hour training has been provided to 104 staff members of the Hillsborough County Department of Corrections. An offer to train staff at the Rockingham County Department of Corrections, as well as the Hillsborough and Rockingham County Attorney’s Offices, have been extended. Contacts have been made with three community law enforcement agencies within our region to offer training to them as well.
- For nearly two years, Network4Health has partnered with the Manchester Community College and Granite State College to offer scholarships to students enrolled in health related programs. We are pleased to report that the University of New Hampshire, College of Health and Human Services is now offering Network4Health sponsored scholarships to their students.
- The City of Manchester’s Mayor has activated a community Emergency Operations Center (EOC) to address the public health crisis that has resulted from homelessness

and substance misuse in the city. Eleven Network4Health partner organizations are represented on the EOC leadership team. 5 members of the N4H Steering Committee and the N4H Executive Director serve on the EOC leadership team.

The unresolved funding negotiations with NH Counties continues to represent significant concern for Network4Health leadership as well as network partners who have been implementing initiatives with waiver funding. Network4Health is committed to continuing current program implementation but understands that funding decreases will necessitate reevaluation of all project priorities and may require modifications to project plans.

Beginning in 2019, 100% of waiver 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 are reported and analyzed.

Administration

During the reporting period, there has been one change the executive leadership of Network4Health. The Care Transitions Project Director left her position in the program. Consistent with ongoing sustainability planning for post waiver operations, the Care Transitions program was placed administratively within the Acute and Transitional Care Services of network partner, The Mental Health Center of Greater Manchester. Coordination of the program has been assigned to a newly hired assistant coordinator who had previously served as a Transitions Coach on the project team. Also, the Associated Executive Director has left the project and there is no plan to fill that position. All other Network4Health leaders continue to operationalize project plans.

Soliciting Community Input

Network4Health operates in 2 of NH's 13 public health regions. The South Central Public Health Region includes the communities of: Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Sandown, Salem, and Windham. The Greater Manchester Public Health Region includes the communities of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Manchester and New Boston.

In collaboration with our Regional Public Health Networks, Network4Health Community Outreach Coordinators facilitated six (6) focus group/community engagement sessions with stakeholders and consumers. A set of predetermined questions have been utilized to evaluate improvements and/or challenges/barriers from the perspective of both providers and clients. This qualitative data has proven invaluable to our work and helps us to answer the question 'why' when we look at quantitative data sources and see gaps.

Groups were held in the following locations with 54 total participants:

- a. Elliot Hospital Patient Family Advisory Council (9 participants, 7 female, 2 male) Manchester, NH
- b. Catholic Medical Center Patient Family Advisory Council (12 Participants, 8 female, 4 male) Manchester, NH
- c. Amoskeag Health (formerly Manchester Community Health Center)(5 participants, 2 male, 3 female) Manchester, NH
- d. Crossroads Recovery Center (9 participants, 2 female, 7 male) Salem, NH
- e. Parkland Medical Center Partial Hospitalization Program (9 participants, 9 female, 0 male) Derry, NH
- f. NAMI (10 participants, 8 female, 2 male) Derry, NH

Standard Questions

1. Have you or someone you know had trouble obtaining or accessing health care and, if yes, what were some of the reasons?
2. Tell us a little bit more about access to 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?

The participant feedback from this reporting period's focus groups is consistent with what has been documented in previous reports. This information is valuable in identifying areas for further improvements in care delivery.

Key Findings/Themes

Biggest barriers to care access

- Insurance
 - Primary Care trying to treat mental illness when not qualified
 - With public insurance (Medicaid) I feel like just a number in the system but with private insurance feels like a person
 - Private insurance can sometimes offer more treatment options but at other times is more restrictive in accessing SUD treatment
 - Coverage is not transparent and understandable
 - Denied services without explanation
 - Confusion over what is In-network vs. out of network
 - Not covering medications
- Cost
 - Self- pay is cheaper than private insurance
 - Large co-pays
- Waiting periods
 - Lack of beds at stabilization center/shelter
 - Lack of treatment beds available

- Lack of affordable housing
- Appointments with specialists
- Workforce shortage
 - Lack of medical professionals trained to handle SUD crisis
 - Lack of advocates
- Lack of resources available in the community
 - Inaccurate diagnoses
 - Lack of coverage for dental
 - Transportation
 - Not enough dual diagnosis treatments available
- Stigma
 - Nurses/staff not empathetic to someone in crisis; Say they are “babysitting”
 - ERs only want to deal with physical issues
 - Stigma of homelessness

Additional barriers

- Lack of nighttime IOP programs available in area
- No mental health ER (South Central doesn't not have Mobile crisis unit)
- No case managers in ER
- Some people are waiting in ER for days for a bed for a mental health bed. No care is given during this time
- Catchment areas for organizations (mental health centers) is a hassle
- Lack of training for Police Departments in mental health crisis
- Lack of after-care following a crisis
- Caregivers of adult children are being left out of care planning
- Language barriers, telephone translation isn't available in specialist's office
- Information and materials use language that can't be understood
- Specialists not taking patients after referral
- Immigration status
- Cultural barriers
- Prevention/ treatment programs are not inclusive of minorities
- Minorities are at a high risk for exposure but are not receiving the prevention needed
- Lack of dermatologists in area
- Lack of Gastro-intestinal specialists

What is going well

- NH Healthy Families (especially for children) is helpful
- Clinicians listing specialties clearly, trial and error to find a match
- Emergency services program in Parkland

Suggestions for improvements

- 24/7 mental health/support hotline
- Make support groups more visible
- Publish materials at a 5th grade reading level instead of the standard 8th grade level

Network4Health Community Outreach Coordinators represent our IDN on multiple community meetings, task forces, and activities related to substance use treatment and prevention. A list of activities and meetings during the reporting period includes:

Greater Manchester Happenings

1. Manchester Safe Station – Assist to coordinate Safe Station partners.
2. Advocated for the continuation of Safe Station as an access point in our community at a Manchester Aldermanic meeting.
3. Linking Actions for Unmet Needs in Children’s Health- “LAUNCH”- advisory committee.
4. Mentor for the Certified Prevention Specialist board and will be attending a certification “Kick Off” on in January 2020.
5. City of Manchester Mayor’s Homelessness Task-force meetings. These meetings have transitioned into an Emergency Operations Center (EOC)/Incident Command Structure (ICS).
6. Leadership provided to recovery ministries within the faith based community to better leverage community resources. Currently the Good Samaritan Network has over 50 Recovery Ministries with a goal of over 100 by the end of 2020.
7. Southern NH Planning Commission- working on a substance use story mapping project.
8. The Manchester Perinatal SUD Alliance at Amoskeag Health. The PSUD Alliance provides support for new mothers in recovery and monitors cases of Neonatal Abstinence Syndrome (NAS).
9. Facilitates the Greater Manchester Substance Use Disorder Collaborative.
10. Youth Collaborative meetings that are focused on substance use disorder treatment and prevention.
11. The Doorways/211 stakeholder meetings.

South Central Happenings

1. South Central Regional Public Health Leadership Team- assists in the coordination of meetings.
2. Derry Mental Health Alliance meetings.
3. Southern NH Human Services Council meetings.
4. Healthy Londonderry Community Wellness Night- co hosted event that included Narcan training.
5. Project First- assisted with education and communications for a post overdose response grant operated by the Salem Fire Department.
6. The Doorways/211- Assisted with partner connections and information sharing.

7. MAT Development in South Central- facilitated relationships between Better Life Partners and community partners in an effort to expand Medicated Assisted Treatment access in the region. This has led to the beginnings of a MAT clinic in Hampstead.
8. Hepatitis A Clinics- The South Central Community Outreach Coordinator has been assisted the Public Health Emergency Preparedness coordinator the SCPHN in hosting Hepatitis A clinics in the region.
9. Turn the Tide Act Senator Round Table- invited to be a part of Senator Shaheen's roundtable discussion at the Derry Municipal Center.

N4H Executive Director represents the network at the Greater Manchester Regional Public Health Network SUD Continuum of Care Collaborative; Hillsborough County Coalition on Mental Health and Justice; Derry Mental Health Alliance; Stand Up Salem; South Central Regional Public Health Network Leadership Team; Manchester Mayor's Council on Prevention, Treatment and Recovery; Well Sense Provider Advisory Council; and, the Manchester Emergency Operations Center on Homelessness and Addiction.

Network Development

During this reporting period, there have been no additions or deletions 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 September and December 2019. Our September meeting featured a review by the City of Manchester Public Health Director of the newly released Manchester Community Health Needs Assessment. Our December meeting featured an overview of health information technology investments that have been made and are planned to be made during the term of the NH 1115 Transformation Waiver. Both meetings dedicate time for network partner announcements and introductions.

Governance

The Network4Health Steering Committee met monthly throughout the reporting period with one exception. The November 2019 was canceled due to a conflict for several members who also serve on the Manchester Emergency Operations Center that was created to address the existing substance use disorder and housing public health crisis in the City. A narrative summary of network operations and financial report were provided by the Executive Director to the Steering Committee.

Ongoing Steering Committee priorities include funding uncertainty related to NH county participation and program sustainability subsequent to the termination of the NH 1115 Transformation Waiver. Network4Health is ready and able to assist in community responses to

opportunities that may be presented including but not limited to the recently announced Maternal Opioid Misuse Grant (awarded to NH DHHS, with Elliot Health System as the lead agency); Local Care Management Network planning and implementation; the NH Mental Health 10 Year Plan implementation and future initiatives surrounding NH Long Term Services and Supports.

Budget

Network4Health has 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	CY 2019 Actuals	CY 2020 Projected	CY 2021 Projected
PPI	\$67,559	\$523,029	\$732,500	\$668,031	\$1,817,000	\$1,408,771
A1	\$0.00	\$37,216	\$290,590	\$867,229	\$2,086,400	\$1,919,400
A2	\$0.00	\$36,268	\$713,415	\$1,011,588	\$1,811,604	\$1,628,279
B1	\$0.00	\$2,800	\$627,580	\$2,479,019	\$4,473,018	\$4,303,018
C	\$0.00	\$11,121	\$250,251	\$286,214	\$654,784	\$654,784
D	\$0.00	\$0.00	\$0.00	\$929,082	\$468,542	\$459,563
E	\$0.00	\$8,329	\$66,295	\$232,194	\$790,515	\$759,856

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. Current salaries covered by the salaries and benefits for 6.45 FTEs including the Executive Director (1.0 fte), Project Management (1.2 fte), Finance Coordinator (1.0 fte), Community Project Leadership (2.25 fte) and Community Education Coordinators (1.0 fte). Consulting services during the reporting period were provided by Bailit Health. Our total Project Design and Capacity Building (PDCB) expense for calendar year 2018 was \$668,031. Total invoiced and paid expenses for PDCB since inception is \$1,991,119.

PROJECT DESIGN AND CAPACITY BUILDING	ACTUAL CY 2016 (Yr1)	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
Total Revenue	\$5,216,890					
Rollover		\$5,149,331	\$4,626,302	\$3,893,802	\$3,225,771	\$1,408,771
Total Revenue	\$5,216,890	\$5,149,331	\$4,626,302	\$3,893,802	\$3,225,771	\$1,408,771
Salary & Benefits		\$473,355	\$639,365	\$651,434	\$710,000	\$355,071
Consulting						
Project Team Support and other N4H administrative support		\$1,826	\$58,268	\$841	\$1,050,000	\$996,700
Quarterly Meeting Expenses		\$1,226	\$1,973	\$1,081	\$6,000	\$6,000
Office Supplies		\$289	\$3,787	\$1,738	\$6,000	\$6,000
Total Other		\$3,340	\$64,028	\$3,660	\$1,062,000	\$1,008,700
Total Expenses	\$67,559	\$523,029	\$732,500	\$668,031	\$1,817,000	\$1,408,771
Variation to Budget (Transfer Funds to Subsequent Year)	\$5,149,331	\$4,626,302	\$3,893,802	\$3,225,771	\$1,408,771	\$ (0)

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.

Include in your narrative detail of Key Organizations and Providers that have been off-boarded as well as new partners and the effective date of the change.

In this section Network4Health provides 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

The Network4Health Behavioral Health Scholarship Program aims to increase the behavioral health workforce by providing up to \$5000 in scholarships to students living or working in Network4Health cities and towns, and pursuing specific degree programs at participating schools. Students can be either full or part-time, and enrolled in either an on-line or traditional program. Award amounts:

- Awards will be no greater than \$2,500 per semester with a maximum amount of \$5,000 per year per student for full-time students.
- Awards for part-time students will be no greater than \$1,250 per semester with a maximum amount of \$2,500 per year per student

Manchester Community College (MCC)

The scholarship supports students currently enrolled in these programs at MCC, with a GPA of 2.5 or higher. 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. Approved programs:

- 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

Results to date: Since inception in August 2018, 41 Network4Health Behavioral Health Scholarships totaling \$61,000 have been awarded. During this period, 21 students totaling \$26,500 have been awarded. Below is the breakdown of awards over time, by degree:

	Fall 2018	Spring 2019	Fall 2019
Associate’s Degree in Behavioral Science	10	7	13

Associate's Degree in Human Services		1	5
Direct Support Services Certificate	1		1
Substance Misuse Prevention Certificate	1		1
Recovery Support Worker Certificate			1
Mental Health Support Certificate			1

Granite State College

The scholarship supports students currently enrolled in these programs at GSC, with a GPA of 2.5 or higher. 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. Approved programs:

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

Results to date: Since inception in September 2018, 42 Network4Health Behavioral Health Scholarships totaling \$40,000 have been awarded. During this period, 9 scholarships totaling \$8,750 have been awarded. Below is the breakdown of awards over time, by degree:

	Summer 2018	Fall 2018	Winter 2019	Spring 2019	Summer 2019	Fall 2019
BS in Human Services	1	1	1	2	3	3
BS in Psychology	1	4	4	5	4	3
BS in Applied Studies – Human Services and Early Childhood Development					2	2
AS in Behavioral Sciences	1	1	1	1	1	1

University of New Hampshire

During this period, Network4Health finalized an agreement for providing scholarships to students. Criteria are nearly the same for the other scholarship programs except for:

- A 500 - 750 word essay is required on why they are choosing a career in behavioral health and what they plan to do with their certificate or degree
- Support is available for either full or part time students, in online or traditional programs with a GPA of 2.5 or higher, although preference will be given to full-time enrolled students.
- The scholarship is available to current and new students enrolled in one of the following degree programs:
 - Adolescent Development Graduate Certificate
 - Child Welfare Graduate Certificate
 - Human Development and Family Studies: Marriage and Family Therapy M.S.
 - Intellectual and Developmental Disabilities Graduate Certificate

- Psychiatric Mental Health (NP Graduate Certificate)
- Social Work (Advanced Standing) M.S.W.
- Social Work M.S.W.
- Social Work and Juris Doctor Dual Degree M.S.W./J.D.
- Social Work and Kinesiology Dual Degree M.S./M.S.W. – (Adventure Therapy)
- Social Work-Occupational Therapy students enrolled in the Primary Care HRSA Project (for educational costs only)
- Substance Use Disorders (Graduate Certificate) Certificate
- The following undergraduate majors could be eligible depending on funding:
 - Social Work
 - Therapeutic Recreation

Students weren't awarded in 2019 although decisions for awards were made for Spring semester 2020 in December 2019. 20 students will be receiving awards totaling \$100,000.

Scholarships for Certified Recovery Support Worker Training with the Mental Health Center of Greater Manchester (MHCGM):

The MHCGM offers a 54 hour training that prepares participants to sit for the NH Certified Recovery Support Worker (CRSW) exam. It is recognized throughout the country as a successful program, and provides the highest level of foundation training in International Certification (IC) & Reciprocity Consortium (RC) Peer Recovery Domains and Core Functions. This level of education is valued by organizations employing recovery support workers and offers all the educational components required to be licensed as a CRSW in NH.

Network4Health funded 5 scholarships for attendees from the Network4Health region for a total of \$2000.00. All 5 completed the program successfully.

Scholarships for Medical Interpreter Training with the Southern NH Area Health Education Center (AHEC):

The Southern NH AHEC offers a 64 hour training that give participants the training needed to provide healthcare interpretation services. This education is valued by organizations in order to increase language capacity in their organization and be able to more readily serve diverse clients/patients.

Network4Health funded 5 scholarships and manuals for attendees from the Network4Health region for a total of \$1,218.00. All graduates were hired or retained in their roles.

Behavioral Health Education Roundtable - October 25, 2019:

Network4Health's Workforce Development Director continues to partner with the Southern NH AHEC and hosted one Behavioral Health Educational Round Table on October 25, 2019.

9 attendees participated in the round table, including representatives from area colleges, Network4Health and community partner organizations. The agenda for the Round Table included:

- Welcome, Introductions, and Recap
- Presentation: Changes to the Health and Wellness, Psychology, and Human Services curricula at Granite State College; Prior learning assessments
 - Courtney Rice, Director of Undergraduate Health & Wellness Programs, Academic Affairs, Granite State College
- AHEC Career Catalog Update
- Group Discussion - The state of articulations in NH
- Special Guest Presentation: “Articulations and Early College Programming in Massachusetts”
 - Christine Williams, JD - Assistant Commissioner for Regulatory Affairs & Strategic Initiatives at the Massachusetts Department of Higher Education
- Next Steps and suggestions for future meetings
 - SAMSHA competencies
 - Presentation requests from: UNH, Antioch, and Manchester CC

The Round Tables have been successful and participants are interested in continuing them. Our next Round Table will be a webinar and is scheduled for February, 2020.

Career and Educational Planning at The Upper Room in Derry:

Network4Health awarded a grant to The Upper Room in Derry in order to continue and expand their HiSet programming . A more comprehensive description of the relationship can be found in the B1 section of this report. However, expansion of workforce development efforts for HiSet participants was included in the funding. This encompasses:

- Post graduate planning and support to assure work, college and post graduate success for students
- Implementation of a behavioral health career awareness curriculum
- Enhancement of relationship between The Upper Room and Manchester Community College for behavioral health career awareness and to set up a pathway for some individuals into Behavioral Health Workforce Education and Training (BHWET) HRSA funded programs. This will be accomplished with instructor-led class visits to MCC Manchester campus on a monthly basis.

The HiSet program began up again in the fall 2019. To date, tours and behavioral health awareness seminars have occurred monthly at MCC.

Training:

Mental Health First Aid

Network4Health contracted with the Mental Health Center of Greater Manchester (MHCGM) to deliver Mental Health First Aid to 2 partners:

- Licensed Nursing Assistant apprenticeship program at Catholic Medical Center
 - Planned to be an integral part of apprenticeship. Courses were held in summer and fall 2019.
 - Each session was 4 hours long, classes were 8 hours total
 - \$2,000/class x 2 classes = \$4,000
 - Number of Attendants

- Class One – 14 Attendants
 - Class Two – 12 Attendants
- Hillsborough County Nursing Home
 - This effort was in partnership with IDN 3 and we split the cost of delivery of up to five, 2 day sessions for 60+ attendees
 - 4 classes held with 2 sessions per class
 - Each session was 4 hours long, classes were 8 hours total
 - \$2,000/class x 4 classes = \$8,000 total; cost to Network4Health =\$2,666.66
 - Number of Attendants
 - Class One – 27 Attendants
 - Class Two – 15 Attendants
 - Class Three – 18 Attendants
 - Class Four – 20 Attendants

Foundations of Management Program with Granite State College

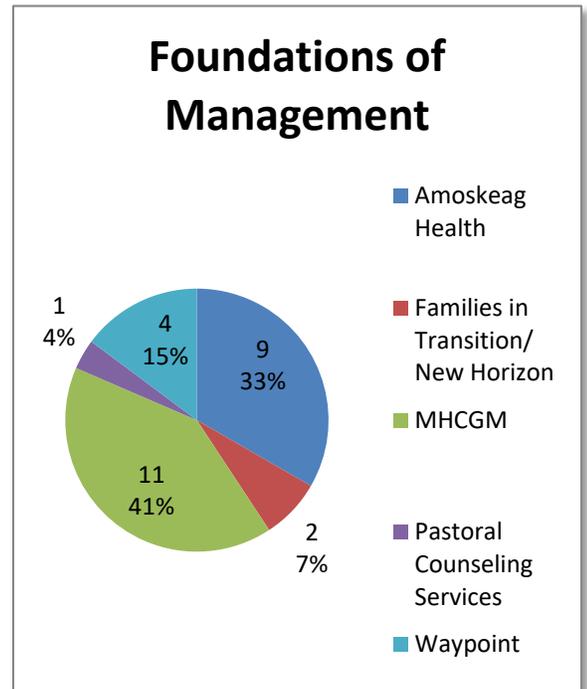
Network4Health once again partnered with Granite State College professional development to offer the Foundations of Management program to our partner organizations. Foundations of Management focused on developing high potential staff who have recently moved into managerial roles, or aspire to become managers/leaders. The program consisted of face-to-face and online modalities in the areas of management/leadership, communication, and conflict resolution. Program participants developed and enhanced skills and perspectives that are essential for managers and leaders. This was accomplished using interactive skill practice, engaged discussion, and other learning methods. All the content was delivered within the context of understanding some of the unique challenges that working for a mission-driven, non-profit and/or health provider can present.

The course started in September 2019 and ran for 6 weeks. Students participated in three 1-day face-to-face classes of 6 hours, and approximately 2 hours per week of online work.

Attendee Data:

- 29 applicants
- 27 accepted; 2 wait-listed
- 27 completed
- 100% completion rate

Student Opinion Results:



Pre- and post-evaluation data show substantive gains in skills, confidence, and feelings of connectedness among practitioners in their fields. Below are a sampling of the comments the students gave upon completing the class:

“What knowledge did you gain as a result of this workshop series?”

- I gained a new perspective on management in general. I feel that I am more confident in how I manage and I’m finding the information in this series to have both confirmed some of my tendencies (some that I thought weren’t managerial enough) are actually better practice than what I realized.
- Self-awareness of my own personality traits and how just simply being aware of these differences can help with understanding and dealing with behaviors and relationships both professionally and personally.

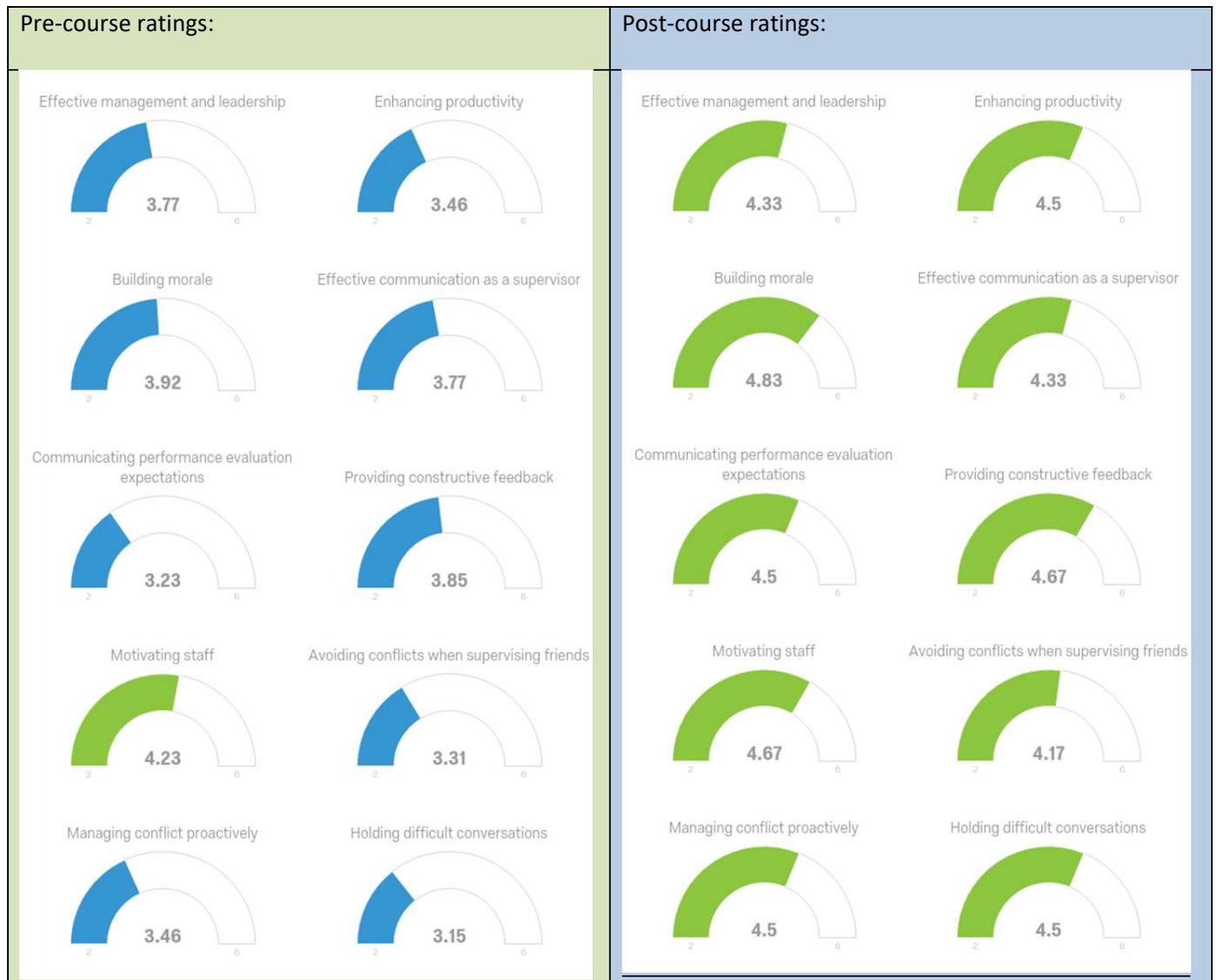
“What skills did you gain as a result of this workshop series?”

- I gained skills in handling challenging conversations and being more direct in my approach to management. I more honed some of the skill set I already had and definitely gained confidence in my skills.
- I gained the skills and importance of active listening. I also learned skills and knowledge on how to enhance productivity and build morale amongst staff.

“How will you carry new knowledge and/or skills to your current employment?”

- I will use the techniques learned to keep my team working productively, support them in managing conflicts successfully, and share the knowledge with other staff to keep the agency working at its best.
- I will work more collaboratively with my staff rather than trying to feel that I have to be the one to make all of the decisions. I will also stop using "compliment sandwiches" in providing feedback to staff.

Results of self-evaluation questions to participants:



Post class data: The students were asked if the components of the program were effective and met their needs (see chart on right):

Network4Health Sponsored Trainings:

For this reporting cycle, Network4Health advertised 335 paid and free trainings (233% of goal), and used \$72,500 of A1 dollars to support a total of 1,166 individuals at 169 different trainings. Nearly all trainings had continuing education unit (CEU) credits offered to attendees.

- Training highlights:



- 10/24/19: Network4Health hosted Cassie Yackley for Foundational Training in Trauma-Informed Care for Professionals: Understanding the Trauma-Responsive Framework (part 1) and Developing Trauma-Responsive Competence (part 2)
- 11/5/19: Network4Health hosted Dr. Mark Redding for a full day session on the Pathways Hub model. Over 100 IDN staff, partners, and other community members attended
- 12/13/19: Network4Health hosted Dr. Mike Gass from UNH for a half-day session on Outdoor Behavioral Health

RFP for Offset Productivity

As was reported in our previous SAR, Network4Health continued to advertise for its RFP for Offset Productivity (12 month period). For our final September 1st deadline, we received proposals from the following partners. All were awarded funds. These are in addition to the \$10,000 awarded to The Upper Room in Derry in the previous reporting period:

NAME OF PARTNER	SUMMARY OF PROJECT	DOLLARS AWARDED	# OF STAFF INCLUDED
Families in Transition	<ul style="list-style-type: none"> • Training on case management and care coordination • General professional development • Obtaining Certified Recovery Support Worker certification • Training to specialize in outreach to SUD/Homeless population 	\$10,000	17
Granite State Independent Living	<p>GSIL proposed to continue to expand upon the professional opportunities for care attendants through offering learning sessions for the ‘basic-ABC’s’ of mental health training. The learning sessions will provide a comprehensive review of the core critical skills to understanding mental illness and offering the fundamentals to respond. This will be an introduction of the risk factors and warning signs of mental health problems, to promote a greater understanding of how to best support the participants who experience mental health issues.</p> <p>In addition, GSIL proposed to offer their Long-Term Support Coordinators the opportunity to attend the Mental Health First Aid provided at the Mental Health Center of Greater Manchester to better support the Care Attendants and consumers who may experience mental health issues.</p>	\$10,000	78
NAMI NH	NAMI NH proposed sending its Family Peer Support Specialists to the following trainings/conferences to improve their clinical knowledge and increase their ability to effectively work with children, adolescents,	\$9,680	22

	<p>and their families:</p> <ul style="list-style-type: none"> • Wraparound Trainings – statewide training that all Family Peer Support Specialists and supervisors participate in every other month • DCYF Conference - provides a diverse learning forum in which best practices in child protection and juvenile justice can be shared in an effort to enhance service quality. • NH Behavioral Health Summit – Provides educational opportunities that address the behavioral health policy and service needs of children and adolescents • Transition Conference - training, collaboration, networking, and information focused exclusively on the transition to life after high school for students with disabilities 		
St. Joseph's Community Services	<p>For the October 2019 day of training, we brought in a speaker from the Referral, Education, Assistance and Prevention (REAP) program for older adults. This program offered information, referral and counseling on stress, relationships, grief, emotional wellbeing, substance use, family dynamics and quality of life matters. In addition, other speakers included a representative of Granite Group Benefits which operates the SJCS Employee Assistance Program (EAP) and offers multifaceted programs on health and well-being. This speaker offered guidance on recognizing and expressing concerns that can arise from witnessing challenging client situations.</p>	\$9,955	~50

Due to the success of the RFP for a 12 month period, Network4Health issued an RFP for a 6 month period. Applicants were asked to meet the same criteria as the 12 month RFP, in using the money to offset costs of sending staff for training or supervision. The maximum award would be \$5000, and organizations would need to have the trainings occur within a 6 month period. One application from Pastoral Counseling Services was received by the 12/06/19 deadline and was awarded funds:

NAME OF PARTNER	SUMMARY OF PROJECT	DOLLARS AWARDED	# OF STAFF INCLUDED
Pastoral Counseling Services	<p>Pastoral Counseling Services will use the offset to productivity funds to provide PCS staff and Board the opportunity to take advantage of a team building, communication and business decision making workshop offered by a pastor at one of our partner organizations in Nashua.</p> <p>The program is designed drill to the core of how we, as an organization work, coach us in making better</p>	\$4,470	18

	<p>tactical and strategic decisions, and to guide us in building sustainable systems that will support our organization to flourish, amid rapid change and growth. With the transition that has occurred at PCS and some recent turn over and confusion over roles, it is felt that such a program would improve communication among staff and offer new insights on how best to work together.</p>		
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The decision to award PCS the funds was made by Network4Health in December 2019 however the actual awarding of the funds occurred on January 10, 2020.

Behavioral Health Physician Assistant/Nurse Practitioner Fellowship

For the past year, Network4Health has been pursuing the creation of a fellowship program for Behavioral Health PA’s (note: Nurse Practitioners would also qualify for this fellowship, however it is geared towards Physician Assistants and will therefore be referenced as the BH PA Fellowship). During this period, Network4Health received a commitment from Catholic Medical Center (CMC) to embark on the creation of this fellowship at their Bedford internal medicine site. Through this fellowship, CMC has:

- Created a first in the nation 12 month fellowship for new or existing PA’s to obtain intensive training in behavioral healthcare management including: Brief interventions, counseling techniques, medication management, referral to services, etc.
- Participants will go through rotations in in-patient psychiatry, geri-psych, pedi-psych, community behavioral health and others. They will also receive 1 hour of supervision per week from a Psychiatrist.
- Upon completion of the fellowship, PA’s will be able to sit for their Certificate of Advanced Qualification in Behavioral Health and then be eligible to bill for BH services under additional codes.

During this period, substantial work has been done to stand up the program but it has not begun yet. Planning is anticipated to go into the first quarter of 2020 which could delay the start until the end of the first quarter of 2020.

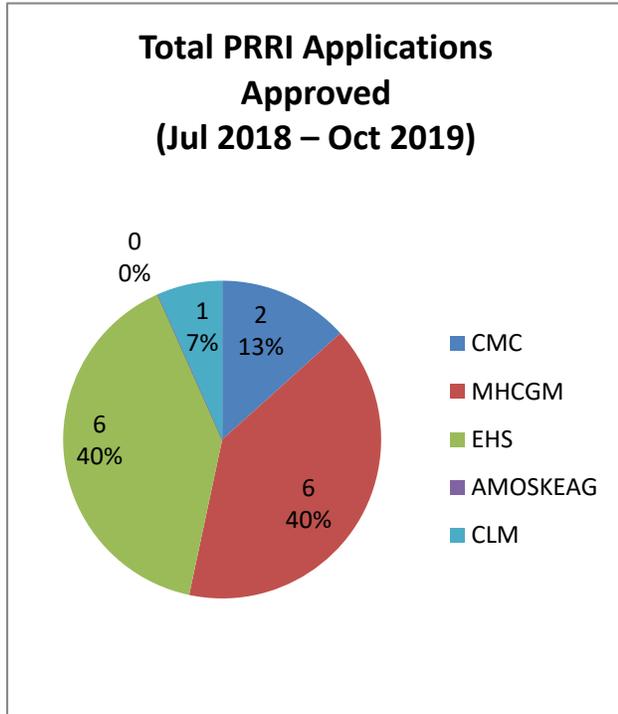
Retention:

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 continuing education units (CEUs)
- Providing funds to offer retention bonuses through the PRRI and CRRRI programs (described below)

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 and/or psych med prescriber (MD, DO or APRN). Interest in this program had waned during the last reporting period, so aggressive marketing was launched in Network4Health’s weekly newsletter, Workforce Wednesday, and email blasts in order to reinvigorate interest. The effort worked. Below is a comprehensive listing of all the PRRI awards to date that have been made. As of this writing, no further funds have been allocated for 2020. Decision to re-open the program will be predicated on the resolving of funding challenges in early 2020.

<i>Name of Partner</i>	<i>Total Applications Approved (Jul 2018 – Oct 2019)</i>	<i>Total Amount Approved</i>
Catholic Medical Center	2	\$ 17,500.00
Mental Health Ctr. of Greater Manchester	6	\$ 53,250.00
Elliot Health Systems	6	\$ 43,500.00
Center for Life Management	1	\$ 2,500.00
<i>Grand total</i>	<i>15</i>	<i>\$ 116,750.00</i>

Clinician Recruitment and Retention Initiative (CRR):

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

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

Even after marketing the program with the PRRI (as stated above) no partner took advantage. When interviewed, our partners stated that clinicians weren't hired like prescribers were, and it was much more difficult to gauge the cost of bringing someone on board, like is done with prescribers. Therefore, it is nearly impossible to attach a hard cost to hiring. Based on this information, the CRR program has been suspended. However, Network4Health will continue to research the feasibility of setting up a different type of program that can offset the costs, or incentivize hires, of these types of clinicians.

Other Progress and Accomplishments:

- Launched new 'Workforce Development Partners Meeting' to replace bi-monthly Network4Health Workforce Committee meeting. These will be virtual meetings with a broader invite list than was previously used. Not only are partners invited, but also non-partners like schools, state organizations and other entities
 - October 30, 2019 meeting topic: "Navigating the Space Between Education and Industry". Agenda:
 - Granite State's new minors and concentrations focused on behavioral health, substance use and other topics
 - [REDACTED], Director of Undergraduate Behavioral Sciences and Human Services, and Senior Instructor at Granite State College
 - [REDACTED] Director of Undergraduate Health & Wellness Programs, Academic Affairs, Granite State College
 - Group discussion (15 mins):
 - What do educators need to know about the BH industry right now?
 - What professional development needs aren't being addressed?
 - Updates on Network4Health workforce development activities
 - Going forward, 5 more meetings will be held from January 2020 until November 2020.
- In the midst of discussions with The Upper Room (TUR) in Derry regarding their HiSet programming (mentioned earlier), it was discovered that not only TUR clients, but also Derry residents would benefit from some sort of job readiness curriculum that would help them

prepare for and be successful in employment. The Community College System of NH (CCSNH) has an excellent program called WorkReady NH that would meet those needs well, but residents of that area have a hard time transporting to Manchester Community College where the classes are held (see <https://www.mccnh.edu/workreadynh> for more information on the class itself).

After discussing the matter with WorkReady NH staff, the Workforce Development Director was able to set up a meeting between CCSNH, TUR and the City of Derry. At that time, WorkReady NH had just been through a service delivery improvement process in which they decided to bring the class out to the communities where it is needed, vs. pushing students toward community college campuses only.

As a result of the meeting, WorkReady NH agreed to bring laptops and an instructor onsite to TUR at least 3 times over the course of 2020, with the first class getting under way in January. TUR will do outreach and referrals and will host the classes in the evenings there.

- During Network4Health’s work with The Upper Room (TUR) to assist them with expanding their programmatic services, it became apparent that TUR would benefit from an Occupational Therapy intern from the UNH Primary Care Behavioral Health Training Program. The Network4Health Workforce Development Director organized a meeting with UNH and TUR to discuss. During the meeting, it was agreed that an intern from this program would spend approximately 6 months evaluating the service model at TUR and then write a recommendation for utilizing OTs to enhance the services to clients. These service enhancements would then be implemented by a second intern coming on board for their internship. These would be billable services. The internships are scheduled to begin early in the spring semester 2020.
- In the fall of 2019, the Network4Health Workforce Director approached Granite State College Professional Development about the opportunity for them to create a northern New England center for integrated care education with Cherokee Health Systems. This would essentially make high quality trainings on integrated care from Cherokee Health Systems available to northern New England participants. Conversations are very initial at this time, but GSC was very open to the idea and more development should occur in the Jan – Jun 2020 reporting period.
- The Network4Health allocated project funds to support lunch and any required meeting materials for quarterly “Community Health Worker (CHW) Connect Lunches.” These quarterly lunch meetings allow local CHW’s to network, share about their individual programs, discuss available resources and build camaraderie. The lunches provide “lunch & learn” type professional presentations and a self-care discussion space. CHW Connect Lunches are coordinated and facilitated by the Manchester Public Health Department. The Network4Health provided up to \$2,000 to support up to 5 CHW Connect Lunch events between December 2019 and December 2020.

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

- “Workforce Wednesday” was published 13 times during this period. We have grown our list to 343 recipients. (see cover below)

- Network4Health has continued to contribute 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. The production of the guide wrapped up this period and finished product is scheduled to be delivered in January of 2020.
- The Workforce Development Director has continued to serve on a variety of state and local committees and groups including, but not limited to:
 - Joint Underwriting Association Stakeholder Meeting at Endowment for Health
 - State Opioid Response Training Committee
 - NH Sector Partnership Initiative
 - Granite State College Healthcare Advisory Council
 - NH Job Corps Workforce Development Council
 - Board member – NH Children’s BH Committee
 - Legislative Commission on the Primary Care Workforce

WORKFORCE WEDNESDAYS

July 17th, 2019

AN EMPLOYER ROLLS OUT AN EMERGENCY LOAN PROGRAM TO HELP WITH EMPLOYEES’ UNEXPECTED EXPENSES

The following is an opinion piece from Maxine Hart and Julieann Thurlow that was published recently in The Boston Globe. The article highlights the successes an employer is having with a workplace financial wellness program.

<https://www.bostonlobe.com/opinion/2019/07/10/employee-loan-program-help-with-unexpected-expenses/>
[By Maxine Hart and Julieann Thurlow, The Boston Globe, July 10, 2019](https://www.bostonlobe.com/opinion/2019/07/10/employee-loan-program-help-with-unexpected-expenses/)

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The cover story in the May 2016 issue of *The Atlantic* magazine shared a simple fact: 47 percent of Americans couldn't come up with \$400 to cover an emergency. And many of those caught in this crisis were middle-class Americans, not just people on the margins.

That article, by journalist and historian Neal Gabler, brought home the findings documented by Federal Reserve Bank researchers: Gabler described his own constant struggles to pay unexpected bills, landing him in the 47 percent despite his considerable success as a writer.

As officers of a suburban cooperative bank north of Boston, we were startled by the article's message — and we recognized that some of our own 90-plus employees were probably among those 47 percent as well.

Within three months, we launched an employee emergency loan program. Over the nearly three years since then, we have made 29 emergency loans of up to \$3,000 to 17 employees — same-day processing, zero interest, no questions asked. They repay the funds over no more than six months by payroll deduction.

Not one loan has gone unpaid.

Now the Federal Reserve Bank of Boston is watching our modest experiment as one potential response to deal with the problems researchers chronicle each year in the [Fed's Report on the Economic Well-Being of US Households](#).

Commonwealth, a Boston-based nonprofit committed to expanding financial security, has conducted a study of our bank's

"Six in ten survey respondents say they would use savings, cash, or its equivalent to pay a \$400 emergency expense. However, three in ten would borrow or sell something. And one in ten simply cannot pay it.

Encouragingly, more adults now say they would pay it with savings, cash, or its equivalent than they did six years ago, a sign of more financial security but some adults would still struggle with a \$400 expense."

Report on the Economic Well-Being of U.S. Households in 2018 - May 2019, the Consumer and Community Research Section of the Federal Reserve Board's Division of Consumer and Community Affairs (DCCA).

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

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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Catholic Medical Center (Lead) including Health Care for The Homeless.	Hospital, <i>Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider</i>	A1, A2, B1, C1, E4
Catholic Medical Center - Amoskeag Family Practice	Hospital, <i>Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider</i>	A1, A2, B1, C1, E4
Catholic Medical Center - Behavioral Health Practice	Hospital, <i>Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider</i>	A1, A2, B1, C1, E4
Catholic Medical Center – Family Health & Wellness at Bedford	Hospital, <i>Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider</i>	A1, A2, B1, C1, E4
Catholic Medical Center – Willowbend Family Practice	Hospital, <i>Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider</i>	A1, A2, B1, C1, E4
American Medical Response of MA	Other	A1, A2
Ascentria Care Alliance	Community-Based Organization providing social and support services	A1, A2
Building Community in NH	Community-Based Organization providing social and support services	A1, A2
Catholic Charities NH	Other, <i>Non CMHC mental health provider</i>	A1, A2
Center for Life Management – Behavioral Health	MHC, SUD	A1, A2, B1, C1, E4
Child and Family Services	Social Services	A1, A2, B1, C1, E4
City of Manchester Health Department	Public Health Organization	A1, A2
Community Crossroads	Home and Community Based Care Provider	A1, A2
Crotched Mountain	Community-Based Organization providing social and support services	A1, A2
Dartmouth Hitchcock - Adult Primary Care	Primary Care Provider	A1, A2, B1
Dartmouth Hitchcock – Pediatric Primary Care	Primary Care Provider	A1, A2, B1
Derry Friendship Center	Other	A1, A2
Easter Seals NH, including Farnum Center	Community-Based Organization providing social and support services and SUD Treatment	A1, A2, B1, E4
Elliot Health Systems – Doctors Park Pediatrics	Hospital, Primary care provider, Non	A1, A2, B1, C1, D3,

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
	CMHC Mental health provider, SUD	E4,
Elliot Health System – Partial Hospitalization Program	Hospital, Primary care provider, Non CMHC Mental health provider, SUD	A1, A2, B1, C1, D3, E4,
Families in Transition – Family Willows Treatment center	Community-Based Organization providing social and support services, SUD	A1, A2, B1, E4
Fusion Healthcare Services	Primary Care	A1, A2, B1
Goodwill Industries of Northern New England	Community-Based Organization providing social and support services	A1, A2
Granite Pathways	Community Based Organization providing social services and supports	A1, A2, E4
Granite State Independent Living	Home and Community Based Care Provider	A1, A2
Granite United Way	Host Agency for the South Central Public Health Network, Administrative Lead for 211-NH	A1, A2
Greater Derry Community Health Services, Inc.	Non Profit H&HS	A1, A2
Hillsborough County	County Corrections; Nursing Facility	A1, A2, C1
Home Health and Hospice Care	Home and Community Based Care Provider	A1, A2, B1
Hope for NH Recovery	Community Based Organization providing social and support services	A1, A2
International Institute of New England	Other	A1, A2
Life Coping Inc.	Home and Community Based Care Provider	A1, A2
Makin' It Happen	Public Health Organization	A1, A2
Manchester Community Health Center – Hollis Street	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Tarrytown	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Westside Neighborhood Health center	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Child Health Services	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Housing and Redevelopment Authority	Other	A1, A2
Manchester School District	Other	A1, A2
Mental Health Center of Greater Manchester-	MHC, SUD	A1, A2, B1, C1, E4
NAMI NH	Community Based Organization providing social services and supports	A1, A2

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
New Hampshire Hospital*	Hospital	A1, A2, B1, C1
New Horizons for NH	Community Based Organization providing social services and supports	A1, A2
NH Legal Assistance/NH Medical Legal Partnership	Other	A1, A2
On the Road to Wellness	Non-CMHC Mental Health Provider	A1, A2, B1
Parkland Medical Center	Hospital	A1, A2, B1
Pastoral Counseling Services	Non-CMHC mental health provider, SUD	A1, A2
Rockingham County	County Corrections; Nursing Facility	A1, A2, C1
ServiceLink Aging and Disability Resource Center of Rockingham County	Community Based Organization providing social services and supports	A1, A2
Southern New Hampshire Services	Community Based Organization providing social services and supports	A1, A2, E4
St. Joseph Community Services, Inc.	Community Based Organization providing social services and supports	A1, A2
The Moore Center	Community Based Organization providing social services and supports	A1, A2
The Upper Room	Community Based Organization providing social services and supports	A1, A2

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**. This table should be the sum of all community-driven projects and also include any IDN administrative staff.

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	2.25	
	C1	0	0	0	0	
	D3PHP	1	1	1	1	
	E4	1	1	1	1	
Licensed Mental Health Professionals	B1	6	4	5	4.3	
	C1	1	1	1	0	
	D3PHP	1	1	1	1	
	E4	0	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
Peer Recovery Coaches	B1	3	2	3	4	
	C1	0	0	0	0	
	D3PHP	1	1	1	1	
	E4	0	0	0	0	
Other Front Line Providers	B1	26	20	26	21.3	
	C1	6	6	6	7	
	D3PHP	3	3	3	3	
	E4	0	0	0	0	

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 A1 Behavioral Health Workforce Capacity Development project budget is presented below. Modifications have been made based on the following factors:

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

Expenses- Actual expenses (paid and invoices received) through December 2019 are presented. Anticipated expenses for the remaining waiver term are also presented. Given that final incentive funding is not expected to be received until mid to late 2021, we have projected expenses in that time period.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
A1: BH Workforce (New)	\$ 862,544	\$ 655,534	\$ 1,339,118	\$ 1,628,035	\$ 715,592
A1: BH Workforce (Rollover)		\$ 825,328	\$ 1,190,272	\$ 1,662,161	\$ 1,203,796
Total Revenue	\$ 862,544	\$ 1,480,862	\$ 2,529,390	\$ 3,290,196	\$ 1,919,388
Recruitment		\$ 5,000	\$ 106,750	\$ 650,000	\$ 650,000

Training/Development	\$ 20,527	\$ 128,474	\$ 535,351	\$ 1,200,000	\$ 1,033,000
Salaries and benefits					
Occupancy		\$ 6,325	\$ 6,325	\$ 6,900	\$ 6,900
Technology (Computer, phone, software)	\$ 1,921	\$ 2,626	\$ 330	\$ 4,500	\$ 4,500
Total Expenses	\$ 37,216	\$ 290,590	\$ 867,229	\$ 2,086,400	\$ 1,919,400
Variation to Budget (Transfer Funds to Subsequent Year)	\$ 825,328	\$ 1,190,272	\$ 1,662,161	\$ 1,203,796	\$ (12)

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

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

- Electronic Health Record (EHR) adoption
- Improved infrastructure
- Electronic communication of protected health information
- Sharing of clinical data between organizations/Shared Care Planning
- Integrated and traceable referral systems
- Event Notification tools
- Data Collection and Data Usage

Electronic Health Record Adoption:

Network4Health continues to support the increased usage and development of electronic medical records (EMR) by our network partners. These improvements have been the foundation of our success.

In the initial plan deployment, our current state analysis showed multiple partners with new EMR purchases, under-developed system usage and minimal resources to support improvement. By providing education and resources to support this development we have moved to a different level of EMR usage that supports organized clinical data, robust care planning, provider decision support, and secure data sharing.

It is these improvements to electronic medical records that have provided the confidence of our partners to share EMR's across organizations. This access has been an important part of the integration of community partners into our primary care and hospital groups and a key part of improving the continuum of patient care.

In 2019, Network4Health released a Request for Proposal (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. Cost for this type of implementation could be shared amongst multiple agencies to decrease the financial constraints held by many of these small community services. RFP proposals are due February 10, 2020.

Electronic communication of protected information:

All HIPAA regulated organizations that have partnered with Network4Health are continuing to use 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. Network4Health will continue to support training to increase staff awareness and use of these technologies including incorporating this functionality into the way we use other services including event notification and shared care planning.

The major hospitals in our region, Catholic Medical Center and Elliot Hospital have now begun allowing patients access to their patient data through the use of “MY LINKS”. This patient facing tool will allow patients to use secure direct messaging to communicate with providers safely as well as provide the ability for patients to aggregate from all of their providers.

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 event notification system 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 the Collective Medical system 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 EMR access amongst more than 60 percent of our partners has allowed shared care planning to flourish.

Network4Health continues to work towards increased data sharing and improved care coordination through shared care planning.

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. Network4Health has continued to lead these discussions with multiple stakeholders and other IDNs to determine a collaborative solution to closed loop referral. These discussions have led to a decision to pursue a state-wide implementation of “Unite Us”. This system has led the industry in care coordination by focusing on community resources and social determinants of health. It would allow our partners to build and scale a coordinated care network, proactively identify service gaps and at-risk populations, empower every community organization to accountably track outcomes together, and leverage outcomes data to take action. Currently our discussions focus on implementation strategies and funding.

Until these discussions are complete, Network4Health continues to work with all partners to support interim workflows to insure closed loop referral functionality through the use of secure direct messaging.

Collective Medical event notification system- Event Notification and Shared Care Planning

As of January 1, 2019, 95 percent of our HIPAA regulated organizations are live with Collective Medical event notification system. From a functional level the system is sending our partners more than sixteen 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 event notification system 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 event notification system to provide more comprehensive workflows and interoperability.

Improved Infrastructure

In a goal to become a “connected” community Network4Health continues to support our community partners to improve Information Technology infrastructure. When analyzing our community gaps early in the waiver process we clearly identified the need to improve infrastructure and equipment in our community based organizations. These improvements have allowed these organizations to participate in workflows supported by electronic tools. Having the equipment to support these workflows has enhanced communication, strengthened relationships and improved patient care.

Data Collection and Data Usage

Network4Health continues to provide guidance to our partners to develop data collection tools to support the Waiver requirements as well as enhance operations. By working with partners to incorporate software like Patient Link and other tools for data collection, educating staff to analyze the quality of data produced and then to use that data to support their organization we have developed an understanding of the power that data has.

Many partners have reached far beyond the waiver requirements to analyze performance through data. Subsequently the Network4Health and its partners have become regional leaders to support data

collection, use and interpretation within our community supporting groups including the Public Health Department and emergency management organizations.

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

	List of providers	12/31/2019 Reporting Period Technology Progress Summary
	<p>Catholic Medical Center (CMC)</p> <p>Amoskeag Family Practice</p> <p>Behavioral Health Practice</p> <p>Bedford Center Internal Medicine and Pediatrics (formerly Family Health & Wellness Center at Bedford)</p> <p>Willowbend Family Practice</p>	<ul style="list-style-type: none"> • 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. • CMC has incorporated Collective Medical event notification system into Primary care practice. Through the efforts of Case Managers and additional resources within the practices Primary care providers are encouraging immediate follow up after emergency room visits to support continuity of care. • 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. • CMC continues to collect CCSA data and is reporting on all required measures to the state • CMC has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows • CMC has implemented My Links patient portal as a patient access tool to provide easy access to aggregated patient records from multiple locations • CMC continues to use secure direct messaging functionality for cross provider communication and transition of care needs

	<p>Catholic Medical Center Healthcare for the Homeless (HCH)</p> <ul style="list-style-type: none"> • New Horizons Homeless Shelter location • Wilson Street Integrated Health location • Families In Transition Lake Street location 	<ul style="list-style-type: none"> • CCSA: was launched in December of 2018 for all patients to complete once per year at minimum. Transitions of Care Coordinator continues to review for completion rates and sends the weekly status report to all clinical staff. CCSA includes the ADL screening, a HARK screening tool, PHQ-2 and PHQ-9, SDOH questions, NIDA screening tool and SLUMS if indicated. Our long term goal is to have a more automated process to reduce manual entry by staff. • CHAN (Community Health Access Network) partners have created a subgroup to finalize the shared care plan tool within the electronic medical record . HCH Team to review data to assign BH and RN case managers to high risk patients. • The Transitions of Care Coordinator uses CMT on a weekly basis to identify HCH patients who have visited area ED's. The information is shared with the Medical Director, the Practice Manager, the CMC Executive Director of Community Services, and BH staff. Cases are reviewed at weekly HCH Integrated Care Team Case Management meetings.
	<p>Center for Life Management – Behavioral Health</p>	<ul style="list-style-type: none"> • CLM IT team completed extensive work to develop a seamless integration with Patient Link to automate the CCSA into their EMR for identification of high-risk patients, transitioning from a manual process. Patient Link has developed the Adult, Preadult and Children templates that will be used for acquiring data directly from the patients. • CLM in conjunction with MHCGM IT has proposed for consideration by the IDN and Collective Medical event notification system having a button present in Collective Medical event notification system 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 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 • CLM continues to collect CCSA data and is reporting on all required measures to the state • CLM has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows • CLM has received access to medical records from the Elliot and Parkland Hospital systems to support the needs of shared patients
	<p>Dartmouth-Hitchcock (DH)</p> <p>Adult Primary Care Pediatric Primary Care</p>	<ul style="list-style-type: none"> • The system-wide DH ACO Department is utilizing Collective Medical event notification system event notification on behalf of the entire system • The DH Manchester BH and care coordination team was trained in the use of Collective Medical event notification system event notification portal, and provided access for patient monitoring • DH continues to collect CCSA data and is reporting on all required

		<p>measures to the state</p> <ul style="list-style-type: none"> • DH has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows
	<p>Easterseals NH Farnum Center</p>	<ul style="list-style-type: none"> • Farnum continues to collect CCSA data and is reporting on all required measures to the state • Farnum has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows
	<p>Elliot Health System - Doctors Park Pediatrics Partial Hospitalization Program</p>	<ul style="list-style-type: none"> • The Elliot IT team completed implementation of Collective Medical event notification system event notification for all Elliot primary care offices, and available in the Collective Medical event notification system portal. Training and workflow development are ongoing to incorporate use of the Collective Medical event notification system portal into the primary care setting. • All patient referrals are entered in the Epic EHR to incorporate an algorithm for referrals of high-risk patients to local community services including Families and Transition and the Mental Health Center of Greater Manchester. • RightFax has been integrated within Epic to enable automation of referrals with Families In Transition and other community based organizations • Elliot continues to collect CCSA data and is reporting on all required measures to the state • Elliot has incorporated the use of Secure direct Messaging into both clinical and revenue cycle workflows • New build for Epic integration of the partial hospitalization program into Epic is complete
	<p>Families in Transition- New Horizons - Family Willows Treatment Center</p>	<ul style="list-style-type: none"> • FIT continues to collect CCSA data and is reporting on all required measures to the state • FIT has incorporated the use of Secure direct Messaging revenue cycle workflows • With the support of Network4Health, FIT has completed build of a robust Electronic Medical System to support all of their owned agencies. Training and go-live dates will happen in the first quarter of 2020. • FIT has begun implementation of Collective Medical event notification system.
	<p>Amoskeag Health, Westside Neighborhood Health Center Child Health Services Hollis Street Tarrytown</p>	<ul style="list-style-type: none"> • 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 • A Depression Report has been developed to track PHQ-9 screenings and progress towards remission. This report has been created and is now ready for testing against the report specification • Amoskeag continues to collect CCSA data and is reporting on all required measures to the state • Amoskeag has incorporated the use of Secure direct Messaging into clinical cycle workflows

		<ul style="list-style-type: none"> • The IDN is working with Amoskeag to support new patient facing data collection tools to support improved patient satisfaction. •
	<p>Mental Health Center of Greater Manchester (MHCGM) – Behavioral Health</p>	<ul style="list-style-type: none"> • MHCGM has received access to Catholic medical Center electronic medical record for mutual MHCGM/CMC patients • MHCGM currently working with Netsmart and Collective Medical event notification system to integrate the CM event notifications automatically into our EMR, bypassing the need for emails, scanning, etc. • 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. • MHCGM in conjunction with CLM IT has proposed for consideration by the IDN and Collective Medical event notification system having a button present in Collective Medical event notification system 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 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 • The Intensive Transition Team and Care Transitions Team have implemented the review of a one year history of emergency department and inpatient utilization with data from Collective Medical as a regular workflow for any clients engaged with this team • MHCGM continues to collect CCSA data and is reporting on all required measures to the state • MHCGM has incorporated the use of Secure direct Messaging into clinical workflows

Evaluation Project Targets

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	17	9	17	16
Shared Care Plan	17	0	18	17
Closed Loop Referral workflow	17	10	18	17
Closed Loop Referral system	3	0	2	3
Data Reporting	17	13	18	17

Performance Measure Name	# of B1	Progress Toward Target		
Data Sharing	17	4	15	17
Care Coordination	2	0	2	2
Direct Secure Messaging	17	18	18	17
Performance Measure Name	# of non B1 HIPAA Regulated Participating Practices			
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	Up to 33	5	24	29
Shared Care Plan	Up to 16	0	4	6
Closed Loop Referral system	Up to 24	0	0	1
Data Sharing	Up to 16	1	3	4
Direct Secure Messaging	Up to 32	6	25	31

*Fusion was removed as a B1 participant in September 2019

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 A2 Health Information Technology to Support Integration project budget is presented below. Modifications have been made based on the following factors:

Revenue- Project budgets reflect the actual funding received. Potential, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced or eliminated as a result of ongoing negotiations with NH counties, or due to unmet performance metrics, Network4Health shall revise budget and project plan deliverables subject to its Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) through December 2019 are presented. Anticipated expenses for the remaining waiver term are also presented. Given that final incentive funding is not expected to be received until mid to late 2021, we have projected expenses in that time period.

Transformation FundA1:F24s	ACTUAL		ACTUAL		ACTUAL		PROJECTED		PROJECTED	
	CY 2017	(Yr2)	CY 2018	(Yr3)	CY 2019	(Yr4)	CY 2020	(Yr5)	CY 2021	(Yr6)
A2 HIT Revenue (New)	\$862,544		\$655,534		\$1,339,118		\$1,628,035		\$715,592	
A2 HIT Revenue (Rollover)			\$ 826,276		\$ 768,395		\$ 1,095,925		\$ 912,356	
Total Revenue	\$ 862,544		\$ 1,481,810		\$ 2,107,513		\$ 2,723,960		\$ 1,627,948	
Event Notificaton System and Shared Care Plan										
Premanage ED - annual Subscription for CMC, Elliot, Parkland			\$ 36,598		\$ 64,906		\$ 85,677		\$ 85,677	
Premanage Primary/Community (\$0.12 per Medicaid member per month) - Software License			\$ 85,605		\$ 68,484		\$ 90,000		\$ 90,000	
Premanage PMDP (\$50 / provider/yr, ~200 providers) - Software License			\$ -		\$ -		\$ 10,927		\$ 10,927	
B1 Integration Enhancement Plan Support Funds										
Integrated Care IEP Implementation Support (care planning tool licensing, other HIT tool licensing, implementation fees, HIT Triang, HIT consulting, existing tool development or customization costs, etc.			\$ 62,616		\$ 304,979		\$ 1,200,000		\$ 954,000	
Secure Messaging										
Direct secure messaging (\$750*30) - Software License							\$ 25,000		\$ 25,000	
Data Aggregator										
Data aggregator implementation			\$ 157,415		\$ 54,750					
Data aggregator Annual Service Fees			\$ 62,675		\$ 125,350				\$ 62,675	
Data Aggregator Customizations, Consulting, Custom Reporting			\$ -		\$ -		\$ -		\$ -	
Secure Data Storage										
Referrals										
Closed Loop Referral System					\$ -		\$ 75,000		\$ 75,000	
CCSA Implementation										
Patient Link Implementation and Licensing Costs			\$ 109,310		\$ -		\$ 75,000		\$ 75,000	
EMR Integration (Technical Assistance Fund)					\$ -		\$ 25,000		\$ 25,000	
Other										
Contingency Fund	\$ 2,170		\$ 11,877		\$ -		\$ 25,000		\$ 25,000	
Internet Connectivity			\$ 148		\$ 32,219		\$ -		\$ -	
HIT Salary	\$ [REDACTED]		\$ [REDACTED]		\$ [REDACTED]		\$ [REDACTED]		\$ [REDACTED]	
Total Expenses	\$ 36,268		\$ 713,415		\$ 1,011,588		\$ 1,811,604		\$ 1,628,279	
Variation to Budget (Transfer Funds to Subsequent Year)	\$ 826,276		\$ 768,395		\$ 1,095,925		\$ 912,356		\$ (331)	

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. This should include the number of participating individuals, major accomplishments, barriers and setbacks.

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

Network4Health's B1 project partners have made impressive strides during the course of the waiver, not just in meeting requirements, but also in creating stronger collaborative relationships across organizations focused on sharing information and providing better integrated care. More than one partner has remarked that without this DSRIP waiver funding and the B1 project, their organization never would have accomplished as much as they have, nor have the strong cross-organizational relationships that developed over the course of the project.

Network4Health saw an expected slowing in the significant increases in integrated care progression compared with past survey periods as partner organizations focus on continuous quality improvement and refinement of their integrated processes. As we strive to weave a stronger fabric of collaboration and integrated healthcare in our network however, we have maintained three consistent threads throughout the B1 project:

- Trauma Informed Care
- The nationally recognized Cherokee Health System evidence-based model of integrated care
- The importance of implementing joint workflows among partners to better address patients' needs and improve information sharing

Our B1 focus on trauma informed care is part of an overall Network4Health commitment to advancing trauma informed care approaches across sectors. Our efforts compliment the work being done in the E4 Integrated Treatment of Co-occurring Disorders project to provide Trauma Informed Responses for Criminal Justice Professionals trainings to organizations in our region.

Within the B1 project we are always thinking of how we can build and strengthen trusting and sustainable relationships among stakeholders. Initially, the B1 project worked closely with primary care and behavioral health providers to establish foundational practices and requirements of the waiver. In 2019, year 4 of the waiver, we were excited to expand the impact of the B1 project in a significant way to a community based partner, the Upper Room, one of New Hampshire's Family Resource Centers located in Derry, NH. The impact is felt by students, families, educators and first responders in the region. This is an exciting and impactful next step for the B1 project.

During this period, the Network4Health risk stratification workgroup, comprised of Network4Health B1 partner organizations and representatives from New Hampshire's Managed Care Organizations, met in July to review and discuss a number of risk stratification algorithms. While risk stratification algorithms vary somewhat from one organization to another based on populations served, this

workgroup has been helpful in raising the importance of utilizing risk stratification best practices and measures in a systematic way to improve care.

Network4Health progressed from having two to three B1 project participants meeting integrated care designation level, and the remainder of practices meets or exceeds the coordinated care designation level. We are pleased to include The Mental Health Center of Greater Manchester as an Integrated Care Designation practice in this reporting period with their significant expansion of medication assisted treatment (MAT) programming. All Network4Health B1 project practices continued to make progress within the specific integrated care designation requirements as outlined by the New Hampshire Delivery System Reform Incentive Payment (NH DSRIP) program's Special Terms and Conditions document during the July to December 2019 reporting period.

During this period, Network4Health's B1 partner Fusion Health Services has withdrawn from the B1 Integrated Healthcare project due to staffing and a decision to move in a different strategic direction. Fusion Health Services will be re-focusing resources on psychiatry care, chronic pain management, inpatient substance use disorder consultations and transitional medication assisted treatment services, but will no longer be providing long term integrated primary care services within their practice. With the approval of our Network4Health Steering Committee, Fusion Health will remain a network partner due to ongoing joint endeavors with other Network4Health partners in expanding access to Medication Assisted Treatment.

The Network4Health team is pleased to share results from the Fall 2019 Site Self-Assessment (SSA) survey tool in Attachment_B1.1. The SSA is completed by each B1 partner across Integrated Delivery Networks (IDN) statewide through the New Hampshire Citizens Health Initiative (NH CHI). The SSA helps Network4Health B1 project participants collectively review our integration progress in alignment with the Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration(HRSA) Center for Integrated Health Solution's *Six Levels of Collaboration/Integration*, and gain a better understanding of the components of integration, fostering internal discussion, and informing strategic planning, both at the organizational and IDN levels. As a region, the SSA shows that Network4Health B1 participants continued to make incremental progress in our region's primary care and behavioral health integration. We continue to hover toward the high end of Level 4: Close Collaboration On-Site with Some System Collaboration per the *SAMHSA-HRSA Six Levels of Collaboration/Integration*, with two organizations ranking themselves as approaching full integration that would align with Level V on the SAMHSA-HRSA scale. Please note when reviewing our report that some practice identification numbers (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, and have been removed in the most recent report to accurately reflect the progression of Network4Health B1 partners.

The most recent SSA also confirmed the following areas of opportunity for collaborative learning and development between B1 partners for the remainder of the waiver time period:

- Further workflow development for the coordination of referrals and specialists
- Patient/family input in integrated primary care and behavioral health
- Role clarification: Evaluation of job description versus the work within day to day processes
- Looking at multiple funding streams and modes of sustainability

In addition to the fall 2019 SSA surveys, Network4Health was pleased to offer all B1 partners a Blueprint for Integrated Healthcare through NH CHI. The Blueprint is a proprietary tool using the practice SSA results to highlight potential areas of improvement to enhance practice integration efforts using SAMHSA-HRSA’s integration levels. Blueprint reports were reviewed with five B1 partners during practice specific debriefing sessions to create an individualized prioritization matrix for integration activities. Key themes throughout many of the Blueprint sessions included:

- Workforce Development/Teamness
- Quality/Continuous Improvement
- Funding/Sustainability
- Community Partnerships/Enhanced Care Coordination
- Data System/Patient Records
- Patient/Family Engagement/Centeredness

Given funding uncertainty for this final year of the NH DSRIP waiver program, partners are strongly focusing on the sustainability of their new integrated models. Much consideration by partners is spent on how to sustain critical but not currently billable multidisciplinary care team roles such as community health workers and patient navigators. Network4Health is committed to supporting the continued development of partner integration models and increased collaboration across Network4Health partners through the end of the waiver.

Staffing

Network4Health continues its contract with the University of New Hampshire (UNH) for support from their New Hampshire Citizen’s Health Initiative team (NH CHI) to manage the continued collection of the Site Self-Assessment (SSA) Evaluation Tool from the Maine Health Access Foundation Integration Initiative for all participating practices for the duration of the waiver, as well as facilitation of an annual Blueprint for Integration session. No additional hires or staff augmentation related to the B1 project team are anticipated at this time.

The following table provides the current staffing for all Network4Health Integration Enhancement Plan (IEP) partners for their June 2019 to May 2020 Integration Enhancement Plans.

Organization	
FQHC s & CMHCs	IEP Staffing
FQHC - Healthcare for the Homeless	<ul style="list-style-type: none"> • New hire, August 2019: Recovery Support Worker/Community Health Worker (1.0 FTE) • No turnover for the following Network4Health funded positions: <ul style="list-style-type: none"> • RN Case Manager (0.5 FTE) • Behavioral Health Clinician (0.5 FTE)

<p>FQHC – Amoskeag Health (formerly Manchester Community Health Center)</p>	<ul style="list-style-type: none"> • The Behavioral Health Consultant (0.8 FTE) employee transferred to another role, but was immediately filled by an internal candidate in November 2019. • No turnover for the following Network4Health funded positions: <ul style="list-style-type: none"> • Case Manager 1 (1.0 FTE) • Case Manager 2 (1.0 FTE) • Community Health Worker 1 (1.0 FTE) • Community Health Worker 2 (1.0 FTE) • Community Health Worker 3 (1.0 FTE) • Community Health Worker Supervisor (1.0 FTE) • Community Health Worker 4 (0.8 FTE)
<p>CMHC - Center for Life Management</p>	<ul style="list-style-type: none"> • Center for Life Management requested a reduction from 1.0 to 0.8 FTE for the below IDN funded role to support retention of their employee beginning in November 2019. <ul style="list-style-type: none"> • Nurse Care Navigator (0.8 FTE)
<p>CMHC - Mental Health Center of Greater Manchester</p>	<ul style="list-style-type: none"> • No turnover for the following Network4Health funded positions: <ul style="list-style-type: none"> • ITT Coordinator (1.0 FTE) • ITT Case Manager 1 (1.0 FTE) • ITT Case Manager 2 (1.0 FTE) • ITT Case Manager 3 (1.0 FTE) • ITT Case Manager 4 (1.0 FTE) • ITT Peer Specialist (1.0 FTE) • APRN (.2 FTE) • ITT Program Assistant/Office support (1.0 FTE)
<p>Primary Care</p>	
<p>Catholic Medical Center Amoskeag Family Practice Bedford Center Internal Medicine Willowbend Family Practice Behavioral Health Services Department</p>	<ul style="list-style-type: none"> • No turnover for the following Network4Health funded positions: <ul style="list-style-type: none"> • 3 x Behavioral Health Patient Navigators
<p>Dartmouth-Hitchcock Adult Primary Care Pediatric Primary Care</p>	<ul style="list-style-type: none"> • Turnover: Family Support Specialist left role in November, 2019. Position was open as of December 31, 2019 • No turnover for the following Network4Health funded positions: <ul style="list-style-type: none"> • 2 x Licensed Mental Health Clinician (1 MLADC, 1 LICSW) – Adult Primary Care • Licensed Mental Health Clinician (LICSW) – Pediatrics

Elliot Health System: Doctors Park Pediatrics	<ul style="list-style-type: none"> • The Pediatric Therapist left role in June 2019. Position was immediately filled by an internal candidate. • No turnover for the following Network4Health funding positions: <ul style="list-style-type: none"> • Social Worker
BH / SUD	
Families in Transition- New Horizons Willows Treatment Program	<ul style="list-style-type: none"> • One Certified Recovery Support Worker (1.0 FTE) left in June 2019. A new team member was hired in August 2019. • No turnover for the following Network4Health funded positions: <ul style="list-style-type: none"> • Director of Operations (1.0 FTE) • Therapist (MLADC) (1.0 FTE) • 1 x Certified Recovery Support Worker (1.0 FTE) • Vice President of Clinical & Supportive Services (.25 FTE)

B1 Partner Integrated Care Progress

Network 4Health is pleased to share the continued progress of each Network4Health B1 practice towards the Integrated Care Designation for practices that have attained Coordinated Care Practice in alignment with the NH DSRIP Special Terms and Conditions during the July to December 2019 reporting period, and the continued progress within the integrated care requirements for Integrated Care Designation practices.

Coordinated Care Designation Practices working towards Integrated Care Designation

Center for Life Management (CLM)

Participating B1 Practice Locations:

- Community Mental Health Center, Derry, NH

July to December 2019 Integrated Care Progress:

Medication-assisted treatment (MAT)

CLM began a Vivitrol-only MAT pilot program in 2019, with plans to build additional capacity through support from the Network4Health E4 community project. A workgroup is ongoing to develop wrap around services for clients receiving MAT through CLM. The CLM team defined and began recruitment efforts for a Certified Recovery Support Worker (CRSW) position as a recovery support wrap around service for their MAT program. Their Medical Director also continues to train and coach agency medical staff to strengthen their knowledge of and comfort with MAT.

Enhanced use of technology

The CLM IT team completed extensive work to develop a seamless integration using data collection tool Patientlink to automate the submission and workflow for their comprehensive core standardized assessment (CCSA) within their electronic health record to support the identification of high risk patients. The CCSA was initially implemented manually, but has now

transitioned to an electronic process with the collected data present in their EMR to identify, assess and address care concerns.

CLM is also participating in a pilot program with Collective Medical to allow an event notification 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 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. The Network4Health HIT Director is coordinating the pilot program between two Network4Health partners and the Collective Medical event notification system team.

CLM's Care Management Workgroup focused on improving communications for primary care visits. The team refined the following forms during the reporting period to support information sharing between client, primary care provider and CLM:

- *Appointment Information Form* for documenting at PCP visits
- *After Visit Summary Form* to provide to clients for their primary care visits to provide communication regarding the behavioral health treatment
- *Nursing Assessment Referral Form* for the referral of high risk clients to the CLM Nurse Navigator

The CLM Care Management Workgroup also began a care plan/case management progress note initiative in preparation for IT implementation to enhance integration/care management documentation in their electronic health record.

Joint Workflows

CLM continues to expand collaboration and case conferences for shared patients with primary care providers at Derry Medical and Southern NH Internal Medicine. 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.

Catholic Medical Center (CMC)

Participating B1 Practice Locations:

- Amoskeag Family Practice
- Willowbend Family Practice
- Bedford Center Internal Medicine and Pediatrics (formerly Family Health & Wellness Center at Bedford)
- CMC Behavioral Health Services

July to December 2019 Integrated Care Progress:

Medication-assisted treatment (MAT)

CMC has significantly increased their MAT services in the reporting period. MAT is now provided by four providers (across all CMC primary care practices) for active CMC patients. Several additional primary care providers completed their x-waiver and have begun MAT

training with a CMC mentor. CMC anticipates the additional providers will begin to prescribe MAT within the first quarter of 2020.

The CMC Addiction Medicine Services moved from the CMC campus to CMC's Amoskeag Family Practice due to a reduction in provider hours. The primary care team anticipates an increase in scale with the new waived physicians increasing availability of MAT.

Two CMC Behavioral Health Services providers began prescribing MAT to CMC inpatients seen via inpatient behavioral health consults. The team provides bridge prescriptions for patients discharged to community MAT providers to support continuity of treatment and transitions of care.

Enhanced use of technology

CMC continues to utilize Collective Medical's event notification system to identify high Emergency Department utilizers. A centralized cross-disciplinary team including Emergency Department providers, behavioral health, case management and primary care meet monthly to review high utilization patients who are patients of any CMC primary care practice. The Mental Health Center of Greater Manchester now attends the monthly case consultation for any shared high utilization patients.

CMC is also in the planning process to utilize Collective Medical's portal for shared care plans. The team is working toward the use of care plans amongst CMC users via the Collective Medical system for patients connected with CMC primary care Patient Navigators or RN Care Coordinators. In addition, the use of the Collective Medical portal shared care plan for patients discussed and managed via the high utilizer workgroup is also in the planning phase.

Joint Workflows

CMC primary care was approved by their legal counsel to begin use of a joint release of information for patients of CMC and The Mental Health Center of Greater Manchester. This approval allows for immediate use of the joint release of information and will facilitate increased sharing of pertinent data for patient care. In addition, primary care teams are reminded regularly of the opportunity to join the weekly consultation time with a Psychiatrist from the Mental Health Center of Greater Manchester for patient consultation.

Dartmouth-Hitchcock (DH)

Participating B1 Practice Locations:

- Adult Primary Care
- Pediatrics

July to December 2019 Integrated Care Progress:

Medication-assisted treatment (MAT)

Dartmouth-Hitchcock primary care launched MAT services and is actively providing MAT to 8 patients in their Adult Primary Care Department in the Manchester location. The MAT multidisciplinary team meets monthly to discuss and review workflows. Medical Assistants were trained during the reporting period in the rooming process for MAT patients. A new provider in the DH clinic is currently taking the x-waiver course and will increase the number of x-waivered providers available to prescribe MAT to four. The MAT multi-disciplinary team has also begun investigating the use of Vivitrol, in addition to Suboxone for MAT patients.

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

DH Behavioral Health Consultants continue to utilize and refine workflows for the Collaborative Care model (formerly referred to as the IMPACT Model) for the treatment of treatment of mild-to-moderate depression and anxiety in the primary care setting.

Psychiatry consultation and supervision for the Behavioral Health Consultants is done weekly over the phone with a DH Psychiatrist based in Lebanon, NH. DH created the required Depression Registry for the Collaborative Care model within Microsoft SharePoint. Planning is underway to move the registry and tracking information to their electronic health record to reduce the duplicative documentation that is currently required. A timeline for this change has not yet been defined.

Enhanced use of technology

DH is working with the Mental Health Center of Greater Manchester to send Continuity of Care Document (CCD) via their electronic health record for behavioral health referrals. Internal work is underway to allow the behavioral health team to initiate these activities. A test patient has been used and the system works on the mental health centers end.

Joint Workflows

The DH Behavioral Health Supervisor worked with Riverbend Community Health Center in Concord, New Hampshire to finalize a joint workflow for shared patients similar to the work DH has done with the Mental Health Center of Greater Manchester. This work facilitates the streamlined sharing of patient information with the two largest community mental health centers near the DH Manchester campus.

Elliot Health System

Participating B1 Practice Locations:

- Doctors Park Pediatrics
- Partial Hospitalization Program (PHP)

July to December 2019 Integrated Care Progress:

Doctors Park Pediatrics:

Medication-assisted treatment (MAT)

Doctors Park Pediatrics has one x-waivered provider, and Pediatric Health Associates has another waived provider. The two practices are co-located to facilitate access to services at either practice.

As a system, Elliot Health System is in the process of developing a free-standing MAT clinic. When up and running, Doctors Park Pediatrics x-waivered provider will collaborate with the MAT clinic for patient intake and MAT induction.

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

The PHQ-9 is administered at each follow-up visit when managing mild-moderate depression by the PCP. Multi-disciplinary team members, such as the psychiatrist, therapist, social worker and behavioral health consultant proactively coordinate and provide care when appropriate.

Enhanced use of technology

To close gaps in care and follow up with patients if an appointment is missed, Elliot Health System's Care Gap team runs daily reports in the electronic medical record (EMR), Epic, to identify and proactively outreach to patients, all of which is shared with the multi-disciplinary team at Doctors Park Pediatrics via Epic.

RightFax has been integrated within Epic to enable automation of referrals with Families In Transition and other community based organizations. Doctors Park Pediatrics currently uses event notification within Epic. The Elliot Health System Case Management team is actively using Collective Medical event notification system, and once an at-risk patient is identified, shares the information with primary care.

Partial Hospitalization Program (PHP)

Medication-assisted treatment (MAT)

The PHP program has a waived nurse practitioner on staff that provides initial MAT services for PHP program participants. During the course of a client's PHP participation the medications are maintained, however, prior to the completion of the program, a referral to an outside MAT provider is established for continuation of treatment. The PHP staff is trained to confirm the scheduling of MAT continuation appointments prior to program discharge.

Enhanced use of technology

The Behavioral Health module of Epic was completed and went live for the PHP team in November 2019. The Comprehensive Core Standardized Assessment and Care Plan for all patients are now standard parts of patients' record, and no longer have to be manually documented.

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

Cognitive behavioral therapy is used in the treatment of mild-to moderate depression in the PHP.

Families in Transition- New Horizons

Participating B1 Practice Locations:

- Willows Substance Use Treatment Center

July to December 2019 Integrated Care Progress:

Joint Workflows

The Willows team and Families in Transition-New Horizons as an agency continue to do extensive work to develop, adapt and document workflows both internally and externally. During the reporting period the team completed work on the following workflows with the following external agencies:

- Referrals and communication with The Mental Health Center of Greater Manchester's Medication Assisted Recovery (MAR) program
- Workflow for when Hope for NH Recovery staff identify individuals that may benefit from substance use treatment and / or in need of recovery housing with Families in Transition-New Horizons

- Referrals to primary care services and care coordination of patients with CMC's Healthcare for the Homeless practice site that is co-located at the Willows Substance Use Treatment Center building.

Enhanced use of technology

Families in Transition-New Horizons, with significant support from Network4Health's A2 HIT project has participated in configuration, testing and training/go-live preparation for their new electronic health record during this reporting period. The completion of this large project will greatly facilitate electronic tracking of the comprehensive core standardized assessment (CCSA) which is currently done on paper, treatment and care plans, electronic referrals and sharing of allowed information between community agencies. Training is set to begin in January 2020.

Integrated Care Designation Practices

Amoskeag Health, formerly known as Manchester Community Health Center

Participating B1 Practice Locations:

- Hollis Street
- Tarrytown
- Westside Neighborhood Health Center
- Child Health Services

July to December 2019 Integrated Care Progress:

Medication-assisted treatment (MAT)

Amoskeag Health's MAT program continued to grow during the reporting period. They added an additional waived provider, a psychiatric nurse practitioner to the team. The provider and MAT Behavioral Health team have joined the University of New Hampshire sponsored MAT Project Echo learning collaborative that begins in February 2020 to continue to hone the team's MAT skill set.

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

Amoskeag's progress in strengthening their implementation of evidence based treatment of mild to moderate depression aligns with their work as a Patient Centered Medical Home. The Amoskeag team completed daily huddles workflows that will include discussion of PHQ-9, emergency department utilization and other key factors to identify high risk patients. A PHQ-9 tracking report, recently developed in collaboration with another local federally qualified health center and the community health center electronic health record consortium CHAN, is ready for use with a quality assurance process to refine the report. The Amoskeag Health diabetes wellness clinic, implemented during this reporting period, has a Behavioral Health Consultant on the team to help patients address behavior change to better manage diabetes and address depression that is a common comorbidity with diabetes and other chronic conditions. A key challenge with the implementation of the selected depression model is limited physical space. In order to accommodate three new medical providers, Amoskeag Health has had to reconfigure space usage, and, unfortunately, lost some rooms previously designated in the Hollis location for warm handoffs and behavioral health visits. Amoskeag is acquiring new space nearby for many of the administrative functions that currently are housed at Hollis, and anticipate having more available space for the clinic in early March.

Enhanced use of technology:

Amoskeag Health disseminates a monthly report from Collective Medical of high emergency department (ED) utilizers organized by provider panel. The report is sent to Case Managers and Community Health Workers for review with their assigned provider(s) and the associated multi-disciplinary care team/care pod. The pod creates a plan for addressing patient needs to support appropriate care, social needs and strategies for reduced ED utilization. The Amoskeag Child Health Services team is also focused on reducing pediatric ED visits for their patient panel by increasing same day access at Child Health Services based on reviewing high ED utilization available in Collective Medical. The Amoskeag Health team convened an ED Utilization workgroup to identify stronger practices and workflows to address patients with high ED utilization based on data available from Collective Medicals event notification system. The Amoskeag workgroup will start to meet in early 2020. They are considering a case conference model to support the management of high risk, high utilization cases.

The following reports and registries were developed during the reporting period with the Amoskeag Health electronic health record consortium (CHAN: Community Health Access Network):

- A Depression Report to track PHQ-9 screenings and progress towards remission. This report has been created and is now ready for testing against the report specification.
- A MAT registry is nearing development completion to support the ongoing MAT services
- CHAN members are collaborating on modifications to the existing Care Plan to provide more integrated care information and goal tracking.

Joint Workflows

In addition to existing joint workflows with Granite Pathways Doorways Program for referrals, the Amoskeag team developed both internal and shared workflows with The Mental Health Center of Greater Manchester (MHCGM) for pediatric behavioral health patients.

ProHealth is an integrated wellness treatment program of the MHCGM which embeds an Amoskeag Health primary care provider(s) into the behavioral health setting at MHCGM. Workflows and protocols were completed in the reporting period and are being modified as required to support continuous process improvement.

Catholic Medical Center – Healthcare for the Homeless (HCH)

Participating B1 Practice Locations:

- New Horizons Homeless Shelter location
- Wilson Street Integrated Health location
- Families In Transition Lake Street location

July to December 2019 Integrated Care Progress:

First in NH Diabetes Recognition for BH Team Member

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

Medication-assisted treatment (MAT)

The new HCH Wilson Street Integrated Health (WSIH) location opened during the reporting period, with the ability to do on-site urine toxicity screens as per MAT protocol. A newly hired x-waivered provider (APRN) finished the credentialing process earlier than anticipated and began practicing at HCH in November 2019. This further expands the capacity for Healthcare for the Homeless' MAT clinic. The HCH MAT team was trained in Vivitrol administration and began prescribing when appropriate.

Healthcare for the Homeless is working toward the following activities to promote wrap around services for their MAT clients:

- Two HCH behavioral health team members continue to make progress with their supervision toward obtaining their MLADC licenses under the Healthcare for the Homeless Behavioral Health Coordinator.
- The HCH Recovery Support Worker is developing collaborative relationships with co-located partners at the Wilson Street building, including HOPE for NH Recovery, a substance use disorder peer based support provider
- HCH is developing a joint workflow Catholic Medical Center's inpatient team to link patients who initiate MAT treatment during inpatient stays back to the HCH team for continued treatment and recovery support services

The HCH MAT Team is scheduled to participate in their second MAT Project ECHO learning collaborative through the University of New Hampshire beginning in January 2020.

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

The manual spreadsheet reporting for the tracking of patients with mild-to-moderate depression proved to be overly cumbersome for the HCH behavioral health team. Use of the tool was temporarily paused and the team focused on documenting requirements for the development of a depression care tracking report that was submitted to their electronic health record consortium, CHAN, for report created. HCH completed quality assurance testing of the report and have submitted corrections to CHAN for revision. Due to the reporting corrections a team training to review the depression model process and tracking report has been moved to February 2020.

Enhanced use of technology

HCH's electronic health record consortium CHAN completed development of the depression report requirements for Provider Level Depression Management reporting in conjunction with Amoskeag Health to streamline tracking of progress with depression model. The report was completed and is currently being reviewed for quality assurance.

HCH's new Medical Director, effective 10/1/2019, has presented alternative models to identify and case manage at-risk patients. A new report request will be submitted to CHAN to support to streamline the identification of high risk patients and the ability to assign them case manager panels within the electronic health record.

Joint Workflows

Monthly workflow sessions continued during the reporting period between HCH and Families in Transition to ensure awareness of programs, key contacts and the modification of workflows between the two organizations. HCH has held initial meetings with representatives from the

Manchester Health Department school nursing team to discuss possible collaboration with Manchester schools. HCH also continues to refine internal workflows with CMC in patient case management to improve discharge planning and transitions of care.

Mental Health Center of Greater Manchester (MHCGM)

Participating B1 Practice Locations:

- Intensive Transition Team

July to December 2019 Integrated Care Progress:

Medication-assisted treatment (MAT)

MHCGM has greatly expanded their MAT program in the reporting period. MHCGM has invested heavily in having their staff providers complete x-waiver certification. The team now includes a total of 12 x-waivered providers.

MHCGM's Medication Assisted Recovery (MAR) program has now expanded to two sites, Cypress Street (Cypress Center and Interim Care Services) and at their Wall Street location. At their Cypress Street location MHCGM has a sub-contract with Network4Health partner Fusion Health Services for 3 nurse practitioners to provide MAT intake services on-site 3 half days per week. The MAR team also includes dedicated peer clinicians to do follow-up behavioral health interventions that are recommended by nurse practitioners at the time of intake. Emergency services team members are also providing ongoing therapy as needed.

Emergency services hours have been extended to 8:00 PM two nights a week to provide additional MAR intake appointments. Overall, 81% of appointments are currently being filled. Approximately 50% of those are no shows for their appointments.

For any clients recommended to a higher level of care at intake, the Intensive Transition Team (ITT) is engaged to help support referrals to residential, intensive outpatient or other programming. The MHCGM maintains the MAR prescription for those patients to support continuity with MHCGM and allow them to easily transition back after completion of high levels of care. MAR clients who remain with MHCGM maintain appointments with the initial induction team for approximately six months. If patients are not state eligible, after approximately six months they are transferred to an x-waivered provider at MHCGM's Bedford Counseling Associates for continuity of care.

MHCGM has also added availability of supported employment staff working with the MAR team. They are also proving MLADC led-groups for MAR clients and separately a family support group opportunity. The team is currently planning for sober activity groups to start in the spring to further provide wrap around services to patients. The MHCGM management team is also working to open MAR induction hours at a third location on Elm Street in Manchester in 2020.

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

MHCGM is a community mental health center that treats and bases all care, including mild-to-moderate depression, on evidence based-models and best practices. They have rigorous training and continuing education requirements for their employees, as well as strong quality assurance, quality improvement and compliance departments.

Enhanced use of technology

MHCGM continues to utilize Collective Medical event notification system to identify individuals at risk who may present in the emergency department of our local hospitals. MHCGM is working towards completion of an integration of the event notifications with their electronic health record, however, in the interim MHCGM has committed a full time Medical Records staff (split between 2 people) to review incoming alerts and triaging them across the agency. Anecdotally, internal clinicians are reaching out about clients for whom they are receiving Collective Medical alerts and requesting the intervention of the B1 supported Intensive Transition Team.

The Intensive Transition Team and Care Transitions Team have implemented the review of a one year history of emergency department and inpatient utilization with data from Collective Medical as a regular workflow for any clients engaged with this team/

MHCGM is receiving secure messages from Elliot Hospital. They are looking to expand and send secure messaging, as well as documentation to Dartmouth Hitchcock via secure messaging.

Joint Workflows

In addition to the general “Primary Care Referrals” workflow, and the specific “Dartmouth Hitchcock Referral” workflows for adult and pediatric patients, MHCGM developed a similar workflow with Amoskeag Health for pediatric referrals. MHCGM also developed an “Information Exchange” workflow with Dartmouth Hitchcock primary care.

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 B1 Integrated Healthcare project budget is presented below. Modifications have been made based on the following factors:

Revenue- Project budgets reflect the actual funding received. Potential, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced or eliminated as a result of ongoing negotiations with NH counties, or due to unmet performance metrics, Network4Health shall revise budget and project plan deliverables subject to its Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) through December 2019 are presented. Anticipated expenses for the remaining waiver term are also presented. Given that final incentive funding is not expected to be received until mid to late 2021, we have projected expenses in that time period.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
B1: Integrated Healthcare Revenue (New)	\$1,035,053	\$ 786,640	\$ 1,606,941	\$ 4,161,755	\$ 4,293,553
B1: Integrated Healthcare Revenue (Rollover)		\$1,032,253	\$ 1,191,313	\$ 319,235	\$ 7,972
Total Revenue	\$1,035,053	\$1,818,893	\$ 2,798,254	\$ 4,480,990	\$ 4,301,525
Salaries and benefits					
Technology (Laptops, phones, software)		\$ 848	\$ 330	\$ 4,000	\$ 4,000
UNH Institute on Health Policy and Practice/Citizen's Health Initiative Baseline and Follow-up Assessments.	\$ 2,800	\$ 4,780		\$ 6,000	\$ 6,000
UNH IHPP/CHI Integration Enhancement Project plan development.		\$ 30,772			
UNH Law IHPP/CHI Integration coaching.		\$ 182,350	\$ 207,880	\$ 131,118	\$ 131,118
Practice level Integrated Healthcare Enhancement Project plan funding.		\$ 293,260	\$ 2,088,705	\$ 4,150,000	\$ 3,979,000
Occupancy		\$ 5,750	\$ 6,325	\$ 6,900	\$ 6,900
Total Expenses	\$ 2,800	\$ 627,580	\$ 2,479,019	\$ 4,473,018	\$ 4,302,018
Variation to Budget (Transfer Funds to Subsequent Year)	\$1,032,253	\$1,191,313	\$ 319,235	\$ 7,972	\$ (493)

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 practice 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	17*	
Integrated Care Practice	Up to 5	5	5	6	

* During this period, Network4Health’s B1 partner Fusion Health Services has withdrawn from the B1 Integrated Healthcare project due to staffing and a decision to move in a different strategic direction. Fusion Health Services will be re-focusing resources on physiatry care, chronic pain management, inpatient substance use disorder consultations and transitional medication assisted treatment services, but will no longer be providing long term integrated primary care services within their practice. In addition, The Mental Health Center of Greater Manchester moved from the Care Coordination Practice designation to the Integrated Care Practice designation.

Site Self-Assessment (SSA) Roll-Up Report

Average Scores: Domain One

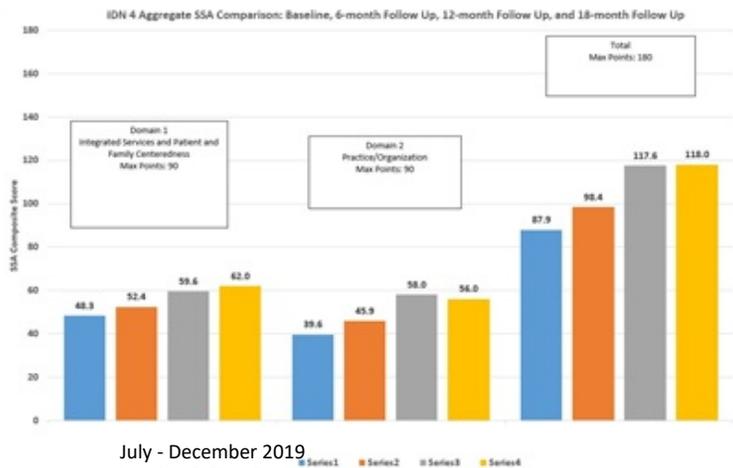
Integrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2	F/U 3
1. Level of integration: primary care and mental/behavioral health care	4.2	5.1	5.4	6.5
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	6.8	7.2	7.8	7.6
3. Treatment plan(s) for primary care and behavioral/mental health care	4.0	4.7	6.0	6.2
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	5.1	5.6	6.2	7.0
5. Patient/family involvement in care plan	5.4	5.6	6.9	6.8
6. Communication with patients about integrated care	5.2	5.4	6.3	6.3
7. Follow-Up of assessments, tests, treatment, referrals and other services	5.9	6.4	6.7	7.0
8. Social support (for patients to implement recommended treatment)	5.9	6.2	7.1	7.3
9. Linking to community resources	5.8	6.3	7.2	7.3

Average Scores: Domain Two

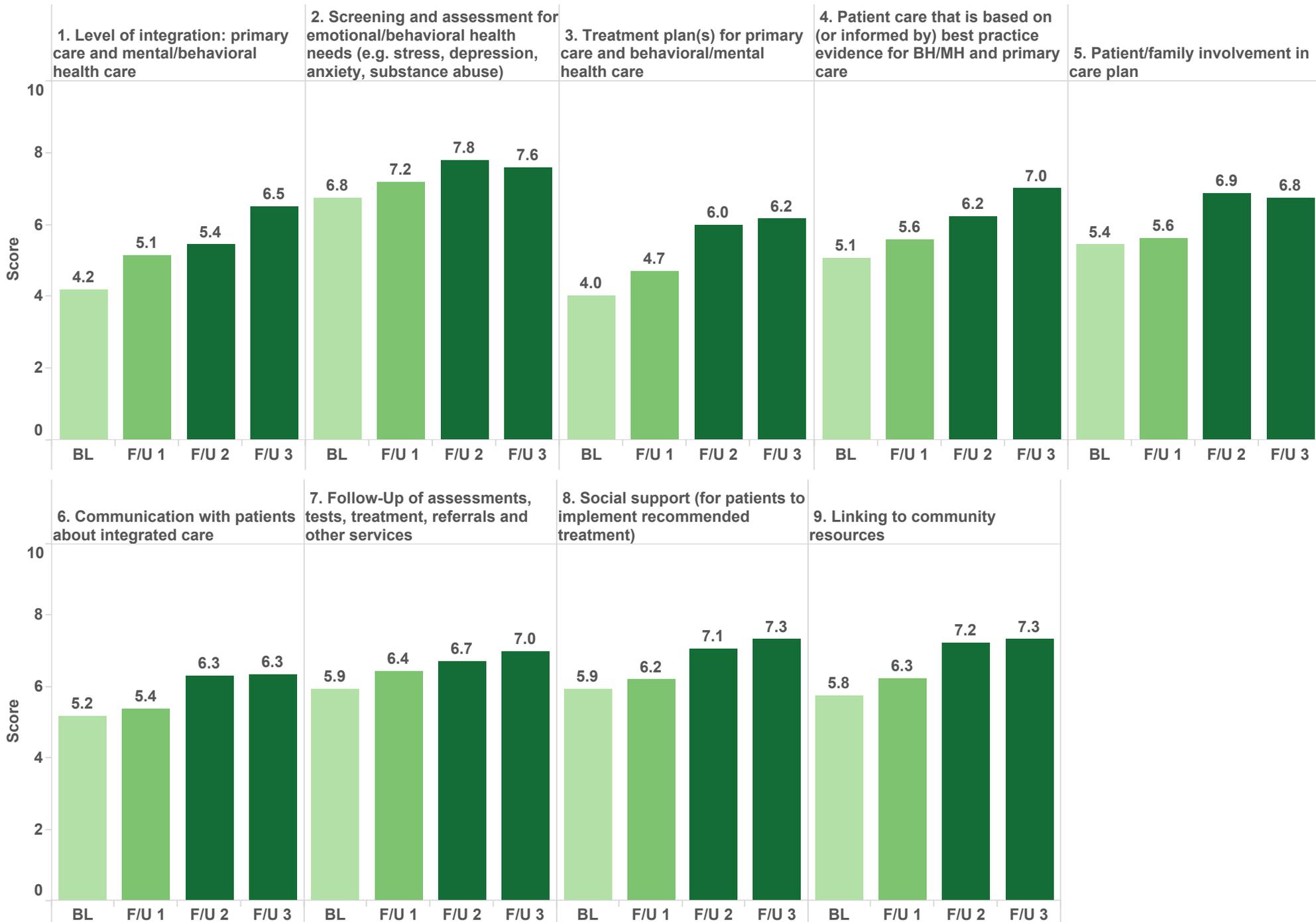
Practice/Organization

	BL	F/U 1	F/U 2	F/U 3
1. Organizational leadership for integrated care	5.1	6.1	6.6	6.8
2. Patient care team for implementing integrated care	3.9	5.0	6.1	6.0
3. Providers' engagement with integrated care ("buy-in")	4.9	5.3	6.8	6.6
4. Continuity of care between primary care and behavioral/mental health	4.9	5.4	6.9	7.1
5. Coordination of referrals and specialists	4.8	5.3	6.9	6.3
6. Data systems/patient records	4.4	5.2	7.0	6.4
7. Patient/family input to integration management	3.9	4.2	5.3	5.0
8. Physician, team and staff education and training for integrated care	3.8	5.1	6.4	6.3
9. Funding sources/resources	3.9	4.4	6.0	5.6

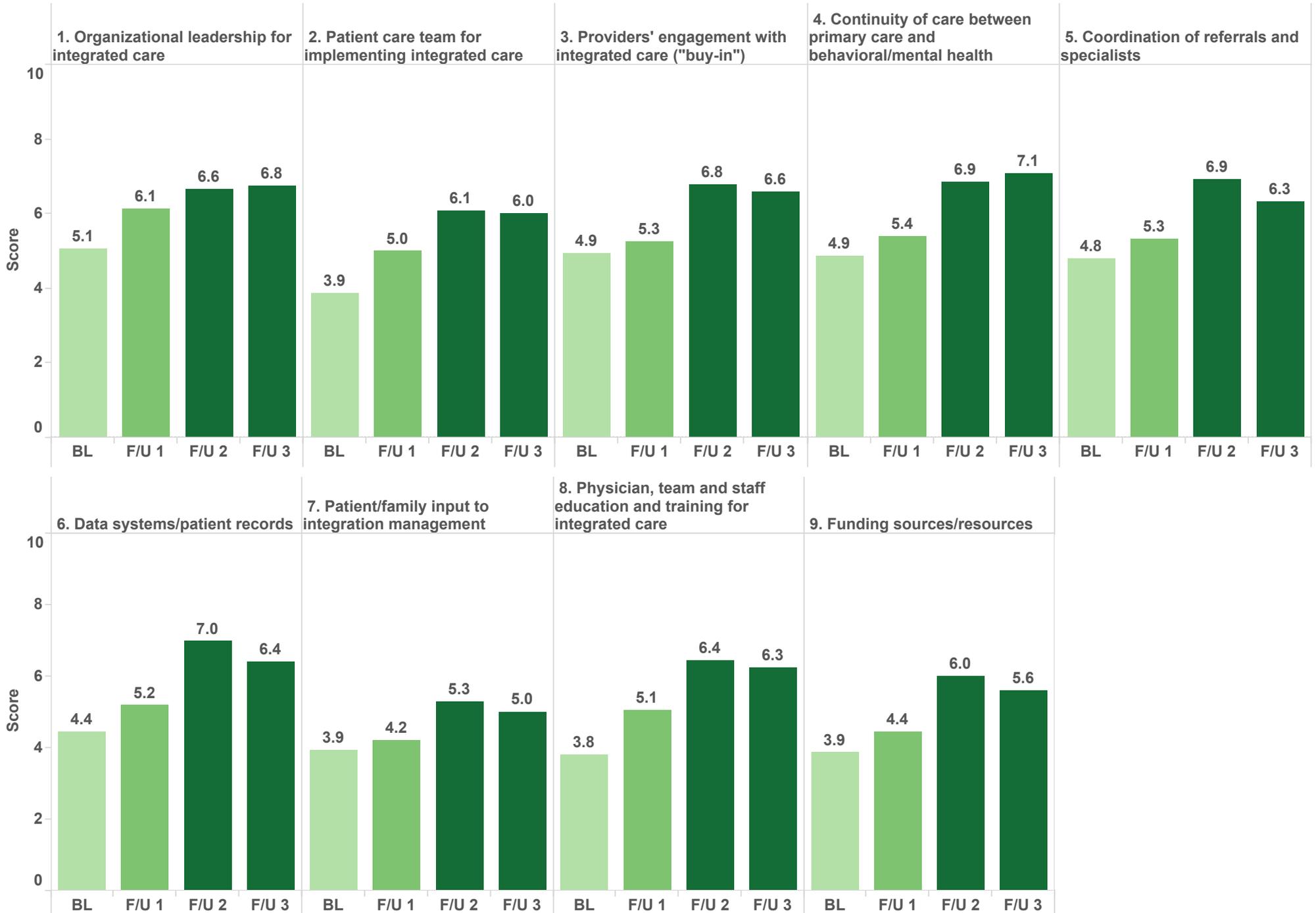


Note: BL - Baseline Assessment; F/U 1 - First Follow-Up Assessment; F/U 2 - Second Follow-Up Assessment, F/U 3 - Third Follow-Up Assessment

Graphics: Domain One, Integrated Services and Patient and Family Centeredness



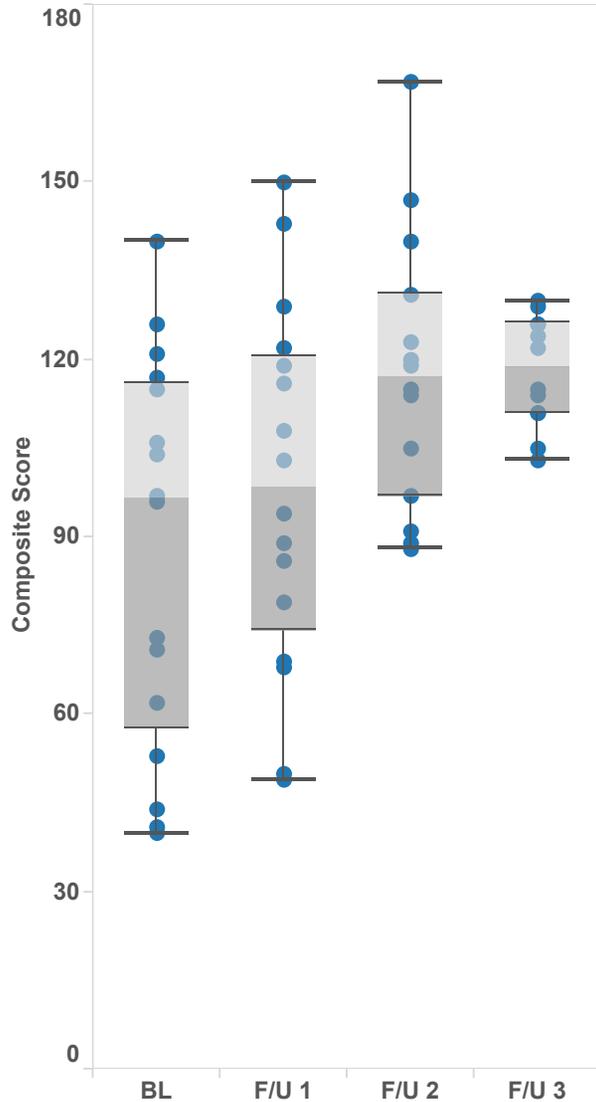
Graphics: Domain Two, Practice/Organization



Site Self-Assessment (SSA) Trend Report

For IDN Leadership Use Only

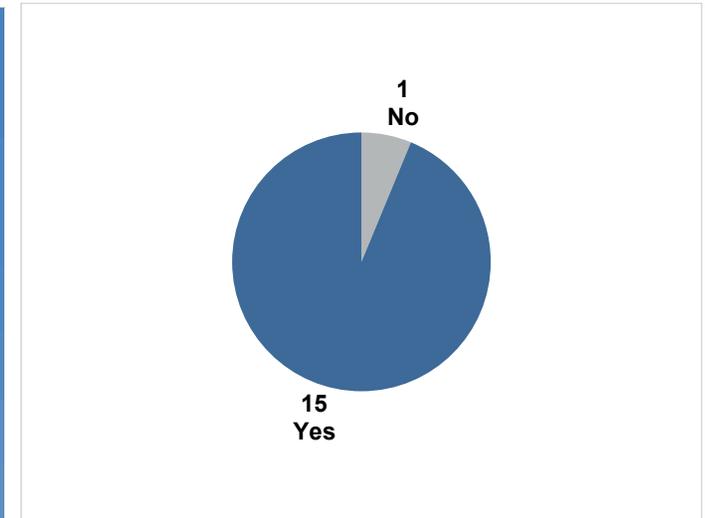
Composite Score Distribution



Composite Scores by Practice

Practice	SSA No.			
	BL	F/U 1	F/U 2	F/U 3
4-113	41	69	123	130
4-115	126	129	147	129
4-106	73	86	120	126
4-112	96	116	97	126
4-110	121	122	131	124
4-109	106	50	119	122
4-117	44	103	140	115
4-121	115	119	114	114
4-105	71	68	89	111
4-114	40	49	105	111
4-101	104	89	91	105
4-102	62	79	115	103
4-103	97	94	88	
4-118	53	108		
4-119	140	150	167	
4-120	117	143		

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



<u>Baseline:</u>	<u>Follow-Up 1:</u>	<u>Follow-Up 2:</u>	<u>Follow-Up 3:</u>
Upper Whisker: 140	Upper Whisker: 150	Upper Whisker: 167	Upper Whisker: 130
Upper Hinge: 116	Upper Hinge: 120.5	Upper Hinge: 131	Upper Hinge: 126
Median: 96.5	Median: 98.5	Median: 117	Median: 118.5
Lower Hinge: 57.5	Lower Hinge: 74	Lower Hinge: 97	Lower Hinge: 111
Lower Whisker: 40	Lower Whisker: 49	Lower Whisker: 88	Lower Whisker: 103

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

SSA No.	3. Treatment plan(s) for primary care and behavioral/ mental health care	6. Communication with patients..	1. Level of integration: primary care and mental/ behavioral health care	5. Patient/family involvement in care plan	4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	7. Follow-Up of assessments, tests, treatment, referrals and other services	8. Social support (for patients to implement recommended treatment)	9. Linking to community resources	2. Screening and assessment for emotional/ behavioral health needs (e.g. stress, depression, anxiety, substance ab..
F/U 3	6.2	6.3	6.5	6.8	7.0	7.0	7.3	7.3	7.6
F/U 2	6.0	6.3	5.4	6.9	6.2	6.7	7.1	7.2	7.8
F/U 1	4.7	5.4	5.1	5.6	5.6	6.4	6.2	6.3	7.2
BL	4.0	5.2	4.2	5.4	5.1	5.9	5.9	5.8	6.8

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

SSA No.	7. Patient/family input to integration management	9. Funding sources/ resources	2. Patient care team for implementing integrated care	8. Physician, team and staff education and training for integrated ca..	5. Coordination of referrals and specialists	6. Data systems/ patient records	3. Providers' engagement with integrated care ("buy-in")	1. Organizational leadership for integrated care	4. Continuity of care between primary care and behavior..
F/U 3	5.0	5.6	6.0	6.3	6.3	6.4	6.6	6.8	7.1
F/U 2	5.3	6.0	6.1	6.4	6.9	7.0	6.8	6.6	6.9
F/U 1	4.2	4.4	5.0	5.1	5.3	5.2	5.3	6.1	5.4
BL	3.9	3.9	3.9	3.8	4.8	4.4	4.9	5.1	4.9

Projects C: Care Transitions-Focused

Narrative

Network4Health's Critical Time Intervention (CTI) program is fully implemented. As of December 31st 2019, we are currently serving 58 clients out of 465 referrals (120 total have consented since inception). Since the program began, 42 participants have graduated. Participants continue to move through the phases of CTI in accordance with fidelity standards of the CTI 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 to complete the Illness Management & Recovery scale (IMR) upon admission.

Of our 42 CTI graduates, 32 completed the IMR scale upon exiting the program. We have calculated that after completing the 9 month CTI program, graduates average a 32.5% IMR score increase. This shows that graduates feel more informed regarding their behavioral health needs.

This reporting period, due to the barrier reduction funds, our Team was able to support participants in receiving needed medications, new photo I.D's (to help gain employment, benefits and housing), help with unknown rent increases and provided transportation for the Diversion Program. All of this helped participants maintain stability in the community and strengthen communication with their coaches and treatment teams.

During this reporting period, the Care Transitions Team completed an internal CTI site self-assessment and an informal CTI Fidelity review. In attendance was the Network4Health Executive Director, Administrative Assistant, Clinical Director and five Care Transition Coaches. The Self-Assessment was scored as a group at 4.53 (Ideally Implemented) and the Fidelity Review had an overall Team score of 69 out of 70 possible points which is a 92 percent rating.

Also during this reporting period, the Care Transitions Clinical Director, Administrative Assistant and the 5 CTI Coaches attended the following trainings:

- July 2019:
 - 7/18/19: Critical Time Intervention (CTI) Fidelity Training: 5 coaches, Clinical Director and Administrative Assistant attended
 - 7/23/19: 5 Coaches and Clinical Director attended the In Person Community of Practice meeting with the other IDN regions.
- September 2019:
 - 9/10/19: 3 Coaches attended the Bed Bug Training
- October 2019:
 - 10/2, 10/23 & 11/13: 1 coach attended the Foundations of Management series
 - 10/16/19: 3 Coaches attended the Trauma Stewardship training
- November 2019:
 - 11/22/19: 5 Coaches attended the In Person Community of Practice meeting with the other IDN regions.
- December 2019:
 - 12/6/19: 4 Coaches and Assistant Coordinator attended a Functional Support Services training provided by The Mental Health Center of Greater Manchester.

Project Targets

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.

In September 2019, the Director of the Care Transitions Team stepped down from her position, and one of the Care Transition Coaches, assumed the role of Interim Director. In December 2019, in a step towards sustainability planning, the Care Transition team was moved into the Emergency & Interim Care Services department at The Mental Health Center of Greater Manchester (MHCGM), alongside MHCGM’s existing Intensive Transition Team. The Coordinator of the Intensive Transition Team took over management of both teams, and the aforementioned Interim Director was named Assistant Coordinator of both teams. Throughout this period of changes, referrals to the Care Transitions Team have remained strong, and fidelity to the model has remained intact.

This reporting period referrals have continued to increase with a record high of 39 referrals received for the month of September and 172 total new referrals in the last 6 months. The increase in referrals is due to the strengthening of our reach in the community and collaborating with new referral sources such as: New Hampshire State Prison for Men and Woman, Farnum Center-Manchester, and Families In Transition.

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

- This data is 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.
- This period our performance measures show that the number of Mental Health and Substance Use Disorder treatment visits continue to decrease as participants work their way through each Phase. In the first three months of CTI, participants average 6.32 appointments and by Phase 3 (months 6-9) they average roughly 5 visits per month. As stated before, it can be summarized that participants are experiencing both improvement in symptom management, resulting in a decrease of services once connected to a treatment team or due to social determinants, harder to engage in Phase 1.
- In this reporting period we were able to increase Community Resource connections by 2.33% from the last reporting period.

Note: The numbers below include the cumulative number of all clients served during this reporting period and since inception of the program. 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.

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	120

Performance Measure Name	Target	Progress Toward Target		
Number of individuals referred to program (cumulative)	Up to 333	163	294	465
Number of individuals completed program (cumulative)	Up to 333	12	30	42
# of days from transition to first BH outpatient visit (n=120)	Up to 20 days	12.08	11.74	11.48
Average # of Mental health & substance abuse visits at end of Phase 1 (n= 98)	Up to 4	6.41	5.74	6.32
Average # of Mental health & substance abuse visits at end of Phase 2 (n=69)	Up to 6	6.25	6.2	6.05
Average # of Mental health & substance abuse visits at end of Phase 3 (n=60)	Up to 8	4.75	5.55	5.15
Increase average # of community resource contacts from program enrollment to program completion (based on number of graduates) (n=42)	Up to 5	N/A	6	6.14

As an example of a participant we were able to engage in the community, we provide the following:

This client was referred to the Care Transitions Team via inpatient to community referral. They came to the team with a total of 8 inpatient hospitalizations over the last two years, 2 of which were Involuntary Admissions (IEA). This resulted in 30 total beds days, client was not connected to any long term mental health treatment and was in great need. By the end of this client's 9 months with the Care Transitions Team and participating in Critical Time Intervention (CTI), this person had no inpatient hospitalizations, was effectively engaging with their new Treatment team and, has since established independence within the community. This is one story of many, that the Care Transitions Team has been a part of since the waiver started.

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 C1 Care Transitions project budget is presented below. Modifications have been made based on the following factors:

Revenue- Project budgets reflect the actual funding received. Potential, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced or eliminated as a result of ongoing negotiations with NH counties, or due to unmet performance metrics, Network4Health shall revise budget and project plan deliverables subject to its Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) through December 2019 are presented. Anticipated expenses for the remaining waiver term are also presented. Given that final incentive funding is not expected to be received until mid to late 2021, we have projected expenses in that time period.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
C1: Care Transitions Revenue (New)	\$ 230,012	\$ 174,809	\$ 357,098	\$ 618,183	\$ 477,085
C1: Care Transitions Revenue (Rollover)		\$ 218,891	\$ 143,449	\$ 214,333	\$ 177,732
Total Revenue	\$ 230,012	\$ 393,700	\$ 500,547	\$ 832,516	\$ 654,817
Salary and benefits- Transitions Coaches (6.0 fte) and Administrative Assistant (1.0 fte)		\$ 219,564	\$ 256,641	\$ 570,000	\$ 570,000
Technology (Laptops, phones, software)	\$ 8,955	\$ 16,640	\$ 14,364	\$ 28,650	\$ 28,650
Barrier Reduction Funds (Client Emergency funds and Interpretation Services)		\$ 887	\$ 1,411	\$ 40,000	\$ 40,000
Occupancy	\$ 2,166	\$ 13,160	\$ 13,798	\$ 16,134	\$ 16,134
Total Expenses	\$ 11,121	\$ 250,251	\$ 286,214	\$ 654,784	\$ 654,784
Variation to Budget (Transfer Funds to Subsequent Year)	\$ 218,891	\$ 143,449	\$ 214,333	\$ 177,732	\$ 33

Projects D: Capacity Building Focused

Narrative

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

With support from Network4Health, The Elliot Hospital Partial Hospitalization Program (PHP) was developed to serve the Greater Manchester community successfully opened in October 2018. Over the course of slightly more than a year, program staff have continued to work closely with our community partners, continued to educate the community in the areas of stigma and discrimination, expanded the community's knowledge on co-occurring disorders, and continued to increase the our patient census. Additionally, The Partial Hospitalization Program has fully participated in Network4Health's B1 Integrated Healthcare project – completing an Integration Enhancement Plan ensuring that the Partial Hospitalization Program and primary care staff are fully versed in more effective care coordination and communication through increased training. Lastly, our participation in the Network4Health E4 Integrated Treatment of Co-Occurring Disorders project has helped to increase our effectiveness in providing treatment for both mental health and substance use issues, by accessing evidence-based curriculum and training bachelor-level staff in both areas.

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.*

REFERRALS/ADMISSIONS

As of December 31, 2019, 293 individuals had been evaluated for the Partial Hospitalization Program, as compared to 185 clients in the previous Semi Annual Report. The Program was able to maintain a daily census of roughly 9-10 individuals, (the maximum census is 12). Available space has been a limiting factor. The Program continues to struggle with referrals from community agencies, in particular, the Manchester Doorway, despite efforts to clarify the benefits of a Partial Hospitalization Program. During this reporting period, the Program received approximately 8 referrals from the Doorway. However, referrals have been received from the Concord Doorway. The largest number of referrals are from individuals who have been informed or referred by graduates of the program. Program staff believe that is one major indicator of our success. To increase our referrals, a consultant is being considered to assist in surveying the community to determine the reason for the lack of referrals and to seek improvements community education efforts.

RECORD REVIEWS

The Program engages in monthly reviews by billing and compliance staff. Additionally, both staff and the supervising psychiatrist review the medical records weekly. Therefore, 100% of the charts have been reviewed and audited for accuracy and appropriateness by three separate departments.

REFERRALS TO AFTERCARE

In order to be effective, any program that addresses co-occurring diagnoses, must collaborate and coordinate with referral agencies – both that send referrals and receive referrals. One of the most effective ways that we have been able increase our referrals is to concentrate on closer collaboration with agencies and staff that have referred clients to us. An example is the Concord Doorway. Through frequent case coordination efforts, a clinical relationship has developed that includes mutual trust of the programs and the staff. Additionally, as stated previously, the Program has focused heavily on improving care coordination with primary care providers that have both referred to the PHP and that have the Program has referred to. As part of this collaboration, PHP staff have been able to educate providers and their staff about specific behavioral patterns that can both enhance and impede a client’s progress. This has resulted in more effective care for mutual clients and reduced stigma towards this population.

Within 72 hours of evaluation, individuals or agencies who refer clients to the PHP are contacted and treatment and discharge plans are discussed. This coordination and collaboration continues throughout the program. 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 providers or programs.

Staff continue to contact patients at 3 months, 6 months and 12-month intervals after the program completion. This has continued to enhance the community collaboration that has already been established for that client. Most importantly, this process has allowed program staff to identify clients who may be struggling with their recovery and immediately re-assist those clients with a resumption of treatment and services.

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	293
# of Program Completions	Up to 80% by 12/31/18	19%	50%	100%
# of chart reviews per quarter	Up to 50% by 12/31/18	50% documentation and 100% billing and coding	100% billing, coding and documentation	100% billing, coding and documentation

Performance Measure Name	Target	Progress Toward Target		
# of patients successfully referred to aftercare programs in the community	Up to 80% by 12/31/18	74%	100%	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 D3 Capacity Building Focused- SUD Expansion project budget is presented below. Modifications have been made based on the following factors:

Revenue- Project budgets reflect the actual funding received. Potential, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced or eliminated as a result of ongoing negotiations with NH counties, or due to unmet performance metrics, Network4Health shall revise budget and project plan deliverables subject to its Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) through December 2019 are presented. Anticipated expenses for the remaining waiver term are also presented. Given that final incentive funding is not expected to be received until mid to late 2021, we have projected expenses in that time period.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
D3 SUD EXP. Revenue (New)	\$ 230,012	\$ 174,809	\$ 357,098	\$ 618,183	\$ 477,085
D3 Revenue (Rollover)		\$ 230,012	\$ 404,821	\$ (167,163)	\$ (17,522)
Total Revenue	\$ 230,012	\$ 404,821	\$ 761,919	\$ 451,020	\$ 459,563
Salaries and Benefits			\$ 570,057	\$ 468,542	\$ 459,563
Rent, Utilities & Housekeeping	\$ -		\$ -		
Cell Phones			\$ -		
Lab	\$ -		\$ -		
Food/Snacks	\$ -		\$ -		

Travel/Training	\$ -		\$ -		
Marketing	\$ -		\$ -		
Miscellaneous Supplies	\$ -		\$ 1,931		
Start Up Costs					
EMR build and implementation	\$ -		\$ 323,189		
FF&E	\$ -		\$ -		
Security	\$ -		\$ 4,938		
IT Hardware/Infrastructure	\$ -		\$ 21,657		
Facility/Construction	\$ -		\$ -		
Signage (internal and external)	\$ -		\$ -		
Miscellaneous/Contingency	\$ -		\$ -		
On-boarding	\$ -		\$ 7,310		
Total Expenses	\$ -	\$ -	\$ 929,082	\$ 468,542	\$ 459,563
Variation to Budget (Transfer Funds to Subsequent Year)	\$ 230,012	\$ 404,821	\$(167,163)	\$ (17,522)	\$ -

Projects E: Integration Focused

Narrative

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

Network4Health E4 Project Progress Update

Network4Health's Integrated Treatment of Co-occurring Disorders (ITCOD)/E4 project 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 partner agencies. The E4 project team continued to follow its implementation plan between July and December 2019, using two parallel approaches to enhance the identification, treatment and referral to integrated treatment for patients with co-occurring disorders:

- Dual Diagnosis Capability (DDC) program assessments and organizational quality improvement plans (QIPs) to support the increased availability of integrated treatment services within Network4Health partner agencies mental health and substance use disorder programs using the Dual Diagnosis Capability in Mental Treatment or in Addiction Treatment Index
- Integrated treatment of co-occurring disorders training and support activities for primary care and community-based social service organizations

Network4Health's E4 project trained a team of New Hampshire-based subject matter experts in dual diagnosis capability assessments and integrated treatment of co-occurring disorders program structure through formal training and practical assessment shadowing with trainers from the Center for Evidence Based Practice at Case Western Reserve University (CEBP) in 2018. The team is led by the Network4Health Director of Co-occurring Disorders. The Director has maintained consultation sessions with the Center for Evidence Based Practice throughout 2018 and 2019 to draw upon the expertise of the Case Western team to inform the Dual Diagnosis Capability (DDC) assessments and quality improvement plan development with Network4Health partners.

A Dual Diagnosis Capability assessment report includes scores on 35 benchmarks across 7 domains within the Dual Diagnosis Capability Index on how capable a program is to work with individuals with co-occurring disorders. As shown in the table below, the scoring range includes: Addiction (AOS) or Mental Health Only Services (MHOS): includes treatment programs that cannot accommodate patients with co-occurring mental health disorders that require ongoing treatment, no matter how stable or functional the patient (assessment score range: 1.0-1.99); Dual Diagnosis Capable (DDC) Programs: treatment programs that have a primary focus on treating substance use or mental health disorders, however are capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring disorders (assessment score range: 2.0-3.49); and Dual Diagnosis Enhanced (DDE) Programs: Programs at this level are designed to treat patients who have unstable or disabling co-occurring mental health disorders or substance use disorders (assessment score range: 3.5-5.0). Thus far, the average scoring of the five agency programs that have been assessed with the DDC is 2.56, which falls on the lower end of "Dual Diagnosis Capable". It is our hope that through the use of E4 project quality improvement plans (QIPs) and consultation support from the Network4Health Co-occurring Disorders Clinical Director, the agencies will be able to work toward increasing their "Dual Diagnosis Capable" competencies.

DUAL DIAGNOSIS CAPABILITY INDEX DESIGNATIONS:	DDC Assessment Score Range
Addiction (AOS) or Mental Health Only Services (MHOS)	1.00 – 1.99
Dual Diagnosis Capable)	2.00 - 3.49
Dual Diagnosis Capable/ Dual Diagnosis Enhanced (DDC/DDE)	3.50 – 4.49
Dual Diagnosis Enhanced (DDE)	4.50 – 5.00

During the *July 2019 to December 2019* project period, the E4 project participants made the following progress:

New Dual Diagnosis Capability Assessments

Network4Health was pleased to welcome two new programs to the project in this reporting period. Catholic Medical Center’s Behavioral Health Services Department completed an onsite Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) program assessment of their adult mental health services in October 2019. Elliot Health System completed their second program assessment completing a Dual Diagnosis Capability in Addiction Treatment (DDCAT) assessment of their Intensive Outpatient/Drug Court program in early December 2019. Assessment reports and program recommendations were developed and delivered to each program by the Network4Health Co-occurring Disorders Clinical Director, with input from the Dual Diagnosis Capability (DDC) Assessors that participated in each onsite visit. Network4Health has maintained contract hours for DDC Assessors with three behavioral health clinicians from partner agencies who were trained in 2018, in addition to our Network4Health Co-occurring Disorders Clinical Director, to provide Dual Diagnosis Capability onsite assessments and program quality improvement recommendations.

Catholic Medical Center’s Behavioral Health Services Department is currently refining their quality improvement plan for the remainder of 2020 based on the delivery of their DDCMHT assessment report in December 2019. The Network4Health Co-occurring Disorders Clinical Director presented the assessment summary report to Elliot Health System’s Intensive Outpatient (IOP)/Drug Court program on January 3, 2020. The IOP/Drug Court team has decided to evaluate the recommendations for future quality improvement initiatives, and has decided not to move forward with a Network4Health E4 project quality improvement plan at this time.

In-progress Quality Improvement Plans

The following E4 project partners continued to make progress towards the goals laid out in each of their quality improvement plans based on their most recent dual diagnosis capability assessment during this reporting period. The Network4Health Co-occurring Disorders Clinical Director meets as needed with each partner to assess progress and provide consulting support for their goals to increase knowledge and capacity to provide integrated treatment for patient with co-occurring mental illness and substance

use disorders. In addition to progress review meetings, each partner is required to submit status reports to Network4Health every quarter outlining the progress made toward their quality improvement plan goals. Partner organizations have all submitted progress reports for the July through September 2019 and October through December 2019 time periods. An overview of the each partners dual diagnosis capability assessment history, quality improvement plan goals and progress made during the reporting period is summarized below:

○ **Center for Life Management (CLM): Adult Services Program**

- Assessment Type: Dual Diagnosis Capability in Mental Health Treatment
- Assessment #1: October 17, 2017
- Assessment #2: February 27, 2019
- Current Quality Improvement Plan Timeline: May 2019 - May 2020
- Quality Improvement Plan goals to increase dual diagnosis capabilities:
 - To support clinician’s knowledge and use of co-occurring disorder interventions through both individual and group supervision.
 - Increase capacity within the CLM electronic health record (EHR) to implement, track, and report upon co-occurring disorder related interventions and documentation related to interventions.
 - Begin process of developing Vivitrol Clinic. Program development may include: policy and procedure development, medication assisted treatment (MAT) related trainings for staff, research and development of intervention protocols and the creation of program related materials. The goal also includes training up to 80 staff.
 - Increase staff’s competency in understanding and treating clients with co-occurring disorders through training efforts. Training may include any of the following: Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), Trauma Informed Care, Stages of Change, Motivational Interviewing, Illness Management & Recovery (IMR), use of American Society of Addiction Medicine (ASAM) Criteria, any core competencies related to substance use disorder, diagnosing substance use disorders using the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). The goal includes training up to 80 staff.
- Quality Improvement Plan Progress July – December 2019:

Through support from the E4 program, CLM continued to provide weekly group supervision to ten supervisees working towards either their Licensed Alcohol and Drug Counselor (LADC) or Masters Level Alcohol and Drug Counselor licensure thus increasing the capacity of CLM to provide treatment to clients with co-occurring mental illness and substance use disorder.

CLM created a weekly Integrated Treatment of Co-Occurring Disorders and Medication Assisted Treatment (ITCOD/MAT) work group based on their initial dual diagnosis capability assessment. The ITCOD/MAT work group has evolved and is currently focused on the definition and creation of wrap-around services for those receiving Vivitrol, as well as defining protocols and clinical expectations of MAT involved clients. Outside of this work group, the Medical Director has provided consultation through supervision sessions to increase the knowledge and comfort of the medical team at CLM regarding the specific use of Vivitrol and broader MAT learning exchanges.

To further support clients in varying stages of recovery and those with co-occurring disorders, CLM is making multiple efforts to increase access to peer recovery opportunities for clients in their agency. CLM created a new Certified Recovery Support Worker (CRSW) position (without funding from the E4 project). This position aims to integrate a peer recovery specialist into the CLM team based model, strengthening service delivery for those with co-occurring disorders. Additionally, CLM has registered ten direct service providers (inclusive of clinicians, community case managers, and community support counselors) for the Self-Management and Recovery Training (SMART) Facilitator program to enhance CLM's peer recovery group options in the southern part of the Network4Health region.

To increase programming options to clients with co-occurring disorders, CLM has resumed the group offering: "Pathways to Recovery". This group is aimed at educating and supporting individuals with co-occurring disorders. Both of the group facilitators are actively involved in a weekly Masters Level Alcohol and Drug Counselor (MLADC) group supervision session to continue to build their competencies in treating those with co-occurring mental illness and substance use disorder.

Electronic health record capacity related to identification and tracking of individuals being treated for co-occurring disorders continues to be refined. There have been numerous changes implemented including capacity to monitor and trigger different points of data entry related to SUD diagnoses, client stage of change, and relevant interventions. Additionally, an enhanced care plan/case management progress note is being piloted within the program, with plans to streamline SUD assessment criteria inclusive of recommended pathways/action steps. CLM intends to use this information moving forward to gauge the efficacy of the assessment criteria, and work towards identifying barriers to effective assessment. The hope is that this work will influence the treatment interventions along the co-occurring disorders treatment continuum.

Enhancing the knowledge and skills of CLM staff continues through trainings and supervision. Training topics have included Harm Reduction Strategies and Motivational Interviewing. MLADC/LADC supervision continues with regular staff attendance, and is a significant weekly platform for learning. Additionally, CLM clinical staff has continued to be active participants in the MAT Extension for Community Healthcare Outcomes (Project ECHO) Learning Collaborative sessions hosted by the University of New Hampshire. CLM's Medical Director is also in the process of developing two foundational trainings on "Addiction and the Brain". These trainings will be an opportunity to discuss MAT and comprehensive addiction treatment. The training will outline how CLM will further integrate MAT into care planning when indicated. It is estimated that between sixty and seventy interdisciplinary staff will attend these trainings.

- **Elliot Health System: Partial Hospitalization Program (PHP)**
 - Assessment Type: Dual Diagnosis Capability in Addiction Treatment
 - Assessment #1: June 10, 2019
 - Quality Improvement Plan Timeline: July 2019- June 2020
 - Quality Improvement Plan goals to increase dual diagnosis capabilities:

- Review, update and/or create marketing and program materials for the program aimed at informing community members and potential clients.
- Perform analysis of existing program to gather information about sustainability.
- Increase family education group availability and frequency
- Increase staff knowledge and skills regarding co-occurring disorder identification, assessment and diagnosing, and treatment interventions.
- Increase capacity within the Elliot Health System electronic health record (EHR), Epic, to implement, track, and report upon co-occurring disorders related interventions and documentation.
- Support licensing and certification of staff members to support the treatment of patients with co-occurring disorders.
- Increase available patient resources for substance use disorders, mental health and co-occurring disorders: both in patient waiting and common areas, as well as for clinicians to utilize in individual and family sessions.
- Quality Improvement Plan Progress July – December 2019:
Elliot Health System has revised marketing brochures for the Partial Hospitalization Program and distributed them to Network4Health partner agencies. Additionally, they are developing a more comprehensive approach to community marketing to assure that community agencies are aware of the program and the services it provides for individuals with co-occurring disorders.

Staff at the Elliot PHP continues to attend trainings to increase their skills and knowledge of identification and treatment of co-occurring disorders. Upcoming plans for trainings include Neurobiology of Addiction, Connect Suicide Prevention, and Compassionate Care for Infants and Families Affected by Perinatal Substance Exposure, HIV Trends & Treatment and Reentry and Recidivism. PHP staff continue to meet for supervisions for both licensure efforts, as well as to monitor and encourage use of evidence based interventions for co-occurring disorders.

EHR changes have been completed, allowing for an increased and improved ability to implement, track and report on co-occurring disorders related interventions. This includes expanding the identification of both substance use and behavioral health diagnoses on EHR documents, and looking critically at the staff members that have access to client files and related documentation, in an effort to protect and increase confidentiality of patients receiving co-occurring disorders treatment.

The Partial Hospitalization Program also increased the display and distribution of client and clinician resources for substance use disorder, mental health and co-occurring disorders within their waiting areas, and staff offices during the reporting period. Additionally, a decision was made to select a Family Based Curriculum through Hazelden, with plans to purchase and implement supportive services for families of clients in the first quarter of 2020.

- **Families in Transition- New Horizons (FIT-NH): Willows Intensive Outpatient Program (IOP) for Men and Women**

- Assessment Type: Dual Diagnosis Capability in Addiction Treatment
- Assessment #1: October 16, 2017
- Assessment #2: February 28, 2019
- Quality Improvement Plan Timeline: May 2019-April 2020
- Quality Improvement Plan goals to increase dual diagnosis capabilities:
 - Increase staff competency in understanding and treating clients with co-occurring disorders through increased training opportunities (both registration fees and staff productivity offset). Training may include any of the following: Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), Trauma Informed Care, Stages of Change, Motivational Interviewing, Illness Management & Recovery (IMR), use of American Society of Addiction Medicine (ASAM) Criteria, any core competencies related to substance use disorder, diagnosing substance use disorders using the Diagnostic and Statistical Manual of Mental Disorders (DSM–5).
 - Provide additional resources to consumers regarding co-occurring disorders such as group education materials, brochures, posters, informational packets, rack cards or multi-media displays.
 - Support licensure efforts of staff through funding for licensure related costs for those working towards their masters level licensed alcohol and drug counseling (MLADC), licensed alcohol and drug counseling (LADC), licensed clinical social worker (LCSW), licensed clinical mental health counselor (LCMHC), certified recovery support worker (CRSW) or Intentional Peer Support (IPS).
 - Support ongoing clinical supervisions (group and individual) for the above roles to support increased treatment capabilities for clients with co-occurring disorders.
- Quality Improvement Plan Progress July – December 2019:

The Families in Transition-New Horizons Willows IOP program staff continue to add resources to the Resource Guide that is aimed at providing the most up to date resources for both clients and staff. The binder has been used in individual and group settings, highlighting topics and educational materials with participants; and to create standardization throughout programming. Additionally, CRSW Supervisors have used the binder as a guide to establish and structure CRSW Supervisions, for staff looking to obtain the CRSW credential.

The Willows IOP Program has implemented the use of a monitor in the waiting room that displays co-occurring messaging throughout the day. This allows the information that is present in displayed brochures to be highlighted while clients are waiting for group or appointments.

The team continues to use the Addiction Severity Index and ASAM criteria to diagnose substance use disorders and to determine the appropriate level of care. Additionally, regular utilization of the PHQ9 (Patient Health Questionnaire for Depression) and PCL5 (a Post-Traumatic Stress Disorder (PTSD) screening tool) is happening during intake with each participant, and the results are being reviewed directly in that session. To help accurately assess both substance use disorder and mental health diagnoses to help guide co-occurring treatment interventions.

Quality assurance meetings are being held each quarter with the team to review charts and submit improvement ideas around co-occurring disorders interventions and documentation.

Fifteen staff members continue to receive clinical supervision, both individual and in group/team formats. Staff also continues to attend multiple trainings, including ASAM and Cognitive Behavioral Therapy (CBT) Strategies to continue their education.

The FIT-NH Willow's Program Manager also continues to research various treatment modalities for treating depression, anxiety and trauma. This continues to be a priority for the treatment program.

- **FIT-NH: Open Doors Program**

- Assessment Type: Dual Diagnosis Capability in Addiction Treatment
- Assessment #1: June 10, 2019
- Quality Improvement Plan Timeline: June 2019-May 2020
- Quality Improvement Plan goals to increase dual diagnosis capabilities:
 - Clarify process of gathering external client information and increase coordination of care efforts with community based providers, including documenting intake process/workflow, process for consent to release, and ensuring coordination with client care team: medical, mental health, SUD providers, community social support agencies, government agencies (e.g. DCYF, Medicaid, etc.)
 - Document process for communication with external agencies (data points to release or request from different types of agencies/provider, frequency of information sharing, etc.)
 - Train all staff on current intake procedures, consent to release process and care coordination workflows of the program.
 - Support licensure efforts of staff through funding for licensure related costs for those working towards their masters level licensed alcohol and drug counseling (MLADC), licensed alcohol and drug counseling (LADC), licensed clinical social worker (LCSW), licensed clinical mental health counselor (LCMHC) and certified recovery support worker (CRSW).
 - Increase staff knowledge and skills regarding co-occurring disorders identification, assessment and diagnosing, and treatment interventions.
 - Increase tools and content utilized in family based interventions and programming.
 - Increase available patient resources for substance use disorder, mental health and co-occurring disorders in patient waiting and common areas, as well as for clinicians to utilize in individual and family sessions.
- Quality Improvement Plan goals to increase dual diagnosis capabilities:

FIT-NH's Open Doors Program has been focusing on increasing staff training in co-occurring disorders. They have sent several clinical staff members to a wide range of co-occurring related trainings and family based co-occurring treatment to build up knowledge and skills. Additionally, The Open Doors team has developed a quality assurance process to assess charts and ensure co-occurring best practice in alignment with the work being done by the Willows IOP team.

The Open Doors program has three staff members working towards licensure that continue to meet for both individual and group supervision with support from Network4Health's E4 project. The team is currently looking at family focused, evidence based curriculums and assessment tools to enhance family based treatment for the first half of 2020.

The Open Doors team has been actively discussing Authorization for the Release of Information (ROI) forms in consult meetings to ensure accuracy, and understanding from the clinical team in regards to limited, yet appropriate completion of the forms (including but not limited to reviewing all options with the client, providing accurate contact numbers and agency information, and all clients have complete parental authorization, as appropriate). Additionally, a policy change has been made in regards to completion of releases happening on an individualized, as needed basis; as opposed to having all clients fill out the same releases for all external parties, regardless of their level of involvement. The Open Doors team has been conducting Quality Assurance on all charts, allowing us to check and assess ROI's and ongoing coordination of care. Specifically, a focus on having clinicians complete notes for all coordination of care efforts for clients. These notes are a focus of the QA process review, and continue to be monitored.

The Open Doors team continues to create and strengthen partnerships with outside agencies to increase effective and positive communication for coordination of care through face to face meetings and discussion of continuum of care services and needs for mutually served clients.

- **Mental Health Center of Greater Manchester (MHCGM): Residential Program (Cypress Center), Emergency Services & Interim Care Program and the Assertive Community Treatment (ACT) program**
 - Assessment Type: Dual Diagnosis Capability in Mental Health Treatment
 - Assessment #1: September 28, 2017
 - Assessment #2: February 27, 2019
 - Quality Improvement Plan Timeline: May 2019-April 2020
 - Quality Improvement Plan Goals to increase dual diagnosis capabilities:
 - Increase family education group availability and frequency
 - Expand medication assisted therapy (MAT) services including, but not limited to below activities:
 - Policy/procedure development
 - MAT related trainings for staff (including ASAM (targeting up to 30% of all staff)
 - Project ECHO MAT Collaborative through the University of New Hampshire (up to 20 staff)
 - intervention protocols and related materials
 - Standardize use of a Stage Wise Assessment for both mental health and substance use disorders throughout the course of treatment

- Provide additional consumer resources regarding co-occurring disorders including but not limited to: brochures, posters, informational packets, rack cards, multi-media displays.
- Support increase of individuals obtaining and maintaining credentials through the State of NH Board of Alcohol and Drug Use Professionals
- Quality Improvement Plan Progress July – December 2019:

MHCGM hosted an educational series for individuals who have a friend or family member with co-occurring disorders; the Family 411 Series was held in July 2019 and there is a meeting planned for January 2020 to discuss partnership with another Network4Health partner to hold groups at a primary care site. Additionally, a Friends and Family Group has been developed and rolled out on site at MHCGM.

Policy/procedure development around Medication Assisted Therapy (MAT) programming has been ongoing, with the most recent revisions occurring in August 2019. As of December 2019, 21.4% of staff has been trained in MAT education, and opioid misuse. MHCGM staff continues to participate in the Project ECHO MAT Collaborative through the University of New Hampshire (36 staff total have attended and participated in 9 sessions from April- December 2019).

In September 2019, four supervisors attended a MITI (Motivational Interviewing Treatment Integrity) training to improve supervisor capacity to evaluate competency in motivational interviewing. As a follow up, each manager sat in on one supervisory session with staff, and reviewed their findings at a Clinical Services Team meeting. Further training on MITI coding is in the process of being scheduled, as well as in house trainings to expand the capacity of MITI at MHCGM. Clinical staff continues to offer, and attend both Introductory and Intermediate Motivational Interviewing trainings, and an onsite monthly Motivational Interviewing Study Group continues to be open to all staff.

MHCGM has worked to standardize the use of Stage Wise Assessment for clients with co-occurring disorders throughout the course of treatment, from intake through treatment planning. Stage of Change indicators continue to be developed for addition to the Cypress Center Treatment Plan.

Client and staff resources continue to be displayed in waiting areas, and the staff portal continues to be a hub for resources accessible to clinicians, for their own use, as well as to share with clients. The Substance Misuse Committee is the approving body for all resources prior to their acceptance into the portal.

There are a number of staff members who have been able to obtain, renew and work towards licensure through the State of NH through the support of the Network4Health E4 project. Currently, MHCGM as an agency has nine x-waivered prescribers (prescribers certified to provide buprenorphine medication assisted therapy to patients with substance use disorder), and an additional five working towards their waiver. Fourteen staff members are working towards credentialing through the Board of Alcohol and Drug Use Professionals, and an additional fifteen staff are actively licensed through the Board.

- **Pastoral Counseling Services (PCS)**

- Assessment Type: Dual Diagnosis Capability in Mental Health Treatment
- Assessment #1: March 29, 2018
- Assessment #2: February 28, 2019

- Quality Improvement Plan Timeline: August 2019- July 2020
- Quality Improvement Plan Goals to increase dual diagnosis capabilities:
 - Support ongoing clinical supervision (both individual and group) and supervisor capacity through consultation for supervising clinician’s applications of co-occurring disorders interventions
 - Support attendance at monthly MLADC-led group collaboration and consultation for all clinical staff
 - Increase staff competency in understanding and treating co-occurring disorders through increased training opportunities (both registration fees and staff productivity offset). Training may include any of the following: Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), Trauma Informed Care, Stages of Change, Motivational Interviewing, use of American Society of Addiction Medicine (ASAM) Criteria, Medication Assisted Treatment, Suicide (pre and post) interventions, diagnosing substance use disorders using the Diagnostic and Statistical Manual of Mental Disorders (DSM–5).
 - Increase group availability for clients with substance use disorder and/or co-occurring disorders by offering up to 3 groups, facilitated by up to 2 staff.
 - Increase staff’s knowledge of local peer recovery support agencies and groups, and referral processes.
 - Increase capacity within the electronic health record (EHR) to implement, track, and report upon co-occurring disorders related interventions and documentation.
- Quality Improvement Plan Progress July – December 2019:

Four PCS clinicians continue to receive individual supervision towards their Masters Level Licensed Alcohol and Drug Counselor (MLADC) licensure. It is expected that one of the clinicians will have completed requirements for licensure within the first quarter of 2020. Additionally, the MLADC on staff continues to offer a monthly co-occurring disorders group collaboration that is open to all staff with the aim of increasing skill and knowledge in identifying and treating co-occurring disorders. To supplement the in-house collaboration, staff has been regularly attending trainings pertinent to identifying, treating and managing co-occurring disorders including but not limited to: Legal and Ethical Issues with Technology in Mental Health, Substance Use Counseling Skills and Core Functions and Substance Use Disorders (Caffeine and Benzodiazepine and Inhalants and Hallucinogens). See attached training grid for additional information on attended trainings by PCS staff.

PCS continues to offer a weekly therapeutic group for clients to discuss strategies for recognizing and addressing co-occurring disorders. The group is co-facilitated by an MLADC and an MLADC eligible clinician.

PCS continues to work on identifying and implementing a clinical Stages of Change/Motivational Interviewing (SOC/MI) assessment tool to complete throughout the treatment process with clients. Discussions to develop policies and identify barriers to implementation continue at staff meetings.

Peer Recover Support for People with Co-occurring SUD and Mental Health Disorders

A new partnership opportunity was solidified in the fall of 2019 with peer support agency partner, Hope for NH Recovery. According to Mental Health America, both quantitative and qualitative research indicates that peer support lowers the overall cost of behavioral health services by reducing re-

hospitalization rates and days spent in inpatient services, increasing the use of outpatient services. Peer support improves quality of life, increases patient engagement and self-management, and increases whole health. Best practice theories believe that there are multiple ways to recovery, and peer support services are an important element of non-clinical support delivered by trained individuals, often with lived experience, to help people to initiate or sustain self-defined recovery. The State of NH has developed a Certified Recovery Support Worker (CRSW) certification process that allows for non-clinical individuals to assist in screening for substance use disorders, monitor client health and safety, and provide practical, non-intensive supports and education. The number of individuals certified as CRSWs at Network4Health partner organizations has greatly increased and multiple agencies now provide recovery coaching, telephone recovery support, crisis intervention, and systems navigation services.

Hope for NH, a Recovery Community Center, offers “a safe judgement free space and peer support to those who are seeking recovery, family and friends of, or those who are in recovery themselves that know the importance of giving back...main focus is to help people learn to get comfortable in their recovery utilizing a non-clinical peer to peer based approach”. Currently, there are seven days of peer support run meetings available at the Manchester location offering a broad range of wellness based recovery meetings for individuals along the continuum of recovery- from those thinking about making a change, to those who are well established in their recovery program. The Hope for NH team agreed to introduce a new meeting, “Double Trouble in Recovery” (DTR), as there was no specifically identified meeting that addressed the interaction of mental health and substance use. DTR is a peer run twelve step group that focuses on co-occurring disorders. Historically, individuals managing a co-occurring disorder face an increased stigma, while exploring and managing their recovery process, and those who use medication to aid in their recovery process, often struggle to find support in traditional 12-step meetings as there has been a belief that an individual must be free of *all* substances in order to truly reach recovery.

Double Trouble in Recovery (DTR) is “a fellowship of men and women who share their experience, strength and hope with one another so that they may solve their common problems and help others to recover from their particular co-occurring addiction(s) and mental disorders. It seeks to address the problems and benefits associated with psychiatric medication as well as other issues crucial to mental health...”. DTR is unique in that it can be initiated by an individual (including clinicians), who may or may not be in recovery themselves; with the ultimate goal of transitioning the group to a traditionally run peer model, once established.

CRSW staff from Hope for NH reviewed Double Trouble in Recovery group materials, created the group and facilitated initial sessions with the intent that staff would step back and the group would transition to a traditional peer run group, as intended for all of Hopes’ meetings. The group was started in November 2019, with an average attendance of approximately twelve peers. The group has now transitioned to being self-led with support from Hope for NH staff as needed.

To further strengthen the Hope for NH team and enhance their ability to identify and provide support for peers with co-occurring mental health and substance use disorder, a decision was made in October 2019 to also support supervision efforts of Hope for NH staff to maintain or work towards their Certified Recovery Support Worker (CRSW) certification. Weekly group supervision and peer collaboration has been implemented on-site with a master’s level licensed alcohol and drug counselor (MLADC) providing supervision.

Co-occurring Disorders Training and Support for Primary Care and Community Based Organizations

Through the E4 project, Network4Health provides evidence-based training to support the increased understanding of substance use disorder, mental health disorders and co-occurring disorders to our primary care and community support partners. The following trainings were supported through the E4 project funds during the July – December 2019 reporting period. A listing of all attendees can be found in Attachment_E4.1

- Substance Use Disorder and Mental Health Topics
 - Non-Suicidal Self Harm was presented by Kimberly Bindas of NH Healthy Families, Clinical Training Department offered on 9/26/2019. There was one attendee.
 - Poverty Competence was presented by Kimberly Bindas of NH Healthy Families, Clinical Training Department offered on 8/26/2019. There was one attendee.
 - 104 Correctional Staff from the Hillsborough County Department of Corrections attended Trauma Informed Responses for Criminal Justice Professionals over multiple course dates.
- Adult Mental Health First Aid
 - Eight staff from two partner agencies (Elliot and Catholic Medical Center) attended Adult Mental Health First Aid, delivered by trainers from partner agency The 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 July – December 2019:
 - July: First Responders. Materials included compassion fatigue and psychological First Aid for First Responders along the continuum, as well as tips for supporting and identifying behavioral health concerns in the First Responder Community.
 - August: Preparing for National Recovery Month. Materials included media samples, event ideas and a toolkit for sharing information.
 - September: Overdose Recognition and Response. Materials included infographics on recognizing and responding to an overdose, information for people who inject drugs on reducing risk or overdose and Naloxone facts.
 - October: Alcohol and health. Materials included information on the interactions between alcohol and energy drinks, as well as alcohol’s effects on both behavioral and physical health.
 - November: Caregiver Support. Materials included a toolkit to help support family and friends who care for individuals with Co-Occurring Disorders.
 - December: ITCOD Project Updates with a focus on Peer Support Agencies in our Network. Materials included an overview of available peer support agencies, their services and who they are designed to serve including referral processes.
- Network4Health’s Co-occurring Disorders Clinical Director applied for a national solicitation and was accepted into a Train the Trainer Event hosted by the SAMHSA GAINS Center: “How Being Trauma-Informed Improves Criminal Justice System Responses”. The Trauma training is designed to be highly interactive and is specifically tailored to community-based criminal justice professionals, including police officers, community corrections personnel, and court personnel. The goal 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 Co-occurring Disorders Clinical Director began outreach to applicable partner agencies shortly after attending the Train the Trainer event, and has provided the training at Hillsborough County Department of Corrections to 104 staff members (see Attachment_E4.1). Feedback from attendees has been positive:

“Dynamic and interesting...could listen all day”

“Information was helpful...will help me think before I respond and help change attitudes”

“Information was relevant and will be used frequently”

“Slow down our approach and help others to do so”

“Feel more confident to identify the signs (of trauma) and adjust our approach”

Progress Assessment

Community of Practice

The Integrated Treatment of Co-occurring Disorders Community of Practice; made up of representatives from all DDC Assessed agencies, continues to meet twice a year with at least one representative from each E4 participating program, though most programs send multiple team members. As a follow-up to the January to June 2019 Community of Practice, the E4 project sponsored two sessions of the second module on Motivational Interviewing Resources for Clinical Supervisors with the 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. Live webinars were offered on July 10, 2019 and July 17, 2019. Representatives from all Network4Health partner programs that had completed a Dual Diagnosis Capability assessment participated in the learning webinar in July 2019. Module 2 provided participants with expanded resources and suggested practices. The trainings were popular with attendees and another set of web based trainings will be organized for the 2020 Community of Practice sessions.

Advisory Board

The Integrated Treatment of Co-occurring Disorders Advisory Board held its second biannual meeting in November 2019 to review the accomplishments of the project, discuss funding levels and brainstorm how best to support E4 project partners with continued progression of integrated treatment services. Additionally, the group discussed program training goals for the final waiver year. The continued uncertainty regarding funding availability has made it difficult for the Advisory Board to solidify plans for continued efforts beyond the end date of the current quality improvement plans between April- June 2020 (4 partners), July 2020 (1 partner) and December 2020 (1 partner) respectively. The Advisory Board supported Network4Health’s proposed plan to not schedule any new Dual Diagnosis Capability assessments in 2020 until the uncertainty of waiver program funding has been resolved. It was also decided that re-assessment of programs for year 2 quality improvement plan funding would be scheduled once funding uncertainty is resolved. Network4Health’s Director of Co-occurring Disorders will focus on working with each participating program to complete their existing quality improvement plan and create a plan for continued progression within the program.

The final activity of the Advisory Board was to confirm moving forward with trainings for 2020 with Dr. David Mee-Lee. Dr. Mee-Lee, a psychiatrist, is a leading expert in co-occurring substance use and mental disorders with over 40 years of experience in person-centered treatment and program development. Dr. Mee-Lee will be providing two trainings to Network4Health participants in April 2020: What Using the ASAM Criteria Really Means: Skill-Building and Systems Change and Integrated Co-Occurring Disorders

Services: Assessment, Staff, Skills and Systems Issues.

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>The following targets have been identified in current Quality Improvement Plans:</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 staff(Target for 2019)</p> <p><u>Treatment Planning and Client/Family Engagement</u> FIT-NH – up to 20 staff</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> 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>	<p><u>Motivational Interviewing I:</u> CLM:31 staff FIT- NH: 34 staff MHCGM: 54 staff PCS:8 staff</p> <p><u>Motivational Interviewing for Supervisors:</u> CLM: 20 staff FIT-NH: 8 staff MHCGM: 11 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: 14 staff FIT-NH: 26 staff MHCGM: 63 PCS: 45 staff Elliot PHP: 7 staff</p> <p><u>Treatment Planning, Client/Family Engagement</u> FIT-NH: 21</p>
The number of staff trained as Program Leaders for Integrated Treatment of Co-Occurring Disorders programs.	Up to 25 in 2018	19	19	19

Performance Measure	Target	Progress Toward Target		
<p>The number of organizations assessed for fidelity to evidence based practice for the integrated treatment of co-occurring disorders.</p> <p>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"> • Addiction-only services (AOS) • Mental Health-only services (MHOS) • Dual-diagnosis capable (DDC) <ul style="list-style-type: none"> ○ AOS/DDC ○ MHOS/DDC ○ DDC • Dual-diagnosis enhanced (DDE) <ul style="list-style-type: none"> ○ DDC/DDE ○ DDE 	<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>	<p>2 additional organizational programs assessed (total 10)</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	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"> 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) <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><u>MHCGM:</u> 1/2018-12/2018: 696 clients</p> <p><u>FIT-NH:</u> 1/2018-12/2018: 322 clients</p> <p><u>CLM:</u> 1/2018-12/2018: 313 clients</p> <p><u>PCS:</u> 1/2018-12/2018: 49 clients</p> <p><u>Parkland:</u> 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><u>MHCGM:</u> 7/2018-6/2019: 761 clients</p> <p><u>FIT-NH:</u> 7/2018-6/2019: 435 clients</p> <p><u>CLM:</u> 7/2018-6/2019: 407 clients</p> <p><u>PCS:</u> 7/2018-6/2019: 33 clients</p> <p><u>Parkland:</u> 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><u>MHCGM:</u> 01/2019-12/2019: 768 clients</p> <p><u>FIT-NH: Willows</u> 01/2019-12/2019: 385 clients</p> <p><u>CLM:</u> 01/2019-12/2019: 406 clients</p> <p><u>PCS:</u> 01/2019-12/2019: 54 clients</p> <p><u>Elliot PHP:</u> 01/2019-12/2019: 135 clients</p> <p><u>FIT-NH: Open Doors</u> 01/2019-12/2019: 55 clients</p> <p><u>CMC: BH Adult Services</u> Reporting to begin after completion of Quality Improvement Plan (QIP) in 2020.</p> <p><u>Parkland:</u> Reporting to begin after completion of Quality Improvement Plan (QIP). QIP is TBD.</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 E4 Integration Focused- Integration of Co-occurring Disorders Treatment project budget is presented below. Modifications have been made based on the following factors:

Revenue- Project budgets reflect the actual funding received. Potential, but not yet received, funding is projected in subsequent reporting periods. If expected revenue is reduced or eliminated as a result of ongoing negotiations with NH counties, or due to unmet performance metrics, Network4Health shall revise budget and project plan deliverables subject to its Steering Committee and NH DHHS approval.

Expenses- Actual expenses (paid and invoices received) through December 2019 are presented. Anticipated expenses for the remaining waiver term are also presented. Given that final incentive funding is not expected to be received until mid to late 2021, we have projected expenses in that time period.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 (Yr3)	ACTUAL CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
E4 INTEGRATED TX COD Revenue (New)	\$ 230,012	\$ 174,809	\$ 357,098	\$ 618,183	\$ 477,085
E4 INTEGRATED TX COD Revenue (Rollover)		\$ 221,683	\$ 330,197	\$ 455,101	\$ 282,769
Total Revenue	\$ 230,012	\$ 396,492	\$ 687,295	\$ 1,073,284	\$ 759,854
Assessor Participation Offset (Training and Assessment Time)	\$ 6,848	\$ 2,970	\$ 2,729	\$ 25,000	\$ 25,000
Program Leader Training		\$ 6,160			
Leader Training and Attendee Participation Offset				\$ 22,659	
Quality Improvement Plan Funds		\$ 39,891	\$ 223,168	\$ 696,000	\$ 688,000
Assessor Training Course Development and Delivery			\$ -	\$ 3,150	\$ 3,150
Tools & Training for Primary Care and Community Support		\$ 14,184	\$ 3,606	\$ 40,000	\$ 40,000
Technology (Laptop, Phone, etc.)	\$ 1,218	\$ 1,515	\$ 919	\$ 1,694	\$ 1,694
Occupancy	\$ 263	\$ 1,575	\$ 1,772	\$ 2,012	\$ 2,012
Total Expenses	\$ 8,329	\$ 66,295	\$ 232,194	\$ 790,515	\$ 759,856
Variation to Budget (Transfer Funds to Subsequent Year)	\$ 221,683	\$ 330,197	\$ 455,101	\$ 282,769	\$ (2)

**Training Attendance Tracking July to December 2019
Network4Health Project E4**

Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
1	Addiction & Recovery- QIP Activity	11/7/2019	Families in Transition/New Horizons	Intake coordinator	4
2	Addressing the Burden of Adult ADHD- QIP Activity	12/3/2019	Pastoral Counseling Services	Clinician	4
3	Adult Mental Health First Aid	7/1 and 7/2/2019	Amoskeag Family Practice/CMC	Care Navigator	4
4	Adult Mental Health First Aid	7/1 and 7/2/2019	CMC	Scheduling Coordinator	4
5	Adult Mental Health First Aid	7/1 and 7/2/2019	CMC	RN	4
6	Adult Mental Health First Aid	7/1 and 7/2/2019	Elliot Partial Hospitalization Program	Case Manager	4
7	Adult Mental Health First Aid	7/1 and 7/2/2019	Family Physicians of Manchester/CMC	Care Coordinator/RN	4
8	Adult Mental Health First Aid	7/1 and 7/2/2019	Granite State Internal Medicine/CMC	Care Coordinator/RN	4
9	Adult Mental Health First Aid	7/1 and 7/2/2019	Webster St Internal Medicine	Care Coordinator/RN	4
10	Adult Mental Health First Aid	7/1 and 7/2/2019	Willowbend Family Practice/CMC	Care Navigator	4
11	Advance Ethics and Clinical Practice - QIP Activity	10/4/2019	Families in Transition/New Horizons	Clinician	4
12	Advanced Ethics and Clinical Practice	10/4/2019	Families in Transition/New Horizons	VP/Clinical Services	4
13	Advancing use of Digital Technologies in Addiction Management Strategies - QIP Activity	11/19/2019	Pastoral Counseling Services	Clinician	4
14	Affirmative Treatment , LGBTQ and Recovery - QIP Activity	10/30/2019	Pastoral Counseling Services	Clinician	4
15	Anxiety And Stress Management for Adolescents - QIP Activity	9/18/2019	Pastoral Counseling Services	Clinician	4
16	ASAM Criteria - QIP Activity	9/4 and 9/5/2019	Families in Transition/New Horizons	Clinician	4
17	ASAM Criteria - QIP Activity	9/4 and 9/5/2019	Families in Transition/New Horizons	Clinician	4
18	Behavioral Health and Co-Occuring Disorders- QIP Activity	9/23/2019	Families in Transition/New Horizons	Clinician	4
19	Behavioral Health Summit- QIP Activity	12/16-17/2019	Families in Transition/New Horizons	Clinician	4

**Training Attendance Tracking July to December 2019
Network4Health Project E4**

Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
20	<i>Behavioral Health Summit- QIP Activity</i>	<i>12/16-17/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Program Manager</i>	<i>4</i>
21	<i>Behavioral Health Summit- QIP Activity</i>	<i>12/16-17/2019</i>	<i>Families in Transition/New Horizons</i>	<i>President</i>	<i>4</i>
22	<i>Behavioral Health Summit- QIP Activity</i>	<i>12/16-17/2019</i>	<i>Families in Transition/New Horizons</i>	<i>VP Clinical Services</i>	<i>4</i>
23	<i>BiPolar I Managing Comorbidities and Increasing Functional Ability</i>	<i>12/5/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
24	<i>Building Responsive Practices and Resiliency in the midst of Distress- QIP Activity</i>	<i>11/22/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
25	<i>Building Responsive Practices and Resiliency in the midst of Distress- QIP Activity</i>	<i>11/22/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Program Manager</i>	<i>4</i>
26	<i>Building Responsive Practices and Resiliency in the midst of Distress- QIP Activity</i>	<i>11/22/2019</i>	<i>Families in Transition/New Horizons</i>	<i>VP Clinical Services</i>	<i>4</i>
27	<i>Cannabis Use Disorder and Treatment: Medical Use - QIP Activity</i>	<i>9/4/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
28	<i>Case Management Employment Program- QIP Activity</i>	<i>11/18 & 11/19/19</i>	<i>Families in Transition/New Horizons</i>	<i>Case manager</i>	<i>4</i>
29	<i>Case Management Employment Program- QIP Activity</i>	<i>11/18 & 11/19/19</i>	<i>Families in Transition/New Horizons</i>	<i>Program Manager</i>	<i>4</i>
30	<i>Case Management Employment Program- QIP Activity</i>	<i>11/18 & 11/19/19</i>	<i>Families in Transition/New Horizons</i>	<i>Case manager</i>	<i>4</i>
31	<i>Case Management Employment Program- QIP Activity</i>	<i>11/18 & 11/19/19</i>	<i>Families in Transition/New Horizons</i>	<i>Case manager</i>	<i>4</i>
32	<i>Changing How We Feel by Changing How We Think- QIP Activity</i>	<i>9/12/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
33	<i>Cognitive Behavioral Therapy - QIP Activity</i>	<i>11/4/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
34	<i>Confidentiality and Ethical Practice- QIP Activity</i>	<i>9/19/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
35	<i>Confidentiality and Ethical Practice- QIP Activity</i>	<i>9/19/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>

**Training Attendance Tracking July to December 2019
Network4Health Project E4**

Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
36	CRSW Academy- QIP Activity	10/14, 10/16, 10/21, 10/23, 10/28, 10/30	Families in Transition/New Horizons	Case Manager	4
37	CRSW Academy- QIP Activity	10/14, 10/16, 10/21, 10/23, 10/28, 10/30	Families in Transition/New Horizons	Case Manager	4
38	Dialectical Behavioral Therapy - QIP Activity	10/24/2019	Families in Transition/New Horizons	Clinician	4
39	Dialectical Behavioral Therapy - QIP Activity	10/24/2019	Families in Transition/New Horizons		
40	Dialectical Behavioral Therapy - QIP Activity	10/24/2019	Pastoral Counseling Services	Clinician	4
41	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Case Manager	4
42	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Case Manager	4
43	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Clinician	4
44	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Case Manager	4
45	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Case Manager	4
46	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Clinician	4
47	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Case Manager	4
48	Effective Client and Family Engagement- QIP Activity	9/11/2019	Families in Transition/New Horizons	Case Manager	4
49	Ethics and Clinical Practice: A Review for Clinicians- QIP Activity	12/7/2019	Pastoral Counseling Services	Clinician	4
50	Ethics Training- QIP Activity	12/7/2019	Families in Transition/New Horizons	Clinician	4
51	Ethics Training- QIP Activity	12/7/2019	Families in Transition/New Horizons	Clinician	4
52	Ethics Training- QIP Activity	12/7/2019	Families in Transition/New Horizons	Clinician	4
53	Framing Young Adult Culture and Values- QIP Activity	9/20/2019	Families in Transition/New Horizons	Clinician	4

**Training Attendance Tracking July to December 2019
Network4Health Project E4**

Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
54	HIV Update for Substance Use Professionals- QIP Activity	10/7/2019	Pastoral Counseling Services	Clinician	4
55	HIV Update for Substance Use Professionals- QIP Activity	10/7/2019	Pastoral Counseling Services	Clinician	4
56	HIV Update for Substance Use Professionals- QIP Activity	10/7/2019	Pastoral Counseling Services	Clinician	4
57	Human Trafficking- QIP Activity	8/15/2019	Families in Transition/New Horizons	Clinician	4
58	I'm a Millennial Framing Youth Culture- QIP Activity	9/20/2019	Families in Transition/New Horizons	Clinician	4
59	Individualized Service Plans using ASAM and MI- QIP Activity	09/04 + 05/2019	Families in Transition/New Horizons	Clinician	4
60	Individualized Service Plans using ASAM and MI- QIP Activity	09/04 + 05/2019	Families in Transition/New Horizons	Clinician	4
61	Individualized Service Plans using ASAM and MI- QIP Activity	09/04 + 05/2019	Families in Transition/New Horizons	Clinician	4
62	Initial Training on Addiction and Recovery	11/6/2019	Families in Transition/New Horizons	Case Manager	4
63	Integrated Dual Disorders Treatment	12/5/2019	Unknown	Unknown	4
64	Integrated Dual Disorders Treatment	12/5/2019	Unknown	Unknown	4
65	Integrated Dual Disorders Treatment	12/5/2019	Unknown	Unknown	4
66	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Clinician	4
67	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Clinician	4
68	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Nurse Practitioner	4
69	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Clinician	4
70	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Clinician	4
71	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Clinician	4
72	Integrated Dual Disorders Treatment- QIP Activity	12/5/2019	Mental Health Center of Greater Manchester	Clinician	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
73	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
74	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
75	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
76	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
77	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
78	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
79	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
80	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
81	<i>Integrated Dual Disorders Treatment- QIP Activity</i>	<i>12/5/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
82	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
83	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
84	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
85	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
86	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
87	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>

**Training Attendance Tracking July to December 2019
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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
88	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
89	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
90	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
91	<i>Legal and Ethical Issues with Technology in Mental Health- QIP Activity</i>	<i>12/20/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
92	<i>Listen, Empathize, Agree, Partner- QIP Activity</i>	<i>8/29/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
93	<i>Management of Aggressive Behavior- QIP Activity</i>	<i>10/22/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Program Manager</i>	<i>4</i>
94	<i>Management of Aggressive Behavior- QIP Activity</i>	<i>10/22/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Program Manager</i>	<i>4</i>
95	<i>Management of Aggressive Behavior- QIP Activity</i>	<i>10/22/2019</i>	<i>Families in Transition/New Horizons</i>	<i>VP Clinical Services</i>	<i>4</i>
96	<i>MAT Project ECHO - QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
97	<i>MAT Project ECHO - QIP Activity</i>	<i>11/20/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Case Manager</i>	<i>4</i>
98	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
99	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Nurse Practitioner</i>	<i>4</i>
100	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>QI</i>	<i>4</i>
101	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
102	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Clinician</i>	<i>4</i>
103	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Nurse Practitioner</i>	<i>4</i>
104	<i>MAT Project ECHO Session 8- QIP Activity</i>	<i>10/16/2019</i>	<i>Mental Health Center of Greater Manchester</i>	<i>Nurse Practitioner</i>	<i>4</i>

**Training Attendance Tracking July to December 2019
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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
105	MAT Project ECHO Session 8- QIP Activity	10/16/2019	Mental Health Center of Greater Manchester	Clinician	4
106	MAT Project ECHO Session 8- QIP Activity	10/16/2019	Mental Health Center of Greater Manchester	Clinician	4
107	MAT Project ECHO Session 8- QIP Activity	10/16/2019	Mental Health Center of Greater Manchester	Clinician	4
108	MAT Project ECHO Session 8- QIP Activity	10/16/2019	Mental Health Center of Greater Manchester	Nurse Practitioner	4
109	MAT Project ECHO Session 8- QIP Activity	10/16/2019	Mental Health Center of Greater Manchester	MD	4
110	MAT Project ECHO Session 8- QIP Activity	11/20/2019	Mental Health Center of Greater Manchester	Clinician	4
111	MAT Project ECHO Session 8- QIP Activity	11/20/2019	Mental Health Center of Greater Manchester	Peer	4
112	MAT Project ECHO Session 8- QIP Activity	11/20/2019	Mental Health Center of Greater Manchester	Clinician	4
113	MDD: Addressing the Needs of Patients with CoMorid Disorders- QIP Activity	12/5/2019	Pastoral Counseling Services	Clinician	4
114	Medication Training- QIP Activity	11/5/2019	Families in Transition/New Horizons	Case Manager	4
115	MITI Coding- QIP Activity	9/1/2019	Mental Health Center of Greater Manchester	Coordinator	4
116	MITI Coding- QIP Activity	9/1/2019	Mental Health Center of Greater Manchester	Coordinator	4
117	MITI Coding- QIP Activity	9/1/2019	Mental Health Center of Greater Manchester	Clinician	4
118	MITI Coding- QIP Activity	9/1/2019	Mental Health Center of Greater Manchester	Clinician	4
119	Motivational Interviewing	11/1/2019	Private Practice	Clinician	4
120	Motivational Interviewing	11/1/2019	Psychiatric Wellness Center	Clinician	4
121	Motivational Interviewing	11/1/2019	Unknown	Unknown	4
122	Motivational Interviewing for Adolescents- QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
123	Motivational Interviewing for Adolescents- QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
124	Motivational Interviewing for Adolescents- QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4

**Training Attendance Tracking July to December 2019
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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
125	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
126	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
127	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
128	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Asst. Coordinator	4
129	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
130	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
131	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
132	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
133	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
134	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
135	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
136	Motivational Interviewing for Adolescents-QIP Activity	10/8/2019	Mental Health Center of Greater Manchester	Clinician	4
137	Motivational Interviewing for Supervisors (II)-QIP Activity	7/10/2019	Mental Health Center of Greater Manchester	Coordinator	4
138	Motivational Interviewing for Supervisors (II)-QIP Activity	7/10/2019	Mental Health Center of Greater Manchester	Coordinator	4
139	Motivational Interviewing for Supervisors (II)-QIP Activity	7/10/2019	Mental Health Center of Greater Manchester	Coordinator	4
140	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Case Manager	4
141	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Clinician	4
142	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Clinician	4
143	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Case Manager	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
144	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Case Manager	4
145	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Asst. Coordinator	4
146	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Case Manager	4
147	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Case Manager	4
148	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Clinician	4
149	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Clinician	4
150	Motivational Interviewing Intermediate- QIP Activity	9/18/2019	Mental Health Center of Greater Manchester	Case Manager	4
151	Motivational Interviewing- QIP Activity	11/1/2019	Families in Transition/New Horizons	Unknown	4
152	Motivational Interviewing- QIP Activity	11/1/2019	Families in Transition/New Horizons	Unknown	4
153	Motivational Interviewing- QIP Activity	11/1/2019	Families in Transition/New Horizons	Unknown	4
154	Motivational Interviewing- QIP Activity	11/1/2019	Families in Transition/New Horizons	Unknown	4
155	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
156	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
157	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
158	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
159	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
160	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
161	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
162	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
163	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Peer	4
164	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
165	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
166	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
167	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
168	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
169	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
170	Motivational Interviewing- QIP Activity	11/1/2019	Mental Health Center of Greater Manchester	Clinician	4
171	New England School of Addiction Studies: School of Best Practices- QIP Activity	8/19-22/2019	Families in Transition/New Horizons	Clinician	4
172	Non-Suicidal Self Harm	9/26/2019	Mental Health Center of Greater Manchester	Director, ITCOD	4
173	Opioids and Marijuana - QIP Activity	7/18/2019	Families in Transition/New Horizons	Clinician	4
174	Parent Child Psychotherapy - QIP Activity	9/16-18/2019	Families in Transition/New Horizons	Clinician	4
175	Parent Child Psychotherapy - QIP Activity	9/16-18/2019	Families in Transition/New Horizons	Clinician	4
176	Poverty Competence	8/26/2019	Families in Transition/New Horizons	Housing Advocate	4
177	Privacy Protection forAddiction Treatment Providers Using IT- QIP Activity	12/17/2019	Pastoral Counseling Services	Clinician	4
178	PTSD and Military - QIP Activity	11/13/2019	Pastoral Counseling Services	Clinician	4
179	Rational Emotive Behavioral Therapy- QIP Activity	11/19/2019	Families in Transition/New Horizons	Clinician	4
180	Recovery and Medication Assisted Treatment - QIP Activity	10/23/2019	Pastoral Counseling Services	Clinician	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
181	Recovery Coach Academy- QIP Activity	10/19/2019	Families in Transition/New Horizons	Support staff	4
182	Schizophrenia and Medication Non-Compliance- QIP Activity	10/28/2019	Pastoral Counseling Services	Clinician	4
183	SMART Recovery- QIP Activity	12/19/2019	Families in Transition/New Horizons	Treatment Coordinator	4
184	SMART Recovery- QIP Activity	12/19/2019	Families in Transition/New Horizons	Treatment Coordinator	4
185	Substance Abuse Counselor Ethics, Confidentiality and Boundaries - QIP Activity	11/27/2019	Pastoral Counseling Services	Clinician	4
186	Substance Use Counseling Skills and Core Functions - QIP Activity	11/1/2019	Pastoral Counseling Services	Clinician	4
187	Substance Use Counseling Skills and Core Functions - QIP Activity	11/1/2019	Pastoral Counseling Services	Clinician	4
188	Substance Use Counseling Skills and Core Functions - QIP Activity	11/1/2019	Pastoral Counseling Services	Clinician	4
189	Substance Use Disorder in Older Adults- QIP Activity	10/28/2019	Families in Transition/New Horizons	Clinician	4
190	Success Outcomes of an Integrated Dual Disorders Program - QIP Activity	10/24/2019	Pastoral Counseling Services	Clinician	4
191	SUD Overview: Caffeine and Benzodiazepines- QIP Activity	11/22/2019	Pastoral Counseling Services	Clinician	4
192	SUD Overview: Caffeine and Benzodiazepines- QIP Activity	11/22/2019	Pastoral Counseling Services	Clinician	4
193	SUD Overview: Caffeine and Benzodiazepines- QIP Activity	11/22/2019	Pastoral Counseling Services	Clinician	4
194	SUD Overview: Caffeine and Benzodiazepines- QIP Activity	11/22/2019	Pastoral Counseling Services	Clinician	4
195	SUD Overview: Caffeine and Benzodiazepines- QIP Activity	11/22/2019	Pastoral Counseling Services	Clinician	4
196	SUD Overview: Inhalants and Hallucinogens- QIP Activity	10/18/2019	Pastoral Counseling Services	Clinician	4
197	SUD Overview: Inhalants and Hallucinogens- QIP Activity	10/18/2019	Pastoral Counseling Services	Clinician	4
198	SUD Overview: Inhalants and Hallucinogens- QIP Activity	10/18/2019	Pastoral Counseling Services	Clinician	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
199	<i>SUD Overview: Inhalants and Hallucinogens- QIP Activity</i>	10/18/2019	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	4
200	<i>SUD Overview: Inhalants and Hallucinogens- QIP Activity</i>	10/18/2019	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	4
201	<i>SUD Overview: Inhalants and Hallucinogens- QIP Activity</i>	10/18/2019	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	4
202	<i>SUD Overview: Inhalants and Hallucinogens- QIP Activity</i>	10/18/2019	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	4
203	<i>Suicide Prevention Training- QIP Activity</i>	12/11/2019	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	4
204	<i>Suicide Prevention Training- QIP Activity</i>	12/11/2019	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	4
205	<i>Suicide Prevention Training- QIP Activity</i>	12/11/2019	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	4
206	<i>Suicide Prevention Training- QIP Activity</i>	12/11/2019	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	4
207	<i>The Brain in Addiction Treatment - QIP Activity</i>	7/30/2019	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	4
208	<i>The Impact of Our Work-Compassion Fatigue and Vicarious Trauma</i>	9/13/2019	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	4
209	<i>The Role of Self in Psychotherapy- QIP Activity</i>	9/24/2019	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	4
210	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Disciplinary Officer</i>	4
211	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Field Training Officer</i>	4
212	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Lieutenant</i>	4
213	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Sergeant</i>	4
214	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Sergeant</i>	4
215	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Sergeant</i>	4
216	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	9/30/2019	<i>Hillsborough County Department of Corrections</i>	<i>Deputy Chief of Security</i>	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
217	Trauma Informed Responses for Criminal Justice Professionals	9/30/2019	Hillsborough County Department of Corrections	Supervisor, Classifications	4
218	Trauma Informed Responses for Criminal Justice Professionals	9/30/2019	Hillsborough County Department of Corrections	Director, Training	4
219	Trauma Informed Responses for Criminal Justice Professionals	9/30/2019	Hillsborough County Department of Corrections	Lieutenant	4
220	Trauma Informed Responses for Criminal Justice Professionals	9/30/2019	Hillsborough County Department of Corrections	Supervisor, Housekeeping	4
221	Trauma Informed Responses for Criminal Justice Professionals	9/30/2019	Hillsborough County Department of Corrections	Field Training Officer	4
222	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
223	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
224	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
225	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
226	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
227	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4
228	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
229	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
230	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
231	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
232	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4
233	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
234	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
235	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
236	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
237	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
238	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
239	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4
240	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
241	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4
242	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
243	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
244	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
245	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
246	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4
247	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Field Training Officer	4
248	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Captain	4
249	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Sergeant	4
250	Trauma Informed Responses for Criminal Justice Professionals	10/2/2019	Hillsborough County Department of Corrections	Lieutenant	4
251	Trauma Informed Responses for Criminal Justice Professionals	11/18/2019	Hillsborough County Department of Corrections	Correctional Officer	4
252	Trauma Informed Responses for Criminal Justice Professionals	11/18/2019	Hillsborough County Department of Corrections	Correctional Officer	4
253	Trauma Informed Responses for Criminal Justice Professionals	11/18/2019	Hillsborough County Department of Corrections	Correctional Officer	4
254	Trauma Informed Responses for Criminal Justice Professionals	11/18/2019	Hillsborough County Department of Corrections	Correctional Officer	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
255	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
256	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
257	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
258	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
259	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
260	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
261	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
262	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
263	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
264	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/18/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
265	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
266	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
267	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
268	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
269	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
270	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
271	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
272	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
273	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
274	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/25/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
275	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
276	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
277	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
278	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
279	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
280	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
281	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
282	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
283	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
284	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
285	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	11/27/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
286	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
287	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
288	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4

**Training Attendance Tracking July to December 2019
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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
289	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
290	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
291	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
292	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Nursing Staff</i>	4
293	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
294	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
295	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
296	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
297	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Nursing Staff</i>	4
298	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
299	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Mental Health Worker</i>	4
300	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
301	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Nursing Staff</i>	4
302	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
303	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4
304	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	12/4/2019	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	4

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
305	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	<i>4</i>
306	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Facilities</i>	<i>4</i>
307	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	<i>4</i>
308	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Nursing Staff</i>	<i>4</i>
309	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	<i>4</i>
310	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Nursing Staff</i>	<i>4</i>
311	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	<i>4</i>
312	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Correctional Officer</i>	<i>4</i>
313	<i>Trauma Informed Responses for Criminal Justice Professionals</i>	<i>12/4/2019</i>	<i>Hillsborough County Department of Corrections</i>	<i>Nursing Staff</i>	<i>4</i>
314	<i>Trauma, Shame and Addiction - QIP Activity</i>	<i>9/12/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>
315	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
316	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
317	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Case Manager</i>	<i>4</i>
318	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Case Manager</i>	<i>4</i>
319	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
320	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Case Manager</i>	<i>4</i>
321	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Case Manager</i>	<i>4</i>
322	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
323	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Case Manager</i>	<i>4</i>

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Unique Attendee #	Course Name	Date(s)	Organization	Role	IDN
324	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
325	<i>Treatment Planning- QIP Activity</i>	<i>8/15/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
326	<i>Twelve Core Functions of a Substance Abuse Counselor- QIP Activity</i>	<i>11/1/2019</i>	<i>Families in Transition/New Horizons</i>	<i>Clinician</i>	<i>4</i>
327	<i>Unmet Needs in Managing Major Depressive Disorder- QIP Activity</i>	<i>10/11/2019</i>	<i>Pastoral Counseling Services</i>	<i>Clinician</i>	<i>4</i>

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 and planning opportunities related to Alternative Payment Models (APM) include:

- All Partner Learning Collaborative, August 20, 2019, "New Hampshire State of Care: Local, Integrated and Accountable". Several Network4Health partners participated in this quarterly learning collaborative meeting that included a presentation by the NH DHHS Associate Commissioner of Population Health and the Medicaid Director. Included in the presentation was a discussion of the NH Medicaid Managed Care Organizations contractual responsibilities relative to Alternative Payment Models and alignment with the goals of the NH Transformation Waiver. Information available from this meeting was shared with our Network4Health B1 Integrated Care partners.
- Network4Health leadership participated in a webinar hosted by the Region 3 Integrated Delivery Network on "Building Blocks for Success in the New Value Based Market" presented by Open Minds. The presentation included an overview, national/state trends and transition considerations for providers. Actual case examples were utilized. Information from the webinar was shared among Network4Health staff and partners.
- Our two community mental health center partners- Center for Life Management and The Mental Health Center of Greater- continue to participate 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.

- Several Network4Health B1 Integrated Care partners have participated in the NH DHHS supported Billing and Coding Workgroup which includes consideration of implications for value based payments.
- Network4Health B1 project leadership shared slides with our network partners from a presentation to the NH Legislative Commission on Primary Care provided by the Director of the UNH Institute for Health Policy and Practice in December 2019. The presentation title was “Alternative Payment Models (APM) Highlights and Updates”.
- Network4Health cohosted a statewide meeting of NH integrated delivery network staff, NH Department of Health and Human Services (DHHS) staff as well as the three Medicaid Managed Care Organizations to learn about the Community Pathways HUB model of care. A presentation was made by one of the model founders and a leader of the Community Pathways HUB Institute in Ohio. The morning session included a comprehensive overview of the Pathways HUBs. The afternoon was a meeting of integrated delivery network leadership, network partners and NH DHHS to explore the potential of the model as part of sustainability planning for NH integrated delivery networks. The discussion included the potential for value based payments in the provision and completion of clinical pathways. Subsequent planning has occurred to identify opportunities to pilot the model.

Network4Health staff continue to meet the three Medicaid Managed Care Organizations. Meetings include 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. The Network4Health Steering Committee monitors all Network4Health activities in support of the pursuit of alternative payment models that support the goals of the Waiver including a service delivery system that is integrated and includes primary care, mental health care, substance use disorder treatment and social health care.